ANZICS Centre for Outcome and Resource Evaluation

ANZPICR Data Dictionary

AUSTRALIAN AND NEW ZEALAND PAEDIATRIC INTENSIVE CARE REGISTRY

Version 3.0
January 2026

Contents

1. Overview

The aim of the Registry is to establish and maintain a secure and confidential high quality clinical database of paediatric intensive care activity, case mix, structure and utilisation, which will facilitate:

- Identification of best practice
- Monitoring of supply and demand
- Monitoring and review of outcomes of treatment episodes
- Strategic planning and resource requirements

Study of the epidemiology of critical illness in children

Standardised national information about activity and outcomes in this area is vital. Only by collecting standardised data will it be possible to ensure the comparison of 'like with like' at a national level.

ANZPIC Registry

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Data Collection Rules

The Dataset
Following input from paediatric intensive care units in Australia and New Zealand, the minimum Registry dataset has been agreed by the ANZICS Paediatric Study Group and the ANZPIC Registry Clinical Advisory Committee.

Admission Information
Identifier, socio-demographic and source information from the time period prior to admission to your unit and at admission to your unit.

Diagnoses and Procedures
Reason(s) for admission to your unit plus any associated diagnoses. The Principal Diagnosis (PDX) is collected as the main reason for ICU admission, the Underlying Diagnosis (UDX) records the root cause leading to admission, and Associated Diagnoses (ADX) capture procedures, adverse events, or morbidities that are pre-existing, acute on admission, or develop during the ICU stay.

PIM2 & PIM3
The Paediatric Index of Mortality risk model versions 2 & 3 (PIM2 & PIM3) are based on fields of data related to diagnoses, admission information, as well as physiology data collected from the time of first contact with your unit doctor (or specialist paediatric retrieval team) to one hour after admission to your unit.

Medical History
Specific acute or chronic conditions documented prior to admission, and/or at admission, and during the admission to your unit.

Physiology
Physiology data collected from the time of first contact with your unit doctor (or specialist paediatric retrieval team) to one hour after admission to your unit.

Intervention Record
A record of any interventions received by the patient during their stay on your unit.

Discharge Information
Outcome data at discharge from your unit and treating hospital.

Additional information
Additional information relevant to the admission.

Data Collection
Data are collected for all admissions/readmissions to PICUs regardless of severity of illness, reason for admission, length of stay etc. For non-PICUs, data are collected for all admissions/readmissions of patients less than 16 years of age. For NICU/PICUs, data are collected for all non-neonates, all cardiac neonates, and all neonates ≥ 35 weeks gestation (corrected). Data are collected for the same time periods for all admissions. There are no exclusions and no exceptions.

Data
Data that are measured and/or recorded in any part of the permanent written or electronic patient record are acceptable e.g. data from charts, case notes or any medium that comprises the permanent patient record. This excludes trends recorded on monitors that will not become part of the permanent patient record. This is based on the assumption that clinically important information is documented.

Summary of Changes in Version 3.0

Item	Description of Revision	Section	Page
SLK581	• Additional information included in collection method rules • '9 = unknown' option for the last character (Sex) has been removed	2.4	15
GEST_WEEKS	• Definition change: variable collected for patients ≤ 1 year old at ICU admission (previously was only collected for patients with a corrected age under 28 days) • Permissible value of 99 has been added • Additional information included in collection method rules	2.6	17
GEST_DAYS	Clarification of the data collection method	2.7	18
SEX	• The field previously labelled 'GENDER' has been renamed to 'SEX' • The code 'U' has been removed from the list of permissible values	2.8	19
IND_ORIGIN	The field became mandatory for records where IND_STATUS = 1	2.12	23
HOSP_OUT	Permissible value added: 7 – Transfer to hospice	2.16	27
IADM_SC	Additional information included in collection method rules	2.18	29
ELECTIVE	Additional information included in definition and collection method rules	2.20	31
RECOVERY	Clarification of the data collection method	2.23	34
FST_CONT	Clarification of the data collection method	2.25	36
DIS_DEC_DT	New data collection field added: ICU Discharge decision date/time	2.26	37
DIS_DT	Additional information included in collection method rules	2.27	38
PDX	Additional information included in collection method rules	3.1	43
UDX	• Included additional detail to the collection method rules in the context of SARS-CoV-2 (diagnostic code 749) • Additonal information on injury mechanism included in collection method rules: If the Principal Diagnosis is an injury, the Underlying Diagnosis should specify the injury mechanism.	3.2	44
CC_NEURO	Added ≥30-day rule to definition and collection method	3.4	46
CC_RESP	Added ≥30-day rule to definition and collection method	3.5	47

Item	Description of Revision	Section	Page
CC_GASTRO	Added ≥30-day rule to definition and collection method	3.6	48
CC_METABOL	Added ≥30-day rule to definition and collection method	3.7	49
CC_MALIG	Added ≥30-day rule to definition and collection method	3.8	50
CC_TECHDEP	Added ≥30-day rule to definition and collection method	3.9	51
CC_CARDIO	Added ≥30-day rule to definition and collection method	3.10	52
CC_RENAL	Added ≥30-day rule to definition and collection method	3.11	53
CC_HAEM	Added ≥30-day rule to definition and collection method	3.12	54
CC_CONGEN	Added ≥30-day rule to definition and collection method	3.13	55
CC_PREM	Added ≥30-day rule to definition and collection method	3.14	56
CC_TRANSPL	Added ≥30-day rule to definition and collection method	3.15	57
CC_MENTALH	Added ≥30-day rule to definition and collection method	3.16	58
PIM_LR	Clarification of the data collection method	4.1	61
PIM3_HR	• Clarification of the data collection method • Septic shock definition changed to Phoenix Criteria	4.2	63-64
PIM3_VHR	Clarification of the data collection method	4.3	65-66
SBPA	Clarification of the data collection method	5.1	69
RS_HR124	Clarification of the data collection method	5.10	78
PF	The field definition changed from 'Plasma Filtration' to 'Plasma Exchange'. The variable name remains PF.	7.4	86
ICPM	Clarification of the data collection method	7.8	90
ECLS_IND	Permissible value added: 8 – Other	7.11	93
ENT_NUT_DT	New data collection field added: Enteral Nutrition Commencement date/time	7.14	96
LIMIT_D	Clarification of the data collection method	8.5	102
GESTATION	The field has been retired	12.1	128
AD_STAN	The field has been retired	12.6	134
Appendix B	• One amendment to the list of diagnostic codes in Appendix B: ANZPIC Registry Diagnostic Codes Table - 749 (SARS-CoV-2) • The version date was updated from 2022 to 2026	13	142
Appendix C	Definition clarification: The condition must be diagnosed ≥30 days prior to ICU admission.	13	145

2. Admission

2.1. Hospital Identifier: SITE ID or PCODE

Definition	A unique identifier for a hospital

Data Element Attributes	
Source	ANZPICR
Context	Required to identify the hospital to which the patient was admitted for the episode of care which includes the current episode of ICU care.
Data Type	Integer
Format	NNN
Permissible Value	PCODE has maximum length 2 digits All ANZPICR sites have PCODE values < 90 International sites have values >= 90 Site ID has maximum length 3 digits
Missing/Null Value	n/a
Collection Method	The hospital identifier is assigned by ANZPICR. It is not included in the submission data but is held centrally by ANZPICR. Included here for information only.
Mandatory Field	Yes

Additional Comments	
Superseded Field	Hospital identifier will use field Site ID in CERS software. Site ID have superseded the PCODE as the hospital identifier. The PCODE is retained for historical data searches.

2.2. ANZPIC Registry ICU Number: ICU_NO

Definition	The number assigned to each separate episode of ICU care

Data Element Attributes	
Source	Hospital medical record / ICU database
Context	Provides a unique identifier for each admission to your unit. Provides differentiation if there is more than one episode of ICU care within a hospital admission.
Data Type	Integer
Format	NNNNNNNNNN
Permissible Value	Maximum length 10 digits
Missing/Null Value	n/a
Collection Method	For non-COMET sites, this field is an 8-digit sequential number where the first 4 digits are usually the year of admission, and the second 4 digits are usually a sequential admission count for the year. For COMET sites, this field is a 10-digit sequential number where the first 4 digits are usually the year of admission, and the second 6 digits are usually a sequential admission count for the year. The number is generated and assigned to each admission record when a patient is admitted to ICU and is software auto-generated. Examples: Non-COMET: The 31st admission in 2015 would usually have ICU_NO coded as 20150031 COMET: The 31st admission in 2015 would have ICU_NO coded as 2015000031
Mandatory Field	Yes

2.3. Medical Record Number: UR_NO

Definition	Unique identifying number for the patient within a hospital

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	Medical record number provides a unique identifier that can aid patient tracking throughout hospital stay/s, particularly when there are multiple admissions to ICU.
Data Type	Text
Format	Free text (e.g. HGX107525)
Permissible Value	Up to 15 characters
Missing/Null Value	n/a
Collection Method	Allocated on first admission to hospital
Mandatory Field	Yes

2.4. Statistical Linkage Key: SLK581

Definition	A statistical linkage key based on a patient's family name, given name, date of birth, and sex

Data Element Attributes	
Source	Auto-generated by data entry software (e.g. COMET) or CIS
Context	Required to enable linkage of episodes of care within the ANZPIC Registry, as well as between the ANZPIC Registry and other datasets, both within ANZICS CORE and external.
Data Type	Text
Format	Free text
Permissible Value	14 characters
Missing/Null Value	n/a
Collection method	This data element is used to enable data linkage while maintaining patient privacy. The SLK-581 is generated as follows: The SLK-581 format is: **XXXXXDDMMYYYYN** The sequence in which the linkage key is completed is as follows: Family name (the first 3 Xs) Given name (the 4th and 5th X) Date of birth by day, month and four-digit year Sex **[XXX]**XXDDMMYYYYN **- 2nd, 3rd and 5th letters of the family name.** In the first three spaces record the 2nd, 3rd and 5th letters of the patient's family name. Example: John S**mit**h = MIH. Short names: if the family name is not long enough to provide the 3 letters, place a '2' in the place of the missing character(s). Example: Ming L**ee** = EE2 Non-alphabetic characters: ignore non-alphabetic characters Example: John O'**Do**n**n**ell = DON Missing family name = enter 999 XXX**[XX]**DDMMYYYN **- 2nd and 3rd letters of given name** In the fourth and fifth spaces record the 2nd and 3rd letters of the patient's given name. Example: J**oh**n Smith = OH. Short names: if the given name is not long enough to provide the 2 letters, place a '2' in the place of the missing character(s). Example: J**o** Brown = O2

	Non-alphabetic characters: ignore non-alphabetic characters Example: J**o**-**a**nne Simons = OA Missing given name = enter 99 XXXXX**[DDMMYYYY]**N **- Date of Birth** The sixth through to the thirteenth characters represent the patient's date of birth. DD represents the day in the month a person was born. If the date is between 1-9, a leading zero should be entered (e.g., 03 for the third day). MM represents the month in the year a person was born. If the month is between 1-9, use a leading zero (e.g., 04 for April). YYYY represents the year a person was born. For example, a date of birth of 3 April 2021 would be formatted as 03042021. If the date of birth is not known or cannot be obtained, the default value of 01011900 should be entered. XXXXXDDMMYYYY**[N] - Sex** The fourteenth character represents the sex of the patient. 1 = male 2 = female 3 = indeterminate
Mandatory Field	Yes

Additional Comments	
Version	2
Revised	May 2016
Revised	January 2026: '9 = unknown' option for the last character (Sex) has been removed. Additional information on the data collection method.

2.5. Date of birth: DOB

Definition	The patient's date of birth

Data Element Attributes	
Source	Birth certificate or other appropriate document Parent/Carer Hospital medical record
Context	Date of birth and date of admission are used to calculate age at admission to your unit. Can help identify patients who may have had multiple admissions to one or more PICUs or who have the same names. Can be used in conjunction with gestation field to generate corrected age for pre-term infants.
Data Type	Date
Format	DD/MM/YYYY
Permissible Value	Valid date
Missing/Null Value	n/a
Collection method	Neonates may have the same date of birth and date of admission.
Mandatory Field	Yes

2.6. Gestation (completed weeks) for patient ≤ 1 year old: GEST_WEEKS

Definition	The patient's gestational age in completed weeks at delivery if patient is ≤ 1 year old at ICU admission

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	For young infants, there is evidence that gestational age can act as an important prognostic factor.
Data Type	Integer
Format	NN
Permissible Value(s)	20 – 43 (weeks); 99 – if gestational weeks unknown but the baby is known to be term
Missing/Null Value	Null
Collection Method	The field GEST_WEEKS is expressed in completed weeks. When gestational age is calculated using the first day of the last normal menstrual period, the first day is counted as day zero, not day one, so a 25-week, 5-day foetus is considered a 25-week foetus. Gestation weeks is expressed as a whole number, rounded down. If the exact gestational age is unknown and the baby is known to be term at admission to ICU, enter 99. For patients with corrected age less than 28 days, the detailed gestational age is collected in completed weeks (GEST_WEEKS) and additional days (GEST_DAYS – please see the next variable). Corrected age is the age after the estimated date of delivery (EDD) at 40 weeks. It is calculated by subtracting the number of weeks of prematurity from the chronological age, defined as the number of weeks and days from the date of delivery until the date of ICU admission. Corrected age = chronological age − (40 − gestational weeks at birth). Example 1. Birth at 31 weeks, 10 weeks old at admission → corrected age 1 week (< 28 days) → GEST_WEEKS = 31. Example 2. Birth at 38 weeks, 5 weeks old at admission → corrected age 3 weeks (< 28 days) → GEST_WEEKS = 38. Example 3. Term baby, 2 months old, gestation unknown → GEST_WEEKS = 99. Example 4. Birth at 30 weeks, 15 weeks old at admission → corrected age 5 weeks (> 28 days) but patient is ≤ 1 year old → GEST_WEEKS = 30
Mandatory Field	Yes, for babies with a corrected age < 28 days at ICU admission

Additional Comments	
Introduced	2019
Revised	January 2026: includes patients ≤1 year old; previously was collected for patients < 28 days corrected age. Clarification of the collection method.

2.7. Gestation (additional days) for patient < 28 days corrected: GEST_DAYS

Definition	Number of additional days beyond completed weeks of gestational age at delivery if the post menstrual age is < 44 weeks (i.e. corrected age < 28 days) at admission to ICU

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	For young infants, there is evidence that gestational age can act as an important prognostic factor.
Data Type	Integer
Format	N
Permissible Value(s)	0 – 6 (days), 9 (if unknown)
Missing/Null Value	Null
Collection Method	For patients with corrected age less than 28 days, the additional days (GEST_DAYS) are recorded in addition to completed gestational weeks (GEST_WEEKS). Corrected age is the age after the estimated date of delivery (EDD) at 40 weeks. It is calculated by subtracting the number of weeks of prematurity from the chronological age, defined as the number of weeks and days from the date of delivery until the date of ICU admission. Corrected age = chronological age − (40 − gestational weeks at birth). Example 1. A baby born at 31 weeks + 2 days' gestation is 8 weeks + 5 days premature. If the chronological age at admission is 10 weeks, the corrected age is 1 week + 2 days. As this is less than 28 days (corrected age), this satisfies the inclusion criteria for this field. Therefore, enter 2 as the value for GEST_DAYS. Example 2. A baby born at 28 weeks + 4 days' gestation is 11 weeks + 3 days premature. If the chronological age at admission is 18 weeks, the corrected age is 6 weeks + 4 days. As this is greater than 28 days, leave this field blank.
Mandatory Field	Yes, for babies with a corrected age < 28 days at ICU admission

Additional Comments	
Introduced	2019
Revised	January 2026: Clarification of the data collection method.

2.8. Sex: SEX

Definition	The biological distinction between males, females, and intersex individuals

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Required to stratify data on the basis of sex and for reporting demographic statistics.
Data Type	Text
Format	A
Permissible Value(s)	M Male F Female I Intersex/Indeterminate
Missing/Null Value	n/a
Collection Method	The Sex field is collected as a code
Mandatory Field	Yes

Additional Comments	
Revised	2017: Codes I, U introduced
Other Notes	Historically, there may be both upper- and lower-case used in this field
Revised	January 2026: the field previously labelled 'GENDER' has been renamed to 'SEX' and the code 'U' has been removed from the list of permissible values

2.9. Weight: WT

Definition	The weight of the patient measured in kilograms at the time of admission to your ICU

Data Element Attributes	
Source	Patient admission details / Medical history / Progress notes (dietician/ anaesthetics) / ICU observation chart
Context	Weight is an indicator of nutrition status and health status. It enables the calculation of a z-score for weight-for-age.
Data Type	Decimal
Format	NNN.N
Acceptable Range or Permissible Value	>= 0.5 and <= 200
Missing/Null Value	COMET = leave field blank Non-COMET = 999
Collection Method	Measured to the nearest 0.1 kg
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered < 0.5	Unable to save screen
Red	Value entered > 200	Unable to save screen
Amber	Value entered > 100 and <= 200	Check value for accuracy

2.10. Postcode: POST

Definition	Postcode of the patient's home address

Data Element Attributes	
Source	Patient admission details
Context	Required to stratify data on the basis of geographical regions.
Data Type	Integer
Format	NNNN
Permissible Value	Four digits
Missing/Null value	9999
Collection Method	Must relate to a patient's residential address at the time of admission to hospital. Where a patient has a postal address that is different from their residential address, please use the residential postcode. For patients admitted while on holiday, the home postcode should be entered rather than the postcode of holiday accommodation. A code of **9990** should be used for patients whose usual residence is overseas in relation to the treating hospital.
Mandatory Field	Yes

2.11. Indigenous Status: IND_STATUS

Definition	Indigenous status of a patient as determined by patient or next of kin

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Required to stratify data based on indigenous status. 'Indigenous' is used in this context to represent the Māori people of New Zealand and Aboriginal and Torres Strait Islander people of Australia who were the original inhabitants of New Zealand and Australia respectively. Indigenous peoples occupy a unique place in the society, history and culture of both Australia and New Zealand. This item recognises that health disparities exist between Indigenous and non-indigenous peoples.
Data Type	Integer
Format	N
Permissible Value(s)	0 Not indigenous 1 Indigenous 9 Unknown
Missing/Null Value	n/a
Collection Method	This data element captures whether a patient identifies as Indigenous to the country where they are receiving treatment. The IND_STATUS field is collected as a numeric code. **Australian Sites:** Patients who identify as Indigenous to Australia, including Aboriginal and/or Torres Strait Islander should be coded as 1 Indigenous. **New Zealand Sites:** Patients who identify as Indigenous to New Zealand (Māori), should be coded as 1 Indigenous. Patients coded as IND_STATUS = 1 should also capture the patient identified Indigenous origin in data element IND_ORIGIN.
Mandatory Field	Yes

2.12. Indigenous Origin: IND_ORIGIN

Definition	Indigenous origin of an indigenous patient as determined by patient or next of kin

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Required to stratify data based on indigenous origin. Indigenous is used in this context to represent the Māori people of New Zealand and Aboriginal and Torres Strait Islander people of Australia who were the original inhabitants of New Zealand and Australia respectively. Indigenous peoples occupy a unique place in the society, history and culture of both Australia and New Zealand. This item recognises that health disparities exist between Indigenous and non-indigenous peoples.
Data Type	Integer
Format	N
Permissible Value(s)	**Australian Hospitals** 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 Not Stated/Unknown **New Zealand Hospitals** 5 Māori
Missing/Null Value	Null
Collection Method	This data element captures a specific indigenous origin for a patient identified as indigenous to the country where they are receiving treatment. Patients coded as IND_STATUS = 1 should use the IND_ORIGIN data element to capture the patient identified indigenous origin. The IND_ORIGIN field is collected as a numeric code. **Australian Sites:** patients identified as Indigenous to Australia must select from option 1 to 4 only. Non-indigenous patients (IND_STATUS = 0) will have null value. **New Zealand Sites:** patients identified as Indigenous to New Zealand must select option 5 (Māori). Non-indigenous patients (IND_STATUS = 0) will have null value.
Mandatory Field	Yes, for records where IND_STATUS = 1

Additional Comments	
Introduced	June 2021
Revised	2022: Clarified and removed code 4 (Not Stated/Unknown) for NZ sites
Other notes	Initially non-mandatory, intended mandatory in 2022
Other notes	January 2026: Field mandatory for records where IND_STATUS = 1

2.13. Date and time of admission to hospital: HADM_DT

Definition	Date and time when the patient was admitted to the hospital for the episode of care which includes the current episode of ICU care

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of hospital length of stay.
Data Type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value	Valid date and time
Missing/Null Value	n/a
Collection Method	The date should be collected in DD/MM/YYYY format and time in a 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. Date and time of hospital admission may be equal to the date and time of admission to ICU.
Mandatory Field	Yes

Additional Comments	
Other Notes	Field mandatory since January 2007

2.14. Hospital admission source: HADM_SC

Definition	The location from where the patient was admitted to the hospital for the current episode of ICU care, as represented by a code

Data Element Attributes	
Source	Hospital administration system / Hospital medical record / Patient admission details
Context	Provides information for analysis of admission patterns and referrals.
Data Type	Integer
Format	N
Permissible Value(s)	1 Home or accident scene 2 Other hospital – Emergency Department 3 Other hospital – Operating Theatre or Recovery 4 Other hospital – ICU or NICU 5 Other hospital – Ward 6 Inborn
Missing/Null Value	n/a
Collection Method	The Hospital Admission source is collected as a code. Other hospital is defined as a different hospital, other than where your ICU is housed. Inborn is defined as born at the hospital housing your ICU.
Mandatory Field	Yes

2.15. Date and time of discharge from hospital: HDIS_DT

Definition	Date and time when the patient was discharged from the hospital for the episode of care which included the current episode of ICU care

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	Required to identify the period in which the ICU episode and the hospital stay occurred and for derivation of hospital length of stay.
Data Type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value	Valid date and time
Missing/Null Value	Null
Collection Method	The date should be collected in DD/MM/YYYY format and time in a 24-hour clock format (0000–2359). 23:59 is the end of one day and 00:00 is the start of the next day. Hospital discharge includes death or transfer to another hospital. Discharge does not include temporary transfer from your hospital to another facility (e.g. for surgery) when direct return to your hospital is expected. Date and time of discharge from hospital may be equal to the date and time of ICU discharge.
Mandatory Field	Mandatory unless Hospital Outcome (HOSP_OUT) = Still in hospital

Additional Comments	
Other Notes	Field mandatory (if discharged from hospital) since January 2007

2.16. Hospital Outcome: HOSP_OUT

Definition	Status at discharge/separation of patient from the hospital for the episode of ICU care, as represented by a code

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	Provides information for analysis of discharge and transfer patterns.
Data Type	Integer
Format	N
Permissible Value(s)	1 Still in hospital (at time of data submission) 2 Died 3 Discharged home 4 Transfer to rehab hospital 5 Transfer to other hospital ICU or NICU 6 Transfer to other hospital ward 7 Transfer to hospice
Missing/Null Value	n/a
Collection Method	The Hospital Outcome field is collected as a code. If a patient is transferred to Hospital-in-the-Home (HITH) they should be considered discharged from hospital. Such patients should be given a hospital outcome of 3 Discharged home.
Mandatory Field	Yes

Additional Comments	
Other Notes	Field mandatory since January 2007
Revised	January 2026: Code 7 (Transfer to hospice) has been introduced

2.17. Date and time of admission to your unit: ADM_DT

Definition	The date and time of admission to your ICU for the current episode of care

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	The date and time of admission to your ICU is used in the calculation of total length of ICU stay.
Data Type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value	Valid date and time
Missing/Null Value	n/a
Collection Method	The date should be collected in DD/MM/YYYY format and time in a 24-hour clock format (0000–2359). 23:59 is the end of one day and 00:00 is the start of the next day. This is **not** necessarily the time of first contact as this may be in another department or hospital. In cases where a newborn infant is admitted to your unit from the delivery room, the date of admission may be the same as the date of birth. Date and time of ICU admission may be equal to the date and time of admission to hospital.
Mandatory Field	Yes

2.18. ICU admission source: IADM_SC

Definition	The location from where the patient was directly admitted to your ICU. ICU admission source should be collected as a code

Data Element Attributes	
Source	Hospital administration system / Hospital medical record / Patient admission details
Context	Provides information for analysis of admission patterns and referrals.
Data Type	Integer
Format	N
Permissible Value(s)	1 Your hospital OT/Recovery 2 Your hospital Emergency Department 3 Your hospital Ward 4 Your hospital Other ICU/NICU 5 Direct ICU Admission 6 OT (direct admission from another ICU/NICU via OT)
Missing/Null Value	n/a
Collection Method	The ICU Admission Source is collected as a code. Definitions: 1. **Your hospital OT/Recovery:** The patient has undergone a surgical procedure or has received anaesthetic for a procedure in the operating theatre or recovery area within your hospital, prior to admission to your ICU. 2. **Your hospital Emergency Department:** Patient admitted to ICU from the emergency department within your hospital. 3. **Your hospital Ward:** Patient admitted to ICU from any other inpatient area within your hospital. 4. **Your Hospital Other ICU/NICU:** Patient admitted from another ICU or NICU within your hospital where your ICU is housed 5. **Direct ICU Admission:** Patient admitted to ICU directly from an outside source, such as in the case of specialist retrieval or inter-hospital transfer. Direct ICU admission can be from home/scene or other acute hospital (ward, ED), or other acute ICU. 6. **OT (direct admission from another ICU/NICU via OT):** Patient was transferred directly to OT from another ICU/NICU within your hospital or another hospital, and then admitted to ICU following a surgical procedure. *(New code introduced in 2018 to allow for differentiation in administrative practices at some sites usually related to neonatal cardiac surgery)*
Mandatory Field	Yes

Additional Comments	
Revised	January 2026: Clarification of the data collection method

2.19. Retrieval: RETRIEV

Definition	An indicator of whether the patient was transferred to your ICU by a specialist ICU retrieval/transport team or equivalent

Data Element Attributes	
Source	Hospital administration system / Hospital medical record / Patient admission details
Context	Required to ascertain whether specialist care of patient was first commenced outside your hospital, or your ICU.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Retrieval field is collected as a code. Any patient transferred to your unit by a specialist ICU retrieval/transport team or neonatal transport team, or equivalent, should be coded as 1 (Yes). This does not include inter-hospital transfers or transportation by non-intensive care specialist teams, such as the Royal Flying Doctor Service (RFDS) or Mobile Intensive Care Ambulance (MICA), where an intensive care doctor was not present.
Mandatory Field	Yes

2.20. Elective: ELECTIVE

Definition	A planned or foreseeable admission to your ICU following elective surgery, or an elective admission to ICU for a procedure, monitoring review of a home ventilation patient

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	This field is used in the weighted calculations for PIM 2/3.
Data Type	Integer
Format	N
Permissible Value(s)	0 Non-elective admission 1 Elective admission
Missing/Null Value	n/a
Collection Method	The Elective field is collected as a code. Includes: • ICU admission (planned or foreseeable) after elective surgery • ICU admission for an elective procedure (e.g., insertion of a central catheter), or elective monitoring, or review of home ventilation. An ICU admission or an operation is considered elective if it could be postponed for more than 6 hours without adverse effect. A non-elective can also be considered an emergency admission. This includes patients who had elective surgery where ICU admission was not expected but was required due to an intra-operative complication or patients admitted after emergency surgery.
Mandatory Field	Yes

Additional Comments	
Revised	January 2026: Clarification of the definition and data collection method

2.21. Unplanned ICU re-admission: UNPL_READ

Definition	Unplanned readmission to ICU within 72 hours of discharge from a previous ICU admission episode within the same hospital admission

Data Element Attributes	
Source	Hospital administration system / Hospital medical record / Patient admission details
Context	A process of care indicator for the ANZPIC Registry.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes, unplanned readmission <72 hours post discharge from ICU
Missing/Null Value	n/a
Collection Method	The Unplanned ICU Re-admission field is collected as a code. Previous admission does not include admission to NICU. The admission is an unplanned or unexpected readmission to your ICU, within 72 hours of previous ICU discharge during the same hospital admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2010

2.22. ICU admission following RRT/MET response call: RRT_adm

Definition	An ICU admission following MET/RRT/emergency response call in a ward or inpatient area

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Used to stratify data based on emergency call information.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes – MET/RRT/Code Blue call
Missing/Null Value	n/a
Collection method	The RRT/MET response field is collected as a code. This data element identifies patients admitted to ICU following a MET/RRT/emergency response call in a ward or inpatient area, where the outcome was admission to ICU. For this field, ICU, intensivist-supervised HDU, NICU, operating theatres, post-operative recovery areas, and the emergency department are not considered ward or inpatient areas. Any other area within the hospital (including day medical unit) is considered a ward or inpatient area for this purpose. The elapsed time to ICU admission should be **within 6 hours** of the MET/RRT/emergency response call. Emergency response admissions include: - MET (Medical Emergency Team) - RRT (Rapid Response Team) - Code Blue (Cardio-Respiratory Arrest) calls.
Mandatory Field	Yes

Additional Comments	
Introduced	January 2017

2.23. Recovery from surgery or procedure: RECOVERY

Definition	The main reason for admission to your unit was for recovery from surgery or a procedure

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	This field is used in the weighted calculations for PIM 2/3.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Recovery from surgery or a procedure field is collected as a code. Include admission when the patient has undergone a surgical procedure or has received anaesthetic for a procedure within the theatre or recovery area, immediately prior to admission to your unit. This includes admission following a radiological procedure or the insertion of a cardiac catheter. These patients are usually from your hospital but may come from adjoining adult or private hospitals to your ICU for observation after their procedures. Do not include patients admitted from theatre if recovery from surgery or anaesthetic is not the main reason for ICU admission. (e.g., if a patient with a head injury is admitted from theatre after insertion of an ICP monitor, the main reason for ICU admission is the head injury, not surgical recovery).
Mandatory Field	Yes

Additional Comments	
Revised	January 2026: Clarification of the data collection method

2.24. Cardiac bypass: BYPASS

Definition	Specifies whether cardiac bypass was performed before and/or during the admission to ICU

Data Element Attributes	
Source	Hospital medical record / Patient admission details / ICU observation chart
Context	Required for epidemiological analysis and assessment of health services provision. This field is also used in the weighted calculations for PIM 2/3.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Admitted following cardiac bypass 2 Bypass procedure during current admission 3 Both 1 & 2 apply
Missing/Null Value	n/a
Collection Method	The Cardiac Bypass field is collected as a code
Mandatory Field	Yes

Additional Comments	
Revised	2009: Codes 2, 3 introduced

2.25. Place of first contact: FST_CONT

Definition	The place of first face-to-face contact between the patient and a doctor from your ICU or specialist paediatric transport team, when management of the patient is taken over

Data Element Attributes	
Source	Hospital administration system / Hospital medical record / Patient admission details
Context	Collected to ascertain place where the management of the patient was first taken over by paediatric specialist doctor or team.
Data Type	Integer
Format	N
Permissible Value(s)	1 Your ICU 2 In your hospital but outside ICU 3 Outside your hospital
Missing/Null Value	n/a
Collection Method	The First Contact field is collected as a code. The First Contact refers to the initial location where the patient receives critical care: 1. **Your ICU:** The patient's first contact occurs directly in your ICU. 2. **In your hospital but outside ICU:** First contact happens somewhere else within your hospital, such as in the Emergency Department or other wards, where the patient is first seen by ICU or specialist transport doctors before admission to the ICU. 3. **Outside your hospital:** The patient first receives care outside your hospital, such as at another hospital or during retrieval, where your ICU or paediatric transport team first takes over management of the patient.
Mandatory Field	Yes

Additional Comments	
Revised	January 2026: Clarification of the data collection method

2.26. ICU Discharge Decision Date and time: DIS_DEC_DT

Definition	Date and time when patient was ready for separation from the intensive care unit for the current episode of ICU care determined by the ICU team

Data Element Attributes	
Source	Hospital administration system / Progress notes
Context	Provides information relating to bed block and actual ICU length of stay. Used to calculate ACHS ICU indicator “Bed Block”.
Data Type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value(s)	Valid date and time
Missing/Null Value	Leave blank
Collection Method	The date should be collected in DD/MM/YYYY format and time should be collected in 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. This should be the date and time when medical or nursing staff determine that the patient is ready for discharge from ICU. For patients who are diagnosed as brain dead, the date and time of certification of brain death should be entered as the date/time of ICU discharge decision. “ICU discharge decision date/time” must be earlier than or equal to “ICU discharge date/time”.
Mandatory Field	No

Additional Comments	
Introduced	January 2026

2.27. Date and time of discharge from your unit: DIS_DT

Definition	The date and time that the patient was discharged from ICU

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	The date and time of discharge from your ICU is used in the calculation of total length of ICU stay.
Data Type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value(s)	Valid date and time
Missing/Null Value	n/a
Collection Method	The date should be collected in DD/MM/YYYY format and time in a 24-hour clock format (0000–2359). 23:59 is the end of one day and 00:00 is the start of the next day. Discharge does not include temporary transfer from your unit (e.g., for surgery) when a direct return to your unit is expected. ICU discharge includes circulatory death or transfer to another ICU or hospital. For brain death, the discharge time is recorded as when the patient goes to the operating theatre if an organ donor or, if not an organ donor, when circulation stops. Date and time of discharge from ICU may be equal to the date and time of hospital discharge.
Mandatory Field	Yes

Additional Comments	
Other Notes	Data submissions to ANZPICR were changed to be based on ICU discharge date (DIS_DT) from 2009 onwards
Revised	January 2026: Clarification of the data collection method

2.28. ICU Outcome: OUTCOME

Definition	Specifies the outcome of the ICU episode and identifies the destination on discharge from ICU

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	Provides information for analysis of discharge and transfer patterns.
Data Type	Integer
Format	N
Permissible Value(s)	1 Discharged to ward or home 2 Died in ICU 3 Transferred to NICU or other ICU 4 Still in ICU (at time of data submission) 5 Died within 24 hours of discharge from ICU for palliative care
Missing/Null Value	n/a
Collection Method	The ICU Outcome field is collected as a code. 1 Discharged to ward – includes transfer to a ward in another hospital. 4 Still in ICU – invalid if ICU discharge date (DIS_DT) is known.
Mandatory Field	Yes

2.29. ICU Transfer: ICU_TRAN

Definition	Specifies the destination hospital the patient was transferred to upon discharge from ICU

Data Element Attributes	
Source	Hospital administration system / Hospital medical record
Context	Provides information for discharge and transfer patterns.
Data Type	Integer
Format	NNN
Permissible Value(s)	Code as per Appendix A: ANZPIC Registry Transfer Site List
Missing/Null Value	Null
Collection Method	The ICU Transfer field is collected as a code. Select the appropriate code from the ANZPIC Registry Transfer Site List provided in Appendix A.
Mandatory Field	Mandatory only if OUTCOME = 3 Transferred to NICU or other ICU, else null

Additional Comments	
References	Appendix A: ANZPIC Registry Transfer Site List

2.30. Comments field: COMMENTS

Definition	Text field recording any additional information considered relevant to the admission

Data Element Attributes	
Context	No dataset specification covers all eventualities. To deal with this a text field has been included for comments/additional information.
Data Type	Text
Format	Free text
Permissible Value	Maximum of 255 characters
Missing/Null Value	n/a
Collection Method	Text entered in this field may provide extra information about data entered elsewhere in a specific field in the dataset or may provide extra information on the admission, which is not collected as part of the dataset. (e.g. patient with tracheostomy who may have intubation hours that are not equal to ventilation hours). No identifiers relating to patients, nurses, doctors, ICUs, hospitals, should be included in text data entered into this field. As there is limited space in this field all text data should be kept to a minimum and be as concise as possible. Text data must not contain any punctuation except a period (full-stop) at the end of each data point.
Mandatory Field	No

3. Diagnoses and Procedures

3.1. Principal Reason for Admission to ICU: PDX

Definition	The principal diagnostic reason for the admission of the patient to ICU

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	To establish the main reason for ICU admission.
Data Type	Integer
Format	NNN[N]
Permissible Value	Code from the ANZPIC Registry Diagnostic Codes Table (Appendix B)
Missing/Null Value	n/a
Collection Method	Select the appropriate code from the list of ANZPIC Registry Diagnostic Codes Table (Appendix B). The Principal Diagnosis is the diagnosis most directly responsible for the ICU admission. For patients admitted post-operatively, the Principal Diagnosis should generally be a 'Post-Procedural Diagnosis' (codes >1100) except if the patient would have required ICU admission regardless of the procedure (e.g., a patient intubated/ventilated for a head injury admitted from theatre after insertion of an ICP monitor, the PDX is 117 Trauma - head; the surgical procedure should be coded as ADX). For admissions due to unexpected complications of a procedure in patients not originally for ICU admission, the complication should be recorded as the Principal Diagnosis. In these cases, code the specific complication as principal diagnosis (e.g., "anaphylaxis" rather than "anaesthetic complication"). **Important:** • Do not use an infection code or mechanism of injury code for the Principal Diagnosis. • If a code is not available for the specific diagnosis, select the closest system code and category 'Other' (e.g., 300 Neurological – Other). In such cases, provide the actual diagnosis and any relevant details in the DIAGTEXT field. If the patient has suffered a cardiac arrest and is subsequently admitted to ICU, the cardiac arrest should be coded as the Principal Diagnosis, even if it occurred in the OT during a procedure or anaesthetic.
Mandatory Field	Yes

Additional Comments	
References	Please refer to Appendix B for the ANZPIC Registry Diagnostic Codes Table, this list is reviewed and updated annually
Revised	January 2026: Clarification of the data collection method

3.2. Underlying Diagnosis Code: UDX

Definition	The underlying condition contributing to the need for admission to ICU

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	To establish the underlying diagnosis associated with the ICU admission.
Data Type	Integer
Format	NNN[N]
Permissible Value	Code from the ANZPIC Registry Diagnostic Codes Table (Appendix B)
Missing/Null Value	Null
Collection Method	Select the appropriate code from the list of ANZPIC Registry Diagnostic Codes Table (Appendix B). The Underlying Diagnosis may be the same as the Principal Diagnosis (e.g., meningitis, pneumonia, or bronchiolitis in a previously well patient). In these cases, record the same diagnosis code for both. If the Principal Diagnosis is a procedure, the Underlying Diagnosis is usually the condition underlying the need for surgery. A Post Procedural Diagnosis (codes >1100) must not be coded as an Underlying Diagnosis. If the Principal Diagnosis is an injury, the Underlying Diagnosis should specify the injury mechanism. Where 'Other' diagnosis codes have been used (e.g., 450 Respiratory – Other), record the actual diagnosis and further details in the DIAGTEXT field.
Mandatory Field	Not mandatory, but should be able to be coded in all but exceptional scenarios

Additional Comments	
References	Please refer to Appendix B for the ANZPIC Registry Diagnostic Code Table, this list is reviewed and updated annually
Revised	January 2026: Clarification of the data collection method

3.3. Other Diagnostic Codes: DIAGTEXT

Definition	Text field enabling the recording of a specific diagnosis

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	To assist in identifying common diagnoses that may require inclusion in future registry updates, or to record a confirmed pandemic infection.
Data Type	Text
Format	Free text
Permissible Value	Maximum of 30 characters
Missing/Null Value	Null
Collection Method	This field to be completed if any of the following are applicable: 1. Where 'Other' diagnosis codes (e.g., 450 Respiratory – Other) have been used in any of the fields PDX, UDX, ADX, then enter actual diagnosis in this field 2. Where there is no existing code in the current ANZPIC Registry Diagnosis Codes Table for the condition, then enter the actual diagnosis in this field 3. When code 748 (Suspected or Confirmed Pandemic Infection) has been used as the UDX or an ADX record, and the infection has been **confirmed**, then enter the actual infection in this field. If not confirmed, this field to be left blank. This text must be brief, must not be in list form, nor contain any commas. Two diagnoses should be separated by a full stop.
Mandatory Field	No

Additional Comments	
Introduced	2009
Revised	2020: Revised to allow for more details if an Underlying or Associated Diagnosis code of 748 (Suspected or Confirmed Pandemic Infection) was used

3.4. Chronic Condition – Neurologic or Neuromuscular: CC_NEURO

Definition	A neurologic or neuromuscular medical condition (listed in appendix C) that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data Type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Neurologic/Neuromuscular category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.5. Chronic Condition – Respiratory: CC_RESP

Definition	Any chronic respiratory medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Respiratory category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.6. Chronic Condition – Gastrointestinal: CC_GASTRO

Definition	Any gastrointestinal medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Gastrointestinal category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.7. Chronic Condition – Metabolic: CC_METABOL

Definition	Any metabolic medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Metabolic category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.8. Chronic Condition – Malignancy: CC_MALIG

Definition	Any malignancy medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Malignancy category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). Coding of this chronic condition may be discontinued five years post remission or final treatment. In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.9. Chronic Condition – Technology Dependency: CC_TECHDEP

Definition	Any technology dependant medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Technology Dependency category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.10. Chronic Condition – Cardiovascular: CC_CARDIO

Definition	Any Cardiovascular medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Cardiovascular category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.11. Chronic Condition – Renal or Urologic: CC_RENAL

Definition	Any Renal or Urologic medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Renal/Urologic category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.12. Chronic Condition – Haematologic or Immunologic: CC_HAEM

Definition	Any Haematologic or Immunologic medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Haematologic/Immunologic category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.13. Chronic Condition – Other Congenital or Genetic Defect: CC_CONGEN

Definition	Any Congenital or Genetic Defect that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Congenital Anomalies category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.14. Chronic Condition – Premature/Neonatal: CC_PREM

Definition	Any Premature/Neonatal medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalization in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. This Chronic Condition field applies only to patients aged up to 1 year (chronological age) at time of ICU admission. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Premature/Neonatal category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.15. Chronic Condition – Transplantation: CC_TRANSPL

Definition	A child who has had solid or bone marrow transplantation ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Transplantation category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2017
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

3.16. Chronic Condition – Mental Health / Behavioural: CC_MENTALH

Definition	Any Mental Health / Behavioural condition that can be reasonably expected to last at least 12 months (unless death intervenes) and requires ongoing treatment of a pharmacological / psychological / psychiatric nature. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Collected to obtain a more complete picture of the complex care of the ICU patient.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Chronic Condition field is collected as a code. The condition must be diagnosed ≥ 30 days prior to the current illness that led to ICU admission. For this field to be coded 'yes', the condition should be listed in the Chronic Mental Health/Behavioural category of the ANZPIC Registry Complex Chronic Conditions Definitions (Appendix C). In COMET, see Diagnosis tab under ICU Admission.
Mandatory Field	Yes

Additional Comments	
Introduced	2020
References	Please refer to Appendix C for the ANZPIC Registry Complex Chronic Conditions Definitions
Revised	January 2026: Definition and data collection method clarified

4. PIM Risk Codes

PIM2 & PIM3 General Instructions
PIM2 & PIM3 are calculated from information collected at the time the patient is admitted to the ICU or when care is commenced by a specialist paediatric transport team.
The conditions must be present at admission to ICU.

4.1. PIM LOW RISK DIAGNOSIS: PIM_LR

Definition	Specific condition associated with reduced mortality risk

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	Weighted field used in PIM 2/3.
Data type	Integer
Format	N
Permissible value(s)	0 None 1 Asthma 2 Bronchiolitis 3 Croup 4 Obstructive sleep apnoea 5 Diabetic keto-acidosis 6 Seizures
Missing/Null Value	n/a
Collection Method	The PIM Low Risk Diagnosis field is collected as a code. The conditions below must be the Principal Diagnosis to qualify for the Low Risk code: **1. Asthma** - Identifies children with a diagnosis of asthma as the main reason for ICU admission. **2. Bronchiolitis** - Identifies children with a diagnosis of bronchiolitis as the main reason for ICU admission. Include children who present with either respiratory distress or central apnoea where the clinical diagnosis is bronchiolitis. **3. Croup** - Identifies children with a diagnosis of croup as the main reason for ICU admission. **4. Obstructive Sleep Apnoea** - Identifies children with a diagnosis of obstructive sleep apnoea as the main reason for ICU admission Include patients admitted following adenoidectomy and or tonsillectomy in whom OSA is the main reason for ICU admission. **5. Diabetic Ketoacidosis** - Identifies children with a diagnosis of diabetic ketoacidosis as the main reason for ICU admission. **6. Seizures** - Include patients who require admission primarily due to status epilepticus, epilepsy, febrile convulsion or other epileptic syndrome where intensive care is required either to control seizures or to recover from the effects of seizures or the treatment. Do not code a PIM LR Dx of seizures if the patient experiences the seizures as a side effect of another diagnosis, e.g., meningitis or head injury, unless the seizures are specifically the reason the ICU admission was required. *Note:* Code 6 only introduced for PIM3.
Mandatory Field	Yes

Additional Comments	
References	PIM 2/3 Information Booklet
Introduction	Code 6 introduced for PIM3
Revised	January 2026: Clarification of the data collection method

4.2. PIM3 High Risk Conditions: PIM3_HR

Definition	Specific condition associated with increased mortality risk in PIM3 model

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	Weighted field used in PIM 3.
Data type	Integer
Format	N
Permissible value(s)	0 None 1 Spontaneous cerebral haemorrhage 2 Cardiomyopathy or myocarditis 3 Hypoplastic left heart syndrome (HLHS) 4 Neurodegenerative disorder 5 Septic shock 6 Necrotising enterocolitis (NEC) is the main reason for ICU admission
Missing/Null Value	n/a
Collection Method	The PIM High Risk Diagnosis field is collected as a code. The conditions below can be the Principal (PDX), Underlying (UDX), or Associated (ADX) diagnosis for ICU admission to qualify for the high risk code. **1. Spontaneous Cerebral Haemorrhage** - Identifies whether the child has a spontaneous cerebral haemorrhage (e.g., from aneurysm or AV malformation). Do not include traumatic cerebral haemorrhage or intracranial haemorrhage that is not intracerebral (e.g., subdural haemorrhage). **2. Cardiomyopathy or Myocarditis** - requires the documented diagnosis of myocarditis or cardiomyopathy. Do not include impaired cardiac function associated with sepsis or surgery or descriptions of poor ventricular function alone. **3. Hypoplastic Left Heart Syndrome** - Identifies whether the child has hypoplastic left heart syndrome. Include only patients at any age where a Norwood procedure, or equivalent, is required to sustain life in the neonatal period, either during the current or a previous hospital admission. *Notes:* Hypoplastic left ventricle is not synonymous with hypoplastic left heart syndrome unless there is also documented ventriculo-arterial concordance. If the patient has undergone a subsequent heart transplant, this diagnosis and high-risk code no longer apply.

4. Neurodegenerative Disorder - Identifies whether the child has a neurodegenerative disorder.

Requires progressive loss of previously acquired developmental milestones (even if no specific condition has been diagnosed), or a diagnosis where this will inevitably occur.

5. Septic Shock - meets Phoenix Criteria for Septic Shock:

- Suspected or confirmed infection, and
- Phoenix Sepsis Score ≥ 2, and
- Phoenix Sepsis Score cardiovascular component ≥ 1.

Cardiovascular component of the score includes:

- Lactate: 5 - 10.9 mmol/L = 1 point; > 11 mmol/L = 2 points
- Vasoactives: 1 = 1 point; > 2 = 2 points
  (any dose adrenaline, noradrenaline, dopamine, dobutamine, milrinone, and/or vasopressin (for shock))
- Hypotension: Mean arterial pressure (mmHg)

Age	1 point	2 points
< 1 month	17 - 30	< 17
1 - 11 months	25 - 38	< 25
1 - < 2 years	31 - 43	< 31
2 - < 5 years	32 - 44	< 32
5 - < 12 years	36 - 48	< 36
12 - 17 years	38 - 51	< 38

For respiratory, coagulation and neurology components of the score, see Table 2 from Sanchez-Pinto et al (2024)

Collected as HR code by ANZPIC Registry but not used in PIM3 calculation. If this diagnosis exists with another HR code, then always preference the other code to ensure it is included in the PIM3 calculation.

6. Necrotising Enterocolitis (NEC) - The patient has a documented diagnosis of an acute episode of necrotising enterocolitis (NEC), which is the main reason for admission to intensive care.

Do not include patients where the admission is for management of sequelae such as strictures, revision of stomas, etc..

Mandatory Field	Yes

Additional Comments	
References	PIM 2/3 Information Booklet
Other Notes	Historically, earlier paediatric data entry software may have only codes 1-5 included, with NEC appearing as code 6 in the PIM3_VHR list.
Revised	January 2026: Septic shock definition changed to Phoenix Criteria: https://pmc.ncbi.nlm.nih.gov/articles/PMC10900966/

4.3. Very High Risk Diagnosis: PIM3_VHR

Definition	Specific condition associated with greatest mortality risk in PIM3 model

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	Weighted field used in PIM 3.
Data type	Integer
Format	N
Permissible value(s)	0 None 1 Cardiac arrest preceding ICU admission 2 Severe combined immune deficiency (SCID) 3 Leukaemia or lymphoma after 1st induction 4 Bone marrow transplant (BMT) recipient 5 Liver failure, acute or chronic, is the main reason for ICU admission *6 Code no longer in use (see PIM3_HR code 6 instead)* 7 SCID and BMT recipient 8 Leukaemia or lymphoma after 1st induction and BMT recipient
Missing/Null Value	n/a
Collection Method	The PIM Very High Risk field is collected as a code. The conditions below can be the Principal (PDX), Underlying (UDX), or Associated (ADX) diagnosis for ICU admission to qualify for the very high risk code. **1. Cardiac Arrest Preceding ICU Admission** - Identifies whether the child had a cardiac arrest prior to ICU admission. Includes both in-hospital and out-of-hospital arrests. Requires either documented absent pulse or the requirement for external cardiac massage for a period of 30 seconds or longer. Precordial thumps or defibrillation without cardiac massage should not be included. Do not include past history of cardiac arrest. **2. Severe Combined Immune Deficiency** - Identifies whether the child has a diagnosis of severe combined immune deficiency (SCID). **3. Leukaemia or Lymphoma after completion of first induction** - Identifies whether the child has leukaemia or lymphoma for which induction has been received irrespective of current presumed state of immunity or remission. Include only cases where the admission is related to leukaemia or lymphoma or the therapy for these conditions. If the patient is admitted for an unrelated reason, (e.g. trauma), do not code this VHR Diagnosis code. **4. Bone Marrow Transplant Recipient** - The patient is a recipient of a bone marrow transplant prior to ICU admission. **5. Liver Failure** - Identifies children in whom acute or chronic liver failure is the main reason for ICU admission.

	Do not include patients admitted for recovery following an elective liver transplant. This coding differs from the PIM2 coding for liver failure. 6. *(Code no longer in Use) Necrotising Enterocolitis (NEC) **7. SCID and BMT Recipient** - The patient has a documented diagnosis of severe combined immune deficiency (SCID) AND is a recipient of a bone marrow transplant (BMT). Patients with severe combined immune deficiency who have had a successful bone marrow transplant following which they have been discharged home, are still considered to have severe combined immune deficiency. **8. Leukaemia or Lymphoma after completion of first induction and BMT recipient** - Identifies whether the child has leukaemia or lymphoma, AND is a recipient of a bone marrow transplant (BMT). Include only cases where the admission is related to leukaemia, lymphoma, the BMT or other therapy for these conditions.
Mandatory Field	Yes

Additional Comments	
References	PIM 2/3 Information Booklet
Revised	Code 6 no longer in use. See PIM3 High Risk Diagnosis code 6 instead.
Revised	January 2026: Clarification of the data collection method

5. Physiology

General Instructions for PIM2 and PIM3 Physiology
PIM2 & PIM3 are calculated from information collected at the time the patient is admitted to the ICU or when care is commenced by a specialist paediatric transport team.
1. Record observations at the time of first face-to-face contact between the patient and a doctor from your intensive care unit (or a doctor from a specialist paediatric transport team), when management of the patient is taken over. **2.** Use the first value of each variable measured within the period from the time of this first contact to one hour after arrival in your ICU. The first contact may be in your ICU, or your emergency department, or a ward in your own hospital, or in another hospital (e.g., on retrieval). **3.** If physiology information was **NOT MEASURED** or is **MISSING**, code as **999**. If using **COMET** software, leave the field **blank**.

5.1. Systolic blood pressure at admission: SBPA

Definition	The patient's systolic blood pressure (SBP) measured in millimetres of mercury (mmHg)

Data Element Attributes	
Source	ICU Admission Summary / Progress Notes / Retrieval documentation / ICU observation chart
Context	SBP used in PIM calculation.
Data Type	Integer
Format	N[NN]
Acceptable Range or Permissible Value(s)	0 – 300
Missing/Null Value	COMET = leave blank Non-COMET = 999
Collection Method	The first systolic blood pressure recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if SBP is from first face-to-face contact (not telephone contact) up to one hour after ICU admission. If both arterial and non-invasive blood pressure (NIBP) are recorded, use the first measurement within the window (first contact → 1 hour after ICU admission), regardless of arterial or NIBP source. Prioritise arterial if both are recorded simultaneously. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Record SBP as 0 if the patient is in cardiac arrest; record 30 if the patient is shocked and the blood pressure is so low that it cannot be measured.
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered > 300	Unable to save screen
Amber	Value entered 0 - 29 or 201 - 300	Check value for accuracy

Additional Comments	
Revised	January 2026: Clarification of the data collection method

5.2. Pupillary reaction: PUPILS

Definition	The pupillary reaction of the patient as represented by a code

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	Pupil reaction used in PIM calculation.
Data Type	Integer
Format	N
Permissible Value(s)	1 Both fixed and dilated 0 All other responses including reactive and unknown
Missing/Null Value	n/a
Collection Method	The Pupillary Reaction field is collected as a code. The first observed pupillary reaction measured and recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Only record as code 1 (Both fixed and dilated) if both pupils are greater than 3mm and both are fixed. Pupil reactions are used as an index of brain function. Do not record a pupil reaction as being fixed if it is due to toxins, drugs, or local injury.
Mandatory Field	Yes

5.3. PaO_2: Oxygen pressure (mmHg): PO2A

Definition	The patient's partial pressure of oxygen (PaO_2), measured in millimetres of mercury (mmHg) from an **arterial** blood sample

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	PaO2/FiO2 ratio used in PIM calculation. Is used in PIM2/PIM3 if oxygen is delivered via ETT, NIV, HFNC or head box.
Data Type	Integer
Format	N[NN]
Acceptable Range or Permissible Value(s)	2 – 700
Missing/Null Value	COMET = leave blank Non-COMET = 999
Collection Method	The first arterial PaO2 recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if recorded within the period from the time of first contact up until one hour after admission to your ICU. If there is more than one PaO2 recorded within the first hour, use the first PaO2 recorded that has a corresponding FiO2 recorded. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Only arterial blood gas measurements are acceptable.
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered < 2 or > 700	Unable to save screen
Amber	Value entered 2 - 19 or 601 - 700	Check value for accuracy

5.4. FiO_2 at time of PaO_2 sample (fraction of oxygen inspired): FIO2A

Definition	The patient's fraction of inspired oxygen (FiO_2), expressed as a fraction

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	PaO2/FiO2 ratio used in PIM calculation. Is used in PIM2/PIM3 if oxygen can be measured accurately e.g. delivered via ETT, NIV, HFNC or head box.
Data Type	Decimal
Format	N.N[N]
Acceptable Range or Permissible Value(s)	0.21 – 1.0
Missing/Null Value	COMET = leave blank Non-COMET = 999
Collection Method	The FiO2 at the time of the first arterial PaO2 recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Record the fraction of inspired oxygen being delivered via endotracheal tube (ETT), non-invasive ventilation (NIV), High Flow Nasal Cannulae (HFNC), or headbox at the same time that the first arterial PaO2 is measured. If room air only, then record FiO2A = 0.21 (21%).
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered < 0.21 or > 1.0	Unable to save screen

5.5. Base excess in arterial, capillary or venous blood: BEA

Definition	The patient's base excess (BE) measured in millimoles per litre (mmols/L)

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	Base excess is used in PIM calculation.
Data Type	Decimal
Format	NN.N or –NN.N
Acceptable Range or Permissible Value(s)	> -49.9 and < 49.9 Indicate negative values
Missing/Null Value	COMET = leave blank Non-COMET = 999
Collection Method	The first base excess value measured and recorded from arterial, capillary or venous blood gas at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval).
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered < -49.9 or > 49.9	Unable to save screen
Amber	Value entered 30.1 to 49.9	Check value for accuracy
Amber	Value entered -49.9 to -30.1	Check value for accuracy

Additional Comments	
Other Notes	As venous values are not used in PIM2/3, any BEA values with BE_SOURCE=3 are not included in the calculation of PIM2/3. This may change in future PIM models.

5.6. Source of base excess: BE_SOURCE

Definition	The source of the base excess (BE) measurement, as represented by a code

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	BE_SOURCE used to determine which BEA measurements are used in PIM2/3 calculation.
Data Type	Integer
Format	N
Permissible Value(s)	0 No BE 1 Arterial 2 Capillary 3 Venous
Missing/Null Value	n/a
Collection Method	The Source of Base Excess field is collected as a code. The source of the first base excess value recorded from arterial, capillary, or venous blood gas at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval).
Mandatory Field	Yes

Additional Comments	
Other Notes	As venous values are not used in PIM2/3, any BEA values with BE_SOURCE=3 are not included in the calculation of PIM2/3. This may change in future PIM models.

5.7. SpO2 – Oxygen Saturation % (via pulse oximetry): SpO2

Definition	The patient's oxygen saturation (SpO2), expressed as a percentage

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	To allow calculation of SpO2/FiO2 ratio.
Data Type	Integer
Format	N[NN]
Acceptable Range or Permissible Value(s)	0 – 100
Missing Value	COMET = leave blank Non-COMET = 999
Collection Method	The first SpO2 measured and recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. If there is more than one SpO2 recorded within this time period, use the first SpO2 that has a corresponding recorded FiO2. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Oxygen saturation is measured via pulse oximetry.
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered > 100	Unable to save screen
Amber	Value entered 0 - 49	Check value for accuracy

5.8. Fraction of inspired oxygen at time of SpO2: FiO2_SAT

Definition	The patient's fraction of inspired oxygen (FiO_2), expressed as a fraction

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	To allow calculation of SpO2/FiO2 ratio.
Data Type	Decimal
Format	N.N[N]
Acceptable Range or Permissible Value(s)	0.21 – 1.0
Missing Value	COMET = leave blank Non-COMET = 999
Collection Method	The FiO2 associated with the first SpO2 measured and recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval). Record the fraction of inspired oxygen being delivered via endotracheal tube (ETT), non-invasive ventilation (NIV), High Flow Nasal Cannulae (HFNC), or headbox at the same time that the first recorded SpO2. If room air only, then record FiO2_SAT = 0.21 (21%).
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered < 0.21 or > 1.0	Unable to save screen

5.9. Lactate: LACTATE

Definition	The patient's lactate measured in millimoles per litre (mmol/L)

Data Element Attributes	
Source	ICU admission summary / Progress notes / Retrieval documentation / ICU observation chart
Context	Allows comparison of lactate values with other fields.
Data Type	Decimal
Format	N[N].NN
Acceptable Range or Permissible Value(s)	0 – 75.00
Missing Value	COMET = leave blank Non-COMET = 999
Collection Method	The lactate value recorded at or about the time of first contact with your ICU doctor or specialist paediatric retrieval team, when management of the patient is taken over. Data may be used if measured and recorded within the period from the time of first contact up until one hour after admission to your ICU. The first contact may be in your ICU, or an Emergency Department or ward in your hospital or another hospital (e.g., on a retrieval).
Mandatory Field	Yes

COMET Warnings		
Warning	**Issue**	**Data entry implication**
Red	Value entered > 75	Unable to save screen
Amber	Value entered 16 - 75	Check value for accuracy

5.10. Respiratory support in the first hour: RS_HR124

Definition	Specifies whether mechanical ventilation was provided at any time during the first hour of admission to ICU

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU observation chart
Context	The field indicating mechanical ventilation during the first hour of admission to your unit is used in the calculation of PIM.
Data type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing Value	n/a
Collection Method	Mechanical ventilation at any time during the first hour in ICU. Mechanical ventilation includes invasive ventilation, mask or nasal continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP), and negative pressure ventilation. Bag/mask ventilation is not counted as mechanical ventilation. High Flow Nasal Cannulae (HFNC) is NOT considered mechanical ventilation when coding this field.
Mandatory Field	Yes

Additional Comments	
Revised	January 2026: Clarification of the data collection method

5.11. Tracheostomy patient indicator: TRACHE

Definition	Specifies whether a patient has a tracheostomy insitu during this ICU admission

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU observation chart
Context	The field indicating whether or not the patient had a tracheostomy is useful in evaluating the complexity of a patient and for validating respiratory support data.
Data type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing Value	n/a
Collection Method	The Tracheostomy field is collected as a code. This field indicates a patient who is admitted with a tracheostomy insitu or who has a tracheostomy inserted during this ICU admission. COMET: auto populate this field with '1' if Intervention Type = Tracheostomy, else zero.
Mandatory Field	Yes

6. RACHS Fields

6.1. Cardiac surgery performed: CARDIAC

Definition	Specifies whether cardiac surgery was performed at any time before and/or during the current admission

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU discharge summary
Context	Values used in the calculation of RACHS.
Data Type	Integer
Format	N
Permissible Value(s)	0 None (i.e., no cardiac surgery performed) 1 Immediately prior to the current admission 2 During the current admission 3 Both 1 & 2 apply
Missing/Null Value	n/a
Collection Method(s)	The Cardiac field is collected as a code. Cardiac surgery does not include surgery performed solely for cannulation or decannulation.
Mandatory Field	Yes

Additional Comments	
Introduced	2007

7. Specific Therapies

7.1. Continuous haemofiltration: CVVH

Definition	An indicator of continuous haemofiltration delivery during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The CVVH field is collected as a code. As the rate of filtration is very small, do not include Slow Continuous Ultrafiltration (SCUF) with ECMO as CVVH.
Mandatory Field	Yes

Additional Comments	
Introduced	2005

7.2. Intermittent haemodialysis: HD

Definition	An indicator of intermittent haemodialysis delivery during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The HD field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2005

7.3. Peritoneal Dialysis: PD

Definition	An indicator of peritoneal dialysis delivery during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The PD field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2005

7.4. Plasma Exchange: PF

Definition	An indicator of plasma exchange delivery during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The PF field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2005
Revised	January 2026: The field definition changed from 'Plasma Filtration' to 'Plasma Exchange'. The variable name remains PF.

7.5. High Frequency Oscillation: HFO

Definition	An indicator of high frequency oscillatory ventilation during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The HFO field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2005

7.6. Inhaled Nitric Oxide: INO

Definition	An indicator of **inhaled** nitric oxide delivery during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The INO field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2005

7.7. Inotropes: INOTROPES

Definition	An indicator of inotrope administration during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 None 1 Commenced within the first hour of admission 2 Commenced after the first hour of admission
Missing/Null Value	n/a
Collection Method	The Inotropes field is collected as a code.
Mandatory Field	Yes

Additional Comments	
Introduced	2009

7.8. Intracranial pressure (ICP) monitoring: ICPM

Definition	An indicator of intracranial pressure monitoring during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The ICPM field is collected as a code. Code as yes anytime ICP is being monitored, whether via an EVD or intracranial / intraparenchymal transducer.
Mandatory Field	Yes

Additional Comments	
Introduced	2005
Revised	January 2026: Clarification of the data collection method

7.9. Ventricular Assist Device: VAD

Definition	An indicator of ventricular assist device therapy during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 None 1 Commenced prior to admission 2 Commenced during this admission
Missing/Null Value	n/a
Collection Method	The VAD field is collected as a code. For ECLS retrievals, code ECMO or VAD as 1 if on ECLS at the time of first face to face contact with the specialist retrieval team or as 2 if not on ECLS at the time of first contact.
Mandatory Field	Yes

Additional Comments	
Introduced	2005: Initially coded as a binary field with values 0, 1
Revised	2011: Revised to above coding categories with values 0, 1, 2

7.10. Extra corporeal membrane oxygenation: ECMO

Definition	An indicator of extracorporeal membrane oxygenation during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 None 1 Commenced prior to admission 2 Commenced during this admission
Missing/Null Value	n/a
Collection Method	The ECMO field is collected as a code. For ECLS retrievals, code ECMO or VAD as 1 if on ECLS at the time of first face to face contact with the specialist retrieval team, or as 2 if not on ECLS at the time of first contact.
Mandatory Field	Yes

Additional Comments	
Introduced	2005: Initially coded as a binary field with values 0, 1
Revised	2011: Revised to above coding categories with values 0, 1, 2

7.11. Indication for ECLS: ECLS_IND

Definition	An indicator of the reason for extracorporeal life support during the patient's ICU admission

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions.
Data Type	Integer
Format	N
Permissible Value(s)	0 None 1 Cardiac surgery 2 Cardiac support (not post cardiac surgery) 3 Cardiac arrest 4 Septic shock 5 Pneumonia 6 ARDS (not associated with pneumonia) 7 Neonatal respiratory failure 8 Other
Missing/Null Value	n/a
Collection Method	The Indication for ECLS field is collected as a code. Indicates the reason for extracorporeal life support (e.g., ECMO or VAD) commenced immediately prior to or during the ICU admission. If multiple instances of ECLS occurred, the indication for the first instance should be recorded. Code must be from 1 to 8 if ECMO or VAD are coded as 1 or 2.
Mandatory Field	Yes

Additional Comments	
Introduced	2011
Revised	January 2026: Code 8 (Other) added to permissible values. Some clarification of the data collection method.

7.12. ECMO for ECPR: ECPR

Definition	Indicates if extracorporeal life support conducted for cardiac arrest, was extracorporeal membrane oxygenation conducted for extracorporeal cardio pulmonary resuscitation

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Used in conjunction with other ECLS fields.
Data type	Integer
Format	N
Permissible value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection method	The ECMO for ECPR field is collected as a code. ECPR field identifies patients whose ECMO cannulation following cardiac arrest is for ECPR. ELSO definition of ECPR: *ECPR denotes Extracorporeal CardioPulmonary Resuscitation, in which ECLS was used as part of the initial resuscitation from cardiac arrest. Patients who are hemodynamically unstable and placed on ECLS emergently without a cardiac arrest are NOT considered ECPR.* ECPR is when ECMO is used as resuscitation when cardiac arrest is unresponsive to usual measures. ECPR is where chest compressions are being performed at the time the decision is made to proceed with cannulation (not at the time of ECMO call out). Examples of coding scenarios: 1. *Cardiac arrest, CPR during cannulation with no return of circulation prior to establishing ECMO flow - code YES.* 2. *Cardiac arrest, CPR during cannulation with return of circulation prior to establishing ECMO flow - code YES.* 3. *Cardiac arrest, return of circulation, but decision to proceed with ECMO cannulation because of haemodynamic instability - code NO.* 4. *Unstable, shocked patient, ECMO call out made during prepping/draping, patient needed a few chest compressions for loss of cardiac output prior to cannulation - code NO.*
Mandatory Field	Yes, if field ECLS_IND is coded 3, indicating cardiac arrest

Additional Comments	
Introduced	January 2017

7.13. Time to Cannulation: CANN_TIME

Definition	The time in minutes from arrest to cannulation if extracorporeal cardiopulmonary resuscitation conducted

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Used in conjunction with other ECLS fields.
Data type	Integer
Format	N[NNN]
Permissible value(s)	0 – 9999 (minutes)
Missing/Null Value	If ECMO is not for ECPR (as defined), then field is left null
Collection method	Enter length of time in minutes from time of cardiac arrest until ECMO flow established. If cannulated for ECMO after cardiac arrest for ECPR, then this field records the length of time between the cardiac arrest and establishment of ECMO flow.
Mandatory Field	Yes, if field ECPR is coded 1 (Yes)

Additional Comments	
Introduced	January 2017

7.14. Enteral Nutrition Commencement Date and Time: ENT_NUT_DT

Definition	Date and time when enteral nutrition was commenced for the patient

Data Element Attributes	
Source	Hospital administration system / Progress notes
Context	Provides information regarding the timing of first enteral nutrition administration during the ICU admission episode. Used to calculate the number of hours from ICU admission to enteral nutrition commencement.
Data type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible value(s)	Valid date and time
Missing/Null Value	Leave blank
Collection method	Enteral nutrition commencement date should be collected in DD/MM/YYYY format; time should be collected in 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. Collected for patients admitted to ICU for > 24 hours. INCLUDE: commencement of any volume or type of nutrition delivered orally or via a feeding tube. EXCLUDE the following CLEAR FLUIDS: water or oral rehydration solution such as glucolyte, gastrolyte, hydralyte, or if type of clear fluid is not specified. “Enteral nutrition commencement date/time” must be between the “ICU admission date/time” and “ICU discharge date/time”.
Mandatory Field	No

Additional Comments	
Introduced	January 2026

8. Additional fields related to ICU deaths

8.1. Principal Cause of Death: CAUSE_DEATH

Definition	The principal diagnostic reason for cause of patient's death

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary / Morbidity & Mortality meeting
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Integer
Format	NNN[N]
Permissible Value(s)	100 – 1999
Missing/Null Value	If ICU Outcome is not coded as 2 Died, field is left null
Collection Method	The Principal Cause of Death field is collected as a code. Select the appropriate code from the list of ANZPIC Registry Diagnostic Codes Table (Appendix B). This should be the reason most directly responsible for death. Where a code is not available for the specific diagnosis, select the closest system code and category 'Other' (e.g., Neurological – Other). Examples of coding scenarios: 1. *Asthma with a cardiorespiratory arrest, hypoxic brain injury and brain death – cause of death is asthma.* 2. *Disseminated fungal infection in a neutropaenic patient following bone marrow transplant for SCID – cause of death is SCID.*
Mandatory Field	Yes, when ICU Outcome is coded as 2 (Died)

Additional Comments	
Introduced	January 2017
References	Please refer to Appendix B for the ANZPIC Registry Diagnostic Codes Table, this list is reviewed and updated annually

8.2. Mode of Death: DEATH_MODE

Definition	Identifies the mode of death if patient dies during their stay in ICU

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Integer
Format	N
Permissible Value(s)	1 Brain death 2 Death with maximal support 3 Death with therapy limited but not withdrawn 4 Death with therapy withdrawn
Missing/Null Value	If ICU Outcome not coded as 2 Died, field is left null
Collection Method	The Mode of Death field is collected as a code. Includes patients who died whilst physically outside your unit but before being discharged from your unit (e.g., in theatre). Also possible for this field to be coded if the patient died after ICU discharge but within hospital.
Mandatory Field	Yes, when ICU Outcome is coded as 2 (Died)

8.3. External Cardiac Massage performed as the terminal event: ECM

Definition	Identifies whether external cardiac massage (ECM) was performed as the terminal event

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	If ICU Outcome not coded as 2 Died, field is left null
Collection Method	The External Cardiac Massage field is collected as a code.
Mandatory Field	Yes, when ICU Outcome coded as 2 (Died)

8.4. Limitation of therapy order: LIMIT

Definition	Identifies whether there was a limitation of therapy order documented in the patient's medical record

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	If ICU Outcome is not coded as 2 Died, field is left null
Collection Method	The Limitation of Therapy Order field is collected as a code.
Mandatory Field	Yes, when ICU Outcome is coded as 2 (Died)

8.5. Date of limitation of therapy order: LIMIT_D

Definition	Identifies the date of limitation of therapy order (if this occurs whilst the child is resident on your unit)

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Date
Format	DD/MM/YYYY
Permissible Value(s)	Field can be left blank if Limitation of Therapy Order not coded as 1 Yes, although it is possible to have this data entered for a child who did not die during the ICU episode.
Missing/Null Value	If Limitation of Therapy Order is not coded as 1 Yes, field is left null
Collection Method	Enter the date when a Limitation of Therapy Order is documented. Applies only if the limitation occurs during the current ICU stay.
Mandatory Field	Yes, when ICU Outcome is coded as 2 (Died) AND Limitation of Therapy is coded as 1 (Yes)

Additional Comments	
Revised	January 2026: Clarification of the data collection method

8.6. Organ Donation: ORG_DON

Definition	Identifies whether the deceased patient was an organ donor

Data Element Attributes	
Source	Progress Notes / ICU Discharge Summary
Context	Required for epidemiological analysis and assessment of health services delivery.
Data type	Integer
Format	N
Permissible Value(s)	1 Brain death not present (DCD not considered) 2 Brain death, organ donor 3 Brain death, contraindication to organ donation 4 Brain death, consent not requested 5 Brain death, consent requested and refused 6 Donation after Cardiac Death (DCD) 7 DCD consent requested and refused 8 DCD consented but did not donate 9 Brain death, consented but did not donate
Missing/Null Value	If ICU Outcome is not coded as 2 Died, field is left null
Collection Method	The Organ Donation field is collected as a code. This field does not apply to tissue donation.
Mandatory Field	Yes, when ICU Outcome is coded as 2 (Died)

9. Intervention Episodes

General Instructions

Fields in this section are completed in the Episodes of Intervention section of the ANZPIC Registry Data Collection Form. This information is to be submitted as a separate electronic file to other patient admission data. Further instructions for the recording of this data are outlined below:

- Invasive ventilation (IV) is mechanical ventilation delivered via ETT or Tracheostomy.
- Non-invasive ventilation (NIV) refers to CPAP, BiPAP or NPV delivered by Mask, Nasal Prong, or Cuirass.
- High Flow Nasal Cannulae (HFNC) – to be regarded as high-flow, threshold must be > 1 L/Kg/min or > 30 L/min.
- Intubation refers to ETT or tracheostomy.
- A respiratory support episode (IV, NIV or HFNC) includes any breaks of <24 hrs. Recommencing a mode of respiratory support after stopping for longer than 24 hours is regarded as a new episode.
- If a respiratory support episode is a mixture of modalities (e.g., HFNC used during the day and CPAP/BiPAP at night, or a failed extubation where non-invasive ventilation has been used for a short length of time between intubations), then assign the episode to the most invasive modality. Where respiratory support is a consecutive process involving the stepping down or up of modalities (e.g., weaning), these should be recorded as separate episodes.
- All episodes of intubation and ECLS are to be recorded, irrespective of breaks of any length in time.
- All episodes of intubation must have a code of 1 to 8 included to describe the extubation. If still intubated on ICU discharge or death, then use code 8 (No extubation). If patient extubated electively as part of withdrawal of care, then use code 1 (Planned, successful).

9.1. Episode Category: EPI_CAT

Definition	The category or mode of respiratory intervention

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required to identify the mode of each intervention.
Data type	Integer
Format	N
Permissible Value(s)	1 Invasive Ventilation 2 Non invasive Ventilation 3 HFNC 4 Intubation 5 ECLS
Missing/Null Value	n/a
Collection Method	The Episode Category field is collected as a code. Definitions: 1. Invasive ventilation (IV) is mechanical ventilation delivered via ETT or Tracheostomy. 2. Non-invasive ventilation (NIV) refers to CPAP, BiPAP or NPV delivered by Mask, Nasal Prong, or Cuirass. 3. High Flow Nasal Cannulae (HFNC) – flow rate must be > 1 L/Kg/min or > 30 L/min. 4. Intubation refers to ETT or tracheostomy. 5. Extracorporeal Life Support (ECLS) includes Extra Corporeal Membrane Oxygenation (ECMO) or Ventricular Assist Device (VAD).
Mandatory Field	Yes

9.2. Episode START Date and Time: EPICOM_DT

Definition	The commencement date and time of the corresponding respiratory intervention episode

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required to identify the period of each intervention.
Data type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value(s)	Valid date and time
Missing/Null Value	n/a
Collection Method(s)	Date should be collected in DD/MM/YYYY format; time should be collected in 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. If the patient was admitted to the ICU on respiratory support or ECLS, the start date/time must be equal to the ICU admission date/time.
Mandatory Field	Yes

9.3. Episode STOP Date and Time: EPICEAS_DT

Definition	The cessation date and time of the corresponding respiratory intervention episode

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	Required to identify the period of each intervention.
Data type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value(s)	Valid date and time
Missing/Null Value	n/a
Collection Method(s)	Date should be collected in DD/MM/YYYY format; time should be collected in 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. If the patient was discharged from ICU on respiratory support or ECLS, the stop date/time must be equal the ICU discharge date/time.
Mandatory Field	Yes

9.4. Extubation description: EXTUB

Definition	The description of the extubation relating to the corresponding episode of intubation

Data Element Attributes	
Source	Progress notes / ICU observation chart
Context	The rate of failed extubation is a process of care measure for the Registry.
Data type	Integer
Format	N
Permissible Value(s)	1 Planned, successful 2 Planned, successful, but with planned reintubation 3 Planned, failed* (upper airway obstruction) 4 Planned, failed* (resp failure/lung disease) 5 Planned, failed* (other) 6 Unplanned, (but) successful 7 Unplanned, failed* 8 No extubation 9 (default value) not an intubation episode ** requiring re-intubation within 24 hours of extubation*
Missing/Null Value	n/a
Collection Method	The Extubation field is collected as a code. All episodes of intubation must have a code of 1 to 8 included to describe the extubation. If still intubated on ICU discharge or death, use code 8 (No extubation). If extubated electively as part of withdrawal of care, use code 1 (Planned, successful).
Mandatory Field	Yes

10.Associated Diagnoses

General Instructions

Fields in this section are completed in the Associated Diagnosis section of the ANZPIC Registry Data Collection Form. An unlimited number of associated diagnoses can be reported per ICU admission. This information is to be submitted as a separate electronic file from other patient admission data. Further instructions for recording this data field are outlined below:

- Associated diagnoses (ADX) include procedures, adverse events and morbidities of interest that are pre-existing or occurring on or during the ICU admission.
- When recording ADX, select the appropriate code from the ANZPIC Registry Diagnostic Codes Table (Appendix B).
- Ensure ADX category is reported as either 1 (Pre-existing), 2 (Acute), or 3 (ICU occurrence). Only use code 9 (Not coded) if your unit cannot submit data in the new ADX file format. Do not use code 9 for unknown timing of diagnosis.
- **ADX Category 1: Pre-existing** captures conditions present more than 30 days before ICU admission.
- **ADX Category 2: Acute (on ICU admission)** captures conditions present at the time of ICU admission**.** This diagnosis should have been present less than 30 days before ICU admission. Include conditions that are present at the time of admission, even if they are diagnosed after admission.
- **ADX Category 3: ICU occurrence** captures diagnoses or events that occur during the ICU admission**.**
- **ADX Date & Time** is mandatory for all post-procedural diagnoses occurring during ICU admission (i.e., diagnosis codes between 1000 and 1999 when ADX Category 3 is reported).
- The following **MANDATORY DIAGNOSES** must be reported if they occur during ICU admission (ADX Category 3):
  - **Post-procedural** (1000 to 1999) – ADX Date & Time (of procedure completion or of return to ICU from theatre etc.) is mandatory
  - **Dysrhythmia requiring intervention** (271) – (excluding sinus bradycardia). Interventions include cooling <36.5°C, anti-arrhythmic drugs, cardioversion, temporary pacing
  - **Cardiac arrest in ICU** (852) – absent pulse or external cardiac massage for > 30 seconds
  - **Emergency chest opening** (1990) – opening of the chest where the sternum is not already open
  - **Chylothorax** (455) – as diagnosed by local guidelines
  - **Vascular thrombosis, other** (261) – requires treatment or is occlusive or symptomatic
  - **Vascular thrombosis, vascular access device related** (272) – requires treatment or is occlusive or symptomatic
  - **Brain infarction or stroke** (305)
  - **Intracranial haemorrhage, non-traumatic** (315) – excluding grade I or II intra-ventricular haemorrhage
  - **Necrotising enterocolitis** (611) – definite or advanced – Modified Bell's Stage II or worse
  - **Pressure injury** (128) – full thickness or tissue loss – National Pressure Ulcer Advisory Panel Stage 3 or worse
  - **Extravasation injury** (129) – full thickness skin loss or worse
  - **Post-operative bleeding** (1108) – requiring surgical intervention

10.1. Associated Diagnosis, Procedure or Event: ADX

Definition	Associated conditions are those listed in addition to the principal reason for the child's admission to your unit (including procedures, adverse events, and/or morbidities that are pre-existing, or occurring on or during the ICU admission).

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU discharge summary
Context	To establish any associated conditions or procedures relating to the ICU admission.
Data type	Integer
Format	NNN[N]
Permissible Value(s)	Code from the ANZPIC Registry Diagnostic Codes Table (Appendix B)
Missing/Null Value	n/a
Collection Method	Select the appropriate code from the list of ANZPIC Registry Diagnostic Codes Table (Appendix B). Associated Diagnoses include other morbidities, procedures, and/or adverse events that are pre-existing, or occurring on or during the ICU admission. For patients who have surgery during their ICU admission, 'post-procedural' diagnoses should be listed as Associated Diagnoses. An unlimited number of Associated Diagnoses can be reported per ICU admission. Only repeat diagnosis codes when it is necessary to indicate separate unique instances. Please see above for additional details pertaining to the mandatory diagnoses that must be reported if occurrence is during ICU admission (ADX_CAT = 3). Where an 'Other' diagnosis codes have been used (e.g., 450 Respiratory – Other), note the actual diagnosis and further details in the DIAGTEXT field.
Mandatory Field	No

Additional Comments	
Introduced	June 2021
References	Please refer to Appendix B for the ANZPIC Registry Diagnostic Codes Table. This list is reviewed and updated as needed.

10.2. Associated Diagnosis Category: ADX_CAT

Definition	To describe the timing of all relevant associated diagnoses - either pre-existing, or occurring on or during the ICU admission

Data Element Attributes	
Source	ICU admission summary/Progress notes/ ICU discharge summary
Context	To establish and detail any associated conditions or procedures relating to the ICU admission.
Data type	Integer
Format	N
Permissible Value(s)	1 Pre-existing 2 Acute (on ICU admission) 3 ICU occurrence (during ICU admission) 9 Not coded
Missing/Null Value	9
Collection Method(s)	Please ensure ADX category is reported as either 1 (pre-existing), 2 (acute), or 3 (ICU occurrence). **ADX Category 1: Pre-existing** captures conditions present more than 30 days before ICU admission. An ADX Date & Time (ADX_DT) can be entered but is not mandatory for this category. Pre-existing conditions cannot be coded for patients <= 30 days of age. **ADX Category 2: Acute (on ICU admission)** captures conditions present at the time of ICU admission**.** This diagnosis should have been made less than 30 days prior to ICU admission. Include conditions that are present at the time of admission, even if the condition is diagnosed after admission. An ADX Date & Time (ADX_DT) can be entered but is not mandatory for this category. **ADX Category 3: ICU occurrence** captures diagnoses or events that occur during the ICU admission**.** If ADX Category 3 is recorded, an ADX Date & Time (ADX_DT) is mandatory when ADX is a post-procedural diagnosis code (i.e., codes between 1000 and 1999). ADX Date & Time (ADX_DT) can be entered but is not mandatory for all other ADX diagnosis codes. Only use code 9 (Not coded) if your unit cannot submit data in the new ADX file format. Do not use code 9 for unknown timing of diagnosis.
Mandatory Field	No

Additional Comments	
Introduction	June 2021

10.3. Associated Diagnosis Date and Time: ADX_DT

Definition	To describe the timing of all relevant associated diagnoses - either pre-existing, or occurring on or during the ICU admission

Data Element Attributes	
Source	ICU admission summary/Progress notes/ ICU discharge summary
Context	To establish and detail any associated conditions or procedures relating to the ICU admission.
Data type	Date/Time
Format	DD/MM/YYYY HH:MM
Permissible Value(s)	Valid date and time
Missing/Null Value	Null
Collection Method(s)	The date should be collected in DD/MM/YYYY format and time in a 24-hour clock format (0000 – 2359). 23:59 is the end of one day and 00:00 is the start of the next day. ADX Date & Time can be entered for all ADX records but it is not mandatory unless ADX_CAT = 3 (ICU occurrence) and ADX is a post-procedural diagnosis (codes between 1000 and 1999).
Mandatory Field	No

Additional Comments	
Introduction	June 2021

11. Retired fields now calculated centrally

11.1. Previous PICU admission: PREV_AD

Definition	The patient has previously been admitted to your PICU during the current hospital admission

Data Element Attributes	
Source	Calculated centrally from data submitted to ANZPICR
Context	
Data Type	
Format	
Acceptable Range or Permissible Value(s)	0 No 1 Yes – readmitted <= 48hrs post discharge 2 Yes – readmitted > 48hrs post discharge
Missing/Null Value	n/a
Collection Method(s)	A previously collected field. Now calculated centrally from data submitted to ANZPICR (comparing matches based on the HADM_DT and UR_NO fields).
Mandatory Field	n/a

Additional Comments	
Superseded Field	This was a mandatory field until 2010 when the new field, UNPL_READ, was introduced
Retired Field	The PREV_AD field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database. **Field used in risk-adjusted LoS model.**

11.2. Intubation commenced date and time: ICOM1

Definition	If the patient was intubated at any time during their stay on your unit, this field documents the date and time of the start of the first intubation episode

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Intubation is defined as having a laryngeal mask, endotracheal tube, endobronchial tube or a tracheostomy tube in situ. If the patient was intubated prior to ICU admission, record the intubation commenced time as equal to the time of admission to ICU.
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.3. Intubation ceased date and time: ICEAS1

Definition	If the patient was intubated at any time during their stay on your unit, this field documents the date and time of the end of the first intubation episode

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Intubation is defined as having a laryngeal mask, endotracheal tube, endobronchial tube or a tracheostomy tube in situ. If the patient was discharged from ICU before extubation, record the intubation ceased time as equal to the time of discharge from ICU.
Mandatory Field	No

Data Submission Validation Report	
Issue(s)	**Action to be taken by unit**
Must be greater than ICOM1	
Must be less than or equal to DIS_DT	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.4. Intubation commenced date and time: ICOM2

Definition	If the patient was intubated at any time during their stay on your unit, this field documents the date and time of the start of the second intubation episode

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Intubation is defined as having a laryngeal mask, endotracheal tube, endobronchial tube or a tracheostomy tube in situ
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.5. Intubation ceased date and time: ICEAS2

Definition	If the patient was intubated at any time during their stay on your unit, this field documents the date and time of the end of the second intubation episode

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Intubation is defined as having a laryngeal mask, endotracheal tube, endobronchial tube or a tracheostomy tube in situ. If the patient was discharged from ICU before extubation, record the intubation ceased time as equal to the time of discharge from ICU.
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.6. Additional hours of intubation: I_ADHR

Definition	Specifies the number of additional hours of intubation for patients who have > 2 episodes of intubation

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Numeric value with up to 2 decimal places (total number of hours)
Missing/Null Value	
Collection Method(s)	The first two episodes are recorded, and length, in hours, of all subsequent episodes are added together for the value in this field
Mandatory Field	No

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.7. Respiratory support commenced: RSCOM1

Definition	Specifies whether the admission received mechanical respiratory support at any time during their stay on your unit. Documents the date and time that the first episode of respiratory support commenced

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Respiratory support is defined as Invasive or Non-invasive and includes SIMV, CPAP, BIPAP, HFOV, jet ventilation and IPPV. Note that High Flow is not classed as mechanical respiratory support.
Mandatory Field	No

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.8. Respiratory support ceased date and time: RSCEAS1

Definition	Specifies whether the admission received mechanical respiratory support at any time during their stay on your unit. Documents the date and time that the first episode of respiratory support ceased

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Respiratory support is defined as SIMV, CPAP, BIPAP, HFOV, jet ventilation and IPPV. Note that High Flow is not classed as mechanical respiratory support. If the patient was discharged from ICU intubated and ventilated, then record the respiratory support ceased time as equal to the time of discharge from ICU.
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.9. Respiratory support commenced date and time: RSCOM2

Definition	If the patient was intubated at any time during their stay on your unit, this field documents the date and time of the start of the second respiratory support episode

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Respiratory support is defined as Invasive or Non-invasive and includes SIMV, CPAP, BIPAP, HFOV, jet ventilation and IPPV. Note that High Flow is not classed as mechanical respiratory support.
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.10. Respiratory support ceased date and time: RSCEAS2

Definition	Specifies whether the admission received mechanical respiratory support at any time during their stay on your unit. Documents the date and time that the second episode of respiratory support ceased

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Date/time field DD/MM/YYYY HH:MM
Missing/Null Value	
Collection Method(s)	Respiratory support is defined as SIMV, CPAP, BIPAP, HFOV, jet ventilation and IPPV. Note that High Flow is not classed as mechanical respiratory support. If the patient was discharged from ICU intubated and ventilated during this second episode, then record the respiratory support cease time as equal to the time of discharge from ICU.
Mandatory Field	

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

11.11. Respiratory support additional hours: RS_ADHR

Definition	Specifies the number of additional hours of respiratory support for patients who have > 2 episodes of respiratory support

Data Element Attributes	
Source	
Context	Required for epidemiological analysis, assessment of health services delivery and measurement of main therapeutic interventions
Data Type	
Format	
Acceptable Range or Permissible Value(s)	Numeric value with up to 2 decimal places (total number of hours)
Missing/Null Value	
Collection Method(s)	The first two episodes are recorded, and length, in hours, of all subsequent episodes are added together for the value in this field
Mandatory Field	No

Additional Comments	
Retired Field	This field is no longer included in the data submission file, but is instead calculated centrally to maintain continuity of this field in the ANZPICR database

12. Retired fields

12.1. RETIRED FIELD - Gestational age: GESTATION

Definition	The patient's gestational age at delivery in weeks if patient is ≤ 1 year old at ICU admission

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	For young infants, there is evidence that gestational age can act as an important prognostic factor
Data Type	Integer
Format	NN
Acceptable Range or Permissible Value	22 – 40 (weeks)
Missing/Null Value	Null
Collection Method	The field GESTATION is expressed in weeks. When gestational age is calculated using the first day of the last normal menstrual period, the first day is counted as day zero and not day one. Therefore, a 25 week, 5 day foetus is considered a 25 week foetus. Gestation is expressed as a whole number, rounded down. If < 37 gestational weeks completed and ≤ 12 months of age at time of admission to your unit, enter number of weeks of gestation. If ≥ 37 gestational weeks completed or > 12 months of age at admission to your unit, enter 40.
Mandatory Field	No

Additional Comments	
Introduced	2007
Retired	January 2026

12.2. RETIRED FIELD – Ethnicity: RACE

Definition	Ethnicity of a patient, as determined by the patient or next of kin

Data Element Attributes	
Source	Hospital medical record / Patient admission details
Context	Required to stratify data based on ethnicity.
Data Type	Integer
Format	N
Permissible Value(s)	1 Caucasian 2 Aboriginal or Torres Strait Islander (ATSI) 3 Māori 4 Pacific Peoples 5 Asian 6 Other
Missing/Null Value	Null
Collection Method	This field collects a patient's ethnicity based on the following definitions: 1 – **Caucasian** Of Caucasoid heritage, includes European, Russian, Middle Eastern and Arabic 2 – **Aboriginal or Torres Strait Islander (ATSI)** Of ATSI descent, who identifies as an ATSI and is accepted as such by the community with which the patient is associated 3 – **Maori** Determined by self-identification 4 – **Pacific Peoples** Patient whose ethnic background originates from the countries of Pacific Oceania, excluding Maori 5 – **Asian** Patient whose ethnic background originates from the countries of Asia, South East Asia and the Indian subcontinent 6 – **Other**
Mandatory Field	No

Additional Comments	
Retired Field	Retired field in 2007, but still optionally recorded by some units

12.3. RETIRED FIELD – Associated Diagnostic Codes: ADX1 – ADX7

Definition	Associated conditions in addition to that listed as the principal reason for the admission of the child to your unit

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	To establish any associated conditions or procedures relating to the ICU admission
Data Type	Integer
Format	NNN[N]
Permissible Value	Code from the ANZPIC Registry Diagnostic Codes Table (Appendix B)
Missing/Null Value	Null
Collection Method	Select the appropriate code from the list of ANZPIC Registry Diagnostic Codes Table (Appendix B). Associated diagnoses include other syndromes, diseases or abnormalities that the patient might have on admission to your unit, as well as additional diagnoses identified during the admission. For patients who have surgery during their ICU admission, the 'Post Procedural' diagnoses should be listed here as Associated Diagnoses. Code up to seven Associated Diagnoses, only repeating/re-using the Principal or Underlying Diagnosis to indicate separate instances or historical diagnoses that are relevant to the present admission. Where 'Other' diagnosis codes have been used (e.g. 450 Respiratory – Other), please note the actual diagnosis and further details in the DIAGTEXT field.
Mandatory Field	No

Additional Comments	
Revised	2010: ADX6 and ADX7 introduced
Retired	June 2021: Associated Diagnosis information now collected using fields ADX, ADX_CAT and ADX_DT (Please refer to Section 10 for the definitions for these data fields)

12.4. RETIRED FIELD – PIM2 High Risk Conditions: PIM_UC

Definition	Specific condition associated with increased mortality risk in PIM2 model

Data Element Attributes	
Source	ICU admission summary / Progress notes / ICU Discharge Summary
Context	Weighted field used in PIM 2 **This field retired from January 2012**
Data type	Integer
Format	NN
Permissible value(s)	0 None 1 Cardiac arrest out of hospital 2 Severe combined immune deficiency (SCID) 3 Leukaemia or lymphoma after 1st induction 4 Spontaneous cerebral haemorrhage 5 Cardiomyopathy or myocarditis 6 Hypoplastic left heart syndrome (HLHS) 7 HIV infection *8 IQ < 35 (ie less than Downs) – code not used from 2009 onwards* 9 Neurodegenerative disorder 10 Liver failure - acute or chronic, is the main reason for ICU admission 11 Cardiac arrest in hospital - preceding ICU admission
Missing/Null Value	n/a
Collection Method	The PIM2 field is collected as a code. Definitions: **1. Cardiac arrest out of hospital** - requires either documented absent pulse or the requirement for external cardiac massage for a period of 30 seconds or longer. Do not include past history of cardiac arrest. **2. Severe combined immune deficiency** - requires the documented diagnosis of SCID. **3. Leukaemia or lymphoma after 1st induction**. Include only cases where the admission is related to leukaemia or lymphoma, or the therapy for these conditions. **4. Spontaneous cerebral haemorrhage** - haemorrhage must be spontaneous (for example, from an aneurysm or AVM). Do not include traumatic cerebral haemorrhage or intracranial haemorrhage that is not intracerebral (e.g. subdural haemorrhage). **5. Cardiomyopathy or myocarditis** - requires the documented diagnosis of myocarditis or cardiomyopathy. **6. Hypoplastic left heart syndrome** – at any age on admission, but include only cases where a Norwood procedure, or equivalent, is required in the neonatal period to sustain life. If a subsequent heart transplant, then this diagnosis and high risk indicator no longer apply.

	7. HIV infection - requires the documented diagnosis of HIV. Identifies whether the child is HIV antigen positive as documented in the case notes prior to or at admission to your unit. **8.** IQ < 35 (i.e. less than Down Syndrome) – code not used from 2009 onwards **9. Neurodegenerative disorder** - requires a history of progressive loss of milestones (even if no specific condition has been diagnosed) or a diagnosis where this will inevitably occur. **10.Liver failure** - acute or chronic, is the main reason for ICU admission. Include patients admitted for recovery following liver transplantation for acute or chronic liver failure. **11.Cardiac arrest in hospital** - preceding ICU admission. Identifies whether or not the child received cardiopulmonary resuscitation INSIDE the hospital prior to admission to your unit regardless of whom it was given by. Requires either documented absent pulse or the requirement for external cardiac massage for a period of 30 seconds or longer. Precordial thumps of defibrillation without cardiac massage should not be included. Do not include past history of cardiac arrest.
Mandatory Field	n/a

Additional Comments	
Retired	January 2012

12.5. RETIRED FIELD - Major non-cardiac structural anomaly: NC_STAN

Definition	Indicator of a major non-cardiac structural anomaly

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Values used in RACHS calculation **Field retired 1/1/2019**
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Major Non-Cardiac Structural Anomaly field is collected as a code. Select the appropriate code from provided coding list from RACHS-1 developers
Mandatory Field	n/a (previously Yes)

Additional Comments	
Introduced	2007
Retired	1/1/2019
References	K.Jenkins et al. Consensus-based method for risk adjustment for surgery for congenital heart disease. *J Thorac Cardiovasc Surg 2002; 123: 110-8*

12.6. RETIRED FIELD - Antenatal diagnosis of major structural anomaly: AD_STAN

Definition	Defines whether the child was diagnosed antenatally with a major structural anomaly

Data Element Attributes	
Source	ICU admission summary / Progress notes
Context	Values collected for possible use in ANZ version of RACHS model
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method(s)	The Antenatal Diagnosis of Major Structural Anomaly field is collected as a code. This field usually only relevant for child less than 1yr old. This field should not be coded yes if the structural anomaly has been repaired and is not related to this admission. The antenatal diagnosis should only be coded if the congenital anomaly diagnosed antenatally is the primary or underlying diagnosis leading to admission e.g., cardiac structural anomaly or congenital diaphragmatic hernia. Check antenatal diagnosis against the list of structural anomalies listed in Appendix C.
Mandatory Field	Yes

Additional Comments	
Introduced	2007
Retired	January 2026

12.7. RETIRED FIELD - Combination of cardiac surgery procedures at a single operation: CP_SOP

Definition	Specifies whether two or more unrelated cardiac surgery procedures were performed at a single operation

Data Element Attributes	
Source	ICU admission summary / progress notes / ICU discharge summary
Context	Value is used in the calculation of RACHS. This field has a weighting in the calculation of RACHS as indicating more complex surgery. **Field retired 1/1/2019**
Data Type	Integer
Format	N
Permissible Value(s)	0 No 1 Yes
Missing/Null Value	n/a
Collection Method	The Combination of Cardiac Surgery field is collected as a code. Cardiac surgery procedures must be performed at a single operation for this field to be coded 1 Yes.
Mandatory Field	n/a (previously Yes)

Additional Comments	
Introduced Field	2007
Retired Field	1/1/2019
References	K.Jenkins et al. Consensus-based method for risk adjustment for surgery for congenital heart disease. *J Thorac Cardiovasc Surg 2002; 123: 110-8.*

13. Appendices

Appendix A: ANZPIC Registry Transfer Site List

CODE	CITY	HOSPITAL	TYPE
101	Other	Other Hospital Transfer ICU	
102	Noumea	Gaston Bourret Hospital ICU	Adult
201	Sydney	The Children's Hospital at Westmead PICU	PICU
202	Sydney	The Children's Hospital at Westmead NICU	NICU
203	Sydney	Sydney Children's Hospital PICU	PICU
204	Sydney	St Vincent's Hospital (Sydney) ICU	Adult
205	Sydney	Liverpool Hospital ICU	Adult
206	Newcastle	John Hunter Children's Hospital PICU	PICU
207	Newcastle	John Hunter Hospital NICU	NICU
208	Sydney	Royal Hospital for Women (Sydney) NICU	NICU
209	Sydney	Royal Prince Alfred Hospital NICU	NICU
210	Sydney	Liverpool Hospital NICU	NICU
211	Sydney	Royal North Shore Hospital NICU	NICU
212	Sydney	Nepean Hospital NICU	NICU
213	Maitland	Maitland Hospital ICU	Adult
214	Tamworth	Tamworth Hospital ICU	Adult
215	Taree	Taree Hospital ICU	Adult
216	Newcastle	Calvary Mater (Newcastle) ICU	Adult
301	Melbourne	Royal Children's Hospital (Melbourne) PICU	PICU
302	Melbourne	Royal Children's Hospital (Melbourne) NICU	NICU
303	Melbourne	Monash Children's Hospital PICU	PICU
304	Melbourne	Monash Medical Centre-Clayton Campus NICU	NICU
305	Melbourne	The Royal Women's Hospital (Melbourne) NICU	NICU
306	Melbourne	Mercy Hospital for Women NICU	NICU
307	Melbourne	The Alfred Hospital ICU	Adult
308	Melbourne	The Royal Melbourne Hospital ICU	Adult
309	Geelong	University Hospital Geelong ICU	Adult
310	Bendigo	Bendigo Hospital ICU	Adult
401	Brisbane	Queensland Children's Hospital PICU	PICU
402	Brisbane	Mater Children's Hospital (Brisbane) PICU *(closed)*	PICU
403	Brisbane	The Prince Charles Hospital PICU *(closed)*	Cardiac
404	Townsville	Townsville Hospital ICU-Paeds	PaedsICU
405	Gold Coast	Gold Coast University Hospital CCCU	PaedsICU
406	Brisbane	Royal Brisbane and Women's Hospital NICU	NICU
407	Brisbane	Mater Mothers' Hospital Brisbane NICU	NICU
408	Sunshine Coast	Sunshine Coast University Hospital PCCU	PaedsICU
409	Gold Coast	Gold Coast University Hospital ICU-adults	Adult
501	Adelaide	Women's and Children's Hospital (Adelaide) PICU	PICU
502	Adelaide	Women's and Children's Hospital (Adelaide) NICU	NICU
503	Adelaide	Flinders Medical Centre ICU	CCMU
504	Adelaide	Flinders Medical Centre NICU	NICU
505	Adelaide	Royal Adelaide Hospital ICU	Adult
601	Perth	Perth Children's Hospital PICU	PICU
602	Perth	Perth Children's Hospital NICU	NICU
603	Murdoch	Fiona Stanley Hospital ICU	Adult
701	Hobart	Royal Hobart Hospital NICU/PICU	NICU/PICU
702	Launceston	Launceston General Hospital ICU	Adult
801	Darwin	Royal Darwin Hospital ICU	Adult
802	Alice Springs	Alice Springs Hospital ICU	Adult

CODE	CITY	HOSPITAL	TYPE
901	Auckland	Starship Children's Hospital PICU	PICU
902	Auckland	Auckland City Hospital NICU	NICU
903	Auckland	Auckland City Hospital CVICU	CVICU
904	Hamilton	Waikato Hospital ICU	Adult
905	Hamilton	Waikato Hospital NICU	NICU
906	Christchurch	Christchurch Hospital ICU	Adult
907	Auckland	Middlemore Hospital ICU	Adult
908	Auckland	Middlemore Hospital NICU	NICU
909	Auckland	Auckland City Hospital DCCM	Adult
910	Wellington	Wellington Hospital NICU	NICU
911	Christchurch	Christchurch Hospital NICU	NICU
912	Wellington	Wellington Hospital ICU	Adult

Appendix B: ANZPIC Registry Diagnostic Codes Table – 2026

Australian and New Zealand Paediatric Intensive Care Registry
Diagnostic Codes Table
2026

INJURY
100 Injury – Other
101 Anaphylaxis
102 Burns
103 Carbon Monoxide Poisoning
104 Drug Toxicity – Iatrogenic
105 Electrocution
127 Envenomation – Not elsewhere specified
124 Envenomation (bite) – Snake
123 Envenomation (sting) – Marine
129 Extravasation Injury
107 Hanging or Strangulation
108 Hyperthermia
109 Hypothermia
110 Immersion (Near Drowning)
121 Ingestion – Drug
122 Ingestion – Non-drug
128 Pressure Injury
112 Smoke Inhalation
113 Trauma – Other
114 Trauma – Abdominal
115 Trauma – Chest
116 Trauma – Facial
117 Trauma – Head
118 Trauma – Skeletal
119 Trauma – Spinal

INJURY MECHANISM
****DO NOT USE FOR PRINCIPAL DIAGNOSIS**
150 Injury Mechanism – Other
162 Crush Injury
151 Cyclist
152 Fall
153 Farm Equipment
154 Firearm Injury
164 Horse Related Injury
161 Motor Bike Rider / Passenger
163 MVA – Driveway Pedestrian
155 MVA – Passenger
156 MVA – Pedestrian
157 Non-Accidental Injury
158 Self-Injury
159 Sports Injury
160 Stab Injury

CARDIOVASCULAR – CONGENITAL
200 Cardiovascular – Congenital – Other
230 Cardiovascular – Congenital – Post Palliation
201 Absent Pulmonary Valve
202 Anomalous Coronary Artery
203 Aortic Insufficiency
204 Aortic Stenosis
224 AP Window
234 ASD – Primum/Partial AVSD (no VSD component)
205 ASD – Secundum/Sinus Venosus ASD/PFO
225 AV Malformation
206 AVSD – Complete/Transitional (with VSD component)
207 Coarctation
208 Cor Triatriatum
237 Double Inlet Left Ventricle
226 Double Outlet Right Ventricle
209 Ebstein's Anomaly
210 Hypoplastic Left Heart Syndrome
231 Hypoplastic LV (not HLHS)
232 Hypoplastic RV
211 Interrupted or Hypoplastic Aortic Arch
233 *l*-TGA (Levo-Transposition of Great Arteries)
227 LV Outflow Obstruction
235 MAPCAs
212 Mitral Insufficiency
213 Mitral Stenosis
236 PAPVD
214 PDA
215 Pulmonary Atresia or Stenosis
228 Pulmonary Insufficiency
229 RV Outflow Obstruction
216 Single Ventricle
217 TAPVD
218 Tetralogy of Fallot
219 Transposition of Great Arteries (*d*TGA)
220 Tricuspid Atresia or Stenosis
221 Tricuspid Insufficiency
222 Truncus Arteriosis
223 VSD

CARDIOVASCULAR – AQUIRED
250 Cardiovascular – Acquired – Other
270 Blocked Aorto-Pulmonary Shunt
251 Cardiac Failure
252 Cardiac Tumour
253 Cardiomyopathy/Myocarditis
254 Dysrhythmia – Supraventricular
255 Dysrhythmia – Ventricular
271 Dysrhythmia Requiring Intervention
256 Endocarditis
269 Heart Block
257 Hypertension – Pulmonary
258 Hypertension – Systemic
259 Kawasaki's Disease
268 Myocardial Infarction/Ischaemia
260 Pericardial Effusion or Tamponade
266 Previous Cardiac Surgery
264 Previous Heart Transplant
267 Pulmonary Embolism
265 Rheumatic Heart Disease
261 Vascular Thrombosis – Other
272 Vascular Thrombosis – Vascular Access Device Related
262 Vasculitis

NEUROLOGICAL
300 Neurological – Other
333 Acute Disseminated Encephalomyelitis (ADEM)
328 Arnold Chiari Malformation
301 Botulism
302 Brain Abscess
303 Brain AV Malformation
329 Brain Cyst
304 Brain Death
305 Brain Infarction or Stroke
306 Brain Tumour
324 Cerebral Aneurysm
331 Cerebral Oedema
334 Congenital Brain Anomaly
307 CSF Shunt Malfunction or Infection
308 Encephalitis
309 Encephalopathy, Acute – Hypoxic Ischaemic
310 Encephalopathy, Acute – Other
311 Encephalopathy, Chronic Degenerative (eg Leigh's Sydrome)
312 Encephalopathy, Chronic Static (eg CP)
330 Epilepsy (Comorbidity)
335 Febrile Convulsion
313 Guillain Barre Syndrome
314 Hydrocephalus
315 Intracranial Haemorrhage – Non-Traumatic
332 Intracranial Haemorrhage – Traumatic
316 Intracranial Hypertension (Raised ICP)
317 Meningitis
318 Meningomyelocele or Spina Bifida
325 Muscular Dystrophy
326 Myasthenia Gravis
319 Myopathy
320 Neuropathy
321 Seizures
322 Spinal Cord Lesion
337 Spinal Muscular Atrophy
327 Tetanus
336 Transverse Myelitis (TM)
323 Venous Sinus Thrombosis

RESPIRATORY – UPPER AIRWAY
400 Upper Airway – Other
401 Choanal Atresia or Stenosis
415 Cleft Palate
402 Epiglottitis
403 Foreign Body – Inhaled
414 Laryngomalacia
404 Laryngotracheobronchitis (Croup)
405 Obstructive Sleep Apnoea
406 Pierre Robin Syndrome
407 Retropharyngeal Abscess
413 Subglottic Haemangioma
408 Subglottic Stenosis
409 Tracheitis
410 Upper Airway Obstruction – Other
411 Upper Respiratory Infection – Other
412 Vocal Cord Paresis

RESPIRATORY – LOWER AIRWAY
430 Lower Airway – Other
431 Asthma
439 Bronchiectasis
432 Bronchiolitis
433 Chronic Lung Disease (Includes BPD)
434 Malacia – Trachea and/or Bronchi
435 Mediastinal Mass
436 Stenosis – Trachea and/or Bronchi
437 Tracheo-oesophageal Fistula
438 Vascular Ring

RESPIRATORY – OTHER
450 Respiratory – Other
469 Lower Respiratory Infection – Other
451 Air Leak Syndrome
452 Apnoea – Central
453 ARDS
454 Aspiration
473 Atelectasis
455 Chylothorax
456 Congenital Diaphragmatic Hernia
457 Congenital Lung Anomaly
458 Cystic Fibrosis
459 Empyema
460 Hyaline Membrane Disease
461 Hypoventilation – Central
462 Lung Abscess
463 Meconium Aspiration Syndrome
470 Pertussis Syndrome
464 Pleural Effusion
465 Pneumonia or Pneumonitis
471 Previous Lung Transplant
474 Pulmonary Haemorrhage
466 Pulmonary Hypoplasia
467 Pulmonary Oedema
468 Respiratory Failure
472 Transient Tachypnoea of the Newborn

RENAL
500 Renal – Other
501 Haemolytic Uraemic Syndrome
507 Hydronephrosis
502 Nephrotic and/or Nephritic Syndrome
505 Previous Renal Transplant
503 Renal Failure – Acute
504 Renal Failure – Chronic
506 Urinary Tract Infection

GASTROINTESTINAL
600 Gastrointestinal – Other
620 Biliary Atresia
601 Bowel Obstruction
621 Bowel Perforation
630 Chylous Effusion
602 Colitis
603 Gastroenteritis
628 Gastro-oesophageal Reflux
604 Gastrointestinal Haemorrhage
605 Gastroschisis or Exomphalos
606 Hepatitis
622 Hirschsprung's Disease
607 Intussusception
608 Liver Disorder – Other
609 Liver Failure – Acute
610 Liver Failure – Chronic

Australian and New Zealand Paediatric Intensive Care Registry
Diagnostic Codes Table
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611 Necrotising Enterocolitis
623 Neonatal Jaundice
612 Oesophageal Atresia
624 Oesophageal Foreign Body
613 Pancreatitis
614 Peritonitis
625 Portal Hypertension
626 Previous Liver Transplant
615 Pyloric Stenosis
616 Short Gut Syndrome
617 Ulcer – Duodenal
618 Ulcer – Gastric or Gastritis
619 Varices – Oesophageal or Gastric
629 Veno Occlusive Disease
627 Volvulus

INFECTION

****DO NOT USE FOR PRINCIPAL DIAGNOSIS**

700 Infection – Other
701 Adenovirus
739 Aspergillosis
702 Bacterium – Other
703 Bacterium – Gram Negative – Other
704 Bacterium – Gram Positive – Other
705 Candida
706 Clostridium
707 CMV
730 E Coli
708 EBV
742 Enterobacter
709 Enterovirus
710 Fungus – Other
711 Haemophilus Influenzae Type B
712 Hepatitis – Viral
713 Herpes Simplex Virus
714 HIV
740 Human Metapneumovirus
715 Influenza Virus
731 Klebsiella
732 Malaria
735 Measles Virus
717 Meningococcus
743 Moraxella
718 Mycoplasma
744 Norovirus
719 Parainfluenzae Virus
747 Parechovirus
720 Pertussis
721 Pneumococcus
722 Pneumocystis Carinii
733 Pseudomonas
746 Rhinovirus
723 Rotavirus
724 RSV
725 Salmonella
741 Staphylococcus – Coagulase Negative
737 Staphylococcus Aureus – Methicillin Sensitive
736 Staphylococcus Aureus – MRSA
727 Streptococcus – Other
745 Streptococcus – Group A
734 Streptococcus – Group B
748 Suspected or Confirmed Pandemic Infection
749 SARS-CoV-2
738 Tuberculosis
728 Varicella
729 Virus – Other
799 No Organism Identified

MISCELLANEOUS

800 Miscellaneous – Other
857 Acid-Base Disorder
801 Acute Life Threatening Event (Near Miss SIDS)
862 Anorexia Nervosa
863 Behavioural Disorder
802 Cardiac Arrest – In Hospital
852 Cardiac Arrest – In ICU
803 Cardiac Arrest – Out of Hospital
804 Chromosomal Anomaly
805 Coagulopathy
839 Craniosynostosis
850 Cystic Hygroma
806 Dehydration
807 Dermatological Disorder
855 Diabetes (Comorbidity)
808 Diabetes Insipidus
809 Diabetes Mellitus with Ketoacidosis
810 Diabetes Mellitus without Ketoacidosis
858 DIC (Disseminated Intravascular Coagulation)
853 Down Syndrome
811 Electrolyte Disorder
812 Endocrine Disorder
864 Failure to Thrive
849 Graft vs Host Disease
847 Haematological Disorder
814 Home Ventilation Patient
815 Hypoglycaemia
816 ICU Diagnostic Monitoring – Elective
817 ICU Procedure (eg CVC Insertion)
818 Immunodeficiency – Congenital
819 Immunosuppression – Acquired
820 Inborn Error of Metabolism
821 Leukaemia or Lymphoma
859 Mitochondrial Disorder
866 Multi Organ Failure
822 Necrotising Fasciitis
840 Neonate – Hydrops Fetalis
841 Neonate – Infant of Diabetic Mother
842 Neonate – IUGR
823 Neutropenia
867 Obesity/Morbid Obesity
848 Organ Donor
860 Osteomyelitis
824 Pancytopenia
825 Phaeochromocytoma
826 Prematurity (<37/40w & <12m of age)
843 Previous Bone Marrow Transplant
827 Respiratory Arrest – In Hospital
851 Respiratory Arrest – In ICU
828 Respiratory Arrest – Out of Hospital
861 Rhabdomyolysis
844 Scoliosis
829 Sepsis
830 Shock – Cardiogenic
831 Shock – Hypovolaemic
832 Shock – Septic
856 SIADH
833 SIRS
865 Skeletal Dysplasia
834 Solid Neoplasm – Malignant (not Lymphoma)
835 Solid Neoplasm – Non-Malignant
836 Syndrome or Malformation (not Chromosomal)
837 Toxic Shock Syndrome
838 Transplant – Bone Marrow
845 Tumour Lysis Syndrome
854 Velo Cardio Facial Syndrome (22q11.2)
846 Wound Infection

POST PROCEDURAL – MISCELLANEOUS / ANAESTHETIC

1100 Post Procedure – Other
1101 Anaesthetic Complication
1106 Cardiac Catheter – Balloon Septostomy
1102 Cardiac Catheter – Diagnostic
1107 Cardiac Catheter – Interventional
1103 Ex-prem, Post GA
1104 Invasive Radiology Procedure
1105 Massive Intraoperative Transfusion (> 1 blood vol)
1109 PEG (Percutaneous Endoscopic Gastrostomy)
1108 Post-operative bleeding
1110 Surgical Complication

POST PROCEDURAL – NEUROSURGERY

1300 Neurosurgery – Other
1301 Craniotomy – Anterior Fossa
1302 Craniotomy – Posterior Fossa
1303 CSF Shunt Insertion or Revision
1304 Decompression – Cranial
1310 Decompression – Craniocervical
1305 Decompression – Spinal Cord
1306 Hemispherectomy or Lobectomy
1307 ICP Monitor or Ventricular Drain Insertion
1308 Intracranial Haematoma Evacuation
1309 Repair Myelomeningocoele
1311 Third Ventriculostomy

POST PROCEDURAL – THORACIC SURGERY

1400 Thoracic Surgery – Other
1401 Diaphragm Plication
1402 Diaphragm Repair
1403 Lung Biopsy
1404 Lung Decortication
1405 Oesophageal Atresia Repair
1406 Pneumonectomy or Lobectomy
1407 Thoracic Tumour Resection
1410 Thoracoscopy
1408 Tracheo-oesophageal Fistula Repair
1409 Tracheopexy
1411 VATS procedure

POST PROCEDURAL – ENT SURGERY

1500 ENT – Other
1501 Adenoidectomy and/or Tonsillectomy
1502 Choanal Atresia Repair
1503 Cricoid Split
1510 Dilatation of Airway
1511 Laryngeal Cleft Repair
1504 Laryngeal Reconstruction
1505 Laryngobronchoscopy
1508 Laryngoplasty
1507 Retopharyngeal Abscess Drainage
1509 Tracheal Reconstruction / Tracheoplasty
1506 Tracheostomy

POST PROCEDURAL – ABDOMINAL / GENERAL SURGERY

1600 General Surgery – Other
1621 Abdominal Aorta Surgery
1601 Abdominal Tumour Resection
1602 Appendicectomy
1603 Bladder Extrophy Repair
1604 Burns Surgery
1605 Fundoplication
1606 Gastroschisis or Exomphalos Repair
1607 GI Endoscopy and/or Sclerotherapy
1608 Intussusception Repair
1609 Kasai
1623 Laparoscopic Surgery
1610 Laparotomy – Other
1615 Laparotomy – Bowel Obstruction
1616 Laparotomy – Bowel Perforation
1617 Laparotomy – GI Haemorrhage
1618 Laparotomy – Necrotising Enterocolitis
1619 Laparotomy – Peritonitis
1620 Laparotomy – Trauma
1611 Transplant – Kidney
1612 Transplant – Liver
1613 Transplant – Small Bowel
1614 Urogenital Surgery – Other
1622 Wound Debridement

POST PROCEDURAL – CRANIOFACIAL SURGERY

1700 Craniofacial Surgery – Other
1706 Cleft Palate Repair
1701 Cranial Vault Reshaping
1702 Dental Surgery
1703 Facial Cleft Repair
1704 Mandibular Mobilisation
1705 Midface Mobilisation

POST PROCEDURAL – ORTHOPAEDIC SURGERY

1800 Orthopaedic Surgery – Other
1801 Fracture Fixation
1802 Spinal Instrumentation

Australian and New Zealand Paediatric Intensive Care Registry
Diagnostic Codes Table
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POST PROCEDURAL – CARDIAC SURGERY

(WITH RACHS RISK CATEGORIES, WHERE APPLICABLE)

1998 Cardiac Surgery Closed – Other
1999 Cardiac Surgery Open – Other
1955 Annuloplasty (RC 3)
1929 Aortic Valve Replacement (RC 3)
1906 Aortic Valvotomy – Valvuloplasty >30d of age (RC 2)
1958 Aortic valvotomy – Valvuloplasty ≤30d of age (RC 4)
1902 Aortopexy (RC 1)
1933 Aortoplasty (not Arch) (RC 3)
1953 Arterial Switch Operation (RC 3)
1966 Arterial Switch Operation with Pulmonary Artery Band Removal (RC 4)
1968 Arterial Switch Operation with Repair of Sub PS (RC4)
1967 Arterial Switch Operation with VSD Closure (RC 4)
1913 ASD and VSD Repair (RC 2)
1914 ASD Primum Repair (RC 2)
1901 ASD Surgery (incl ASD Secundum, Sinus Venosus ASD, Patent Foramen Ovale Closure) (RC 1)
1962 Atrial Septectomy (RC 4)
1952 Atrial Switch Operation (RC 3)
1965 Atrial Switch Operation with Repair of Sub PS (RC 4)
1964 Atrial Switch Operation with VSD Closure (RC 4)
1988 Chest Closure
1942 Closure of Semilunar Valve, Aortic or Pulmonary (RC3)
1904 Coarctation Repair >30d of age (RC 1)
1924 Coarctation Repair ≤30d of age (RC 2)
1927 Common Atrium Closure (RC 2)
1979 Damus-Kaye-Stansel Procedure (RC 6)
1974 Double Switch (RC 4)
1989 ECMO Cannulation/Exploration
1990 Emergency Chest Opening
1957 Excision of Intracardiac Tumour (RC 3)
1986 Fontan Conversion
1946 Fontan Procedure (RC 3)
1987 Fontan Take-down
1921 Glenn Shunt (RC 2)
1959 Konno Procedure (RC 4)
1931 Left Ventricular Outflow Tract Patch (RC 3)
1944 Left Ventricular to Pulmonary Artery Conduit (RC 3)
1928 Left Ventricular to Right Atrial Shunt Repair (RC 2)
1935 Mitral Valve Replacement (RC 3)
1934 Mitral Valvotomy – Valvuloplasty (RC 3)
1997 PA Plasty or Repair
1992 Pacemaker Insertion/Replacement
1905 Partially Anomalous Pulmonary Venous Connection Surgery (RC 1)
1903 PDA Surgery >30d of age (RC 1)
1993 PDA Surgery ≤30d of age
1948 Pulmonary Artery Banding (RC 3)
1911 Pulmonary Outflow Tract Augmentation (RC 2)
1909 Pulmonary Valve Replacement (RC 2)
1908 Pulmonary Valvotomy – Valvuloplasty (RC 2)
1991 Pulmonary Venous Stenosis Repair
1954 Reimplantation of Anomalous Pulmonary Artery (RC3)
1941 Repair Anomalous Coronary Artery with Intrapulmonary Tunnel (Takeuchi) (RC 3)
1940 Repair of Anomalous Coronary Artery without Intrapulmonary Tunnel (RC 3)
1923 Repair of AP Window (RC 2)
1956 Repair of Coarctation and VSD Closure (RC 3)
1960 Repair of Complex Anomaly (Single Ventricle) by VSD Enlargement (RC 4)
1950 Repair of Cor Triatriatum (RC 3)
1912 Repair of Coronary AV fistula (RC 2)
1945 Repair of Double-Outlet Right Ventricle with or without Repair of Right Ventricular Obstruction (RC 3)
1971 Repair of Hypoplastic or Interrupted Arch with VSD Closure (RC 4)
1970 Repair of Hypoplastic or Interrupted Arch without VSD Closure (RC 4)
1925 Repair of Pulmonary Artery Stenosis (RC 2)
1949 Repair of Tetralogy of Fallot with Pulmonary Atresia (RC 3)
1920 Repair of Total Anomalous Pulmonary Veins >30d of age (RC 2)
1947 Repair of Transitional or Complete Atrioventricular Canal with or without Valve Replacement (RC 3)
1963 Repair of Transposition-VSD Sub PS (Rastelli) (RC4)
1969 Repair of Truncus Arteriosus (RC 4)
1976 Repair of Truncus Arteriosus and Interrupted Arch (RC 5)
1918 Repair of Unspecified Septal Defect (RC 2)
1910 Right Ventricular Infundibulectomy (RC 2)
1943 Right Ventricular to Pulmonary Artery Conduit (RC 3)
1930 Ross Procedure (RC 3)
1977 Stage 1 Repair of Hypoplastic Left Heart Syndrome (Norwood) (RC 6)
1978 Stage 1 Repair of Non-Hypoplastic Left Heart Syndrome Conditions (RC 6)
1907 Sub Aortic Stenosis Resection (RC 2)
1951 Systemic to Pulmonary Artery Shunt (RC 3)
1961 Total Repair of Anomalous Pulmonary Veins ≤30d of age (RC 4)
1919 Total Repair of Tetralogy of Fallot (RC 2)
1926 Transection of Pulmonary Artery (RC 2)
1994 Transplant – Heart
1995 Transplant – Heart Lung
1996 Transplant – Lung
1972 Transverse Arch Graft (RC 4)
1938 Tricuspid Valve Replacement (RC 3)
1939 Tricuspid Valve Repositioning for Ebstein Anomaly >30d of age (RC 3)
1975 Tricuspid Valve Repositioning for Neonatal Ebstein ≤30d of age (RC 5)
1937 Tricuspid Valvotomy - Valvuloplasty (RC 3)
1973 Unifocalisation for Tetralogy of Fallot – Pulmonary Atresia (RC 4)
1936 Valvectomy of Tricuspid Valve (RC 3)
1922 Vascular Ring Surgery (RC 2)
1932 Ventriculomyotomy (RC 3)
1917 VSD Closure and Pulmonary Artery Band Removal (RC 2)
1916 VSD Closure and Pulmonary Valvotomy or Infundibular Resection (RC 2)
1915 VSD Repair (RC 2)

Appendix C: ANZPIC Registry Complex Chronic Condition Definitions

Complex chronic conditions include any medical condition that can be reasonably expected to last at least 12 months (unless death intervenes) and to involve either several different organ systems or one organ system severely enough to require specialty paediatric care and probably some period of hospitalisation in a tertiary care centre. The condition must be diagnosed ≥ 30 days prior to ICU admission.

Category	Subcategory	Examples, further notes
Congenital Anomalies		
Congenital malformations and deformations of the musculoskeletal system	Congenital malformations of spine and bony thorax	Scoliosis, Spina bifida occulta, Klippel-Feil syndrome, Congenital spondylolisthesis, Cervical rib, Osteopetrosis, Diaphyseal dysplasis, Jeune syndrome (Asphyxiating thoracic dystrophy)
	Congenital malformation of skull and face bones	Craniosynostosis, Hypertelorism, Pierre-Robin Syndrome, Crouzons Syndrome/Craniofacial Dysostosis, Aperts, Pfeiffer, Saethre-Chotzen
	Osteodystrophies and osteogenesis imperfecta	Osteochrondrodysplasia, Osteopetrosis, Albers-Schonberg disease, Enchondromatosis, Polyostotic fibrous dysplasia, Diaphyseal dysplasia
Chromosomal abnormalities	Sex chromosome anomalies	Gonadal Dysgensis, Turner Syndrome, Kleinfelter Syndrome, Fragile X Syndrome
	Autosomal monosomies, deletions/translocations/anomalies	Cri-du-chat syndrome
	Trisomies and partial trisomies of autosomes	Trisomy 13, 18 or 21
	Congenital malformation syndromes involving early overgrowth	Beckwith-Wiedermann, Sotos
Phakomatoses	Neurocutaneous	Neurofibromatosis, Tuberous sclerosis, Peutz-Jegher, Sturge-Weber, Von Hippel Lindau, Hamartoses (except lymphoedema or vascular)
Other congenital malformation syndromes	Congenital malformation syndromes affecting multiple systems	Marfan's Syndrome, Alport's Syndrome, McCune-Albright syndrome
	Congenital malformation syndromes predominantly associated with small stature	Noonan's Syndrome
Diaphragm and abdominal wall	Congenital malformations of diaphragm	Diaphragmatic hernia
	Congenital malformations of the abdominal wall	Exomphalos, Gastroschisis, Omphalocele, Prune belly syndrome/Eagle-barrett syndrome
Connective tissues	Ehlers Danlos syndrome	
Congenital exposure syndromes	Syndromes due to in-utero exposure to drug or toxin	Foetal alcohol syndrome, foetal phenytoin syndrome

Category	Subcategory	Examples, further notes
Other congenital anomalies	Teratology	Conjoined twins
	Ectodermal dysplasia	
	Connective tissue	Epidermolysis bullosa, Ehlers Danlos syndrome
	Multiple congenital malformations, not elsewhere classified	VACTERL association
Premature/Neonatal *(Note: Applies only to patients aged up to 1 year (chronological age) at time of ICU admission)*		
Disorders relating to length of gestation and foetal growth	Newborn light or small for gestational age < 750g	
	Gestation age <= 26 completed weeks only	
Cerebral injury and other cerebral disturbances during the perinatal period	Cerebral haemorrhage, subdural haemorrhage or tentorial tear due to birth trauma	
	Unilateral IVF >= grade 3	
	Birth injury to spine or spinal cord	
	Hypoxic ischaemia encephalopathy (HIE) - any	
	Kernicterus due to isoimmunization or other specified reason	
	Neonatal cerebral leucomalacia	
Respiratory disorders specific to the perinatal period	Chronic respiratory disease originating in newborn period (excluding chronic lung disease as a consequence of mechanical respiration)	Bronchopulmonary Dysplasia (BPD), Wilson-Mikity Syndrome
Congenital infections	Congenital viral disease	Congenital rubella, CMV, Herpes simplex, Varicella, HIV, Hepatitis B
	Other congenital infections	Toxoplasmosis, syphilis
Other disorders originating in the perinatal period	Necrotising enterocolitis stage 3	Stage 3: Advanced NEC: severely ill, marked distension, signs of peritonitis, hypotension, metabolic & respiratory acidosis, DIC, +/- bowel perforation.
	Hydrops Foetalis due to haemolytic disease or other	
Malignancy *(Note: All malignancies are considered chronic until 5 years post last treatment)*		
Malignancy	Malignant neoplasms - all sites	Ewings, Neuroblastoma, Phaemochromocytoma, Lymphoma and Leukaemia
	Neoplasms of uncertain or unspecified behaviour, any site	
	Neurofibromatosis (non-malignant)	
	Chemotherapy: via any route	
Cardiovascular		
Heart	Absent pulmonary valve	
	Aortic valve or supravalvular atresia or stenosis	
	Aortic valve incompetence	

Category	Subcategory	Examples, further notes
	AV canal defect – complete or partial including Primum ASD	
	DILV	
	DORV	
	Ebstein's anomaly	
	Hypoplastic left heart syndrome	
	Hypoplastic right heart syndrome	
	Left ventricular outflow obstruction	
	Mitral valve stenosis	
	Mitral valve incompetence	
	Pulmonary valve atresia or stenosis	
	Pulmonary valve incompetence	
	Tetralogy of Fallot – with or without RV outflow obstruction	
	Tricuspid valve atresia or stenosis	
	Tricuspid valve incompetence	
	Unrepaired ASD	Considered chronic until repaired
	Unrepaired VSD	Considered chronic until repaired
Vessels	Anomalous coronary artery from pulmonary artery	
	Anomalous pulmonary venous drainage – total or partial	
	Aortic atresia	
	Aortopulmonary window	
	Coarctation of the aorta	
	Interrupted or Hypoplastic aortic arch	
	MAPCAS	
	Pulmonary artery atresia or stenosis	
	Pulmonary Arterio-Venous Malformation (AVM)	
	Transposition of the Great Arteries – d or l	
	Truncus arteriosus	
	Unrepaired PDA	Considered chronic until repaired
Cardiomyopathies	Cardiomyopathy – any	
	Hypertrophic Obstructive Cardiomyopathy (HOCM)	
Acquired Cardiovascular Diseases	Cardiac tumour	
	Endocarditis	
	Kawasaki's disease with coronary aneurysms	
	Myocardial ischaemia or infarction	
	Pericarditis or effusion - chronic	
	Pulmonary hypertension	
	Rheumatic heart disease	
	Vascular thrombosis or occlusion – chronic or recurrent	
	Vasculitis	

Category	Subcategory	Examples, further notes
	Systemic hypertension	
	Valvular stenosis or incompetence	
Rhythm Disorders – recurrent or chronic	Supraventricular tachyarrhythmias	
	Ventricular tachyarrhythmias	Catecholaminergic polymorphic ventricular tachycardia (CPVT), Brugada syndrome, Congenital long QT syndromes (Jervell and Lange-Nielson, Romano-Ward), Short QT syndrome
	Heart block – congenital or acquired	
	Sick sinus syndrome	
Haematologic/Immunologic		
Anaemias	Anaemia due to enzyme disorders	G6PD deficiency
	Thalassaemia	
	Sickle-cell disorders	
	Other aplastic anaemias and other bone marrow failure syndromes	
Immunodeficiency	Functional disorders of polymorphonuclear neutrophils	Chronic granulomatous disease
	Immunodeficiency with predominantly antibody defects	Selective deficiencies of immunoglobulins or hyper IgM etc.
	Combined immunodeficiencies	Severe combined immunodeficiency (SCID), Wiskott-Aldrich syndrome, Ataxia Telangiectasia, DiGeorge syndrome (22q11del)
	Common variable immunodeficiency	
	Human immunodeficiency virus [HIV] disease	
	Congenital agranulocytosis	Kostmann syndrome
	Cyclic neutropaenia	
	Other imunodeficiency	Complement defects
Coagulation/haemorrhagic	Hereditary factor VIII deficiency	Hemophilia A
	Hereditary deficiency of other clotting factors	Factor IX deficiency = Hemophilia B (aka Christmas disease), von Willebrand's disease, deficiencies of Factors I, II, V, VII, X, XIII.
	Congenital and hereditary thrombocytopaenia purpura	
Hemophagocytic Syndromes	Hemophagocytic lymphohistiocytosis	Familial or genetic HLH
	Haemophagocytic syndrome, infection-associated	
	Other histiocytosis syndromes	Langerhans's Cell Histiocytosis (LCH). Other synonyms for this include: Histiocytosis X, Eosinophilic granuloma, Letterer-Siwe disease, Hand-Schüller-Christian syndrome
Diffuse diseases of connective tissue	Wegener's granulomatosis	
	Systemic lupus erythematosus	

Category	Subcategory	Examples, further notes
	Mucocutaneous lymph node syndrome (Kawasaki)	
Other haematologic/ immunologic	Resection of spleen	
Respiratory		
Airway	Bronchogenic cyst	
	Bronchomalacia	
	Laryngeal cleft	
	Laryngeal web	
	Subglottic stenosis	
	Tracheal rings	
	Tracheal stenosis	
	Tracheal web	
	Tracheoesophageal fistula	
	Tracheomalacia	
Lungs	Alveolocapillary dysplasia	
	Congenital diaphragmatic hernia	
	Congenital lobar emphysema	
	Cystic adenomatoid malformation	
	Cystic fibrosis	
	Lymphangiectasis	
	Pulmonary hypoplasia	
	Pulmonary sequestration (including Scimitar syndrome)	
Other respiratory	Alpha 1 antitrypsin deficiency	
	Central hypoventilation syndrome	Ondine's curse
	Ciliary dyskinesia (including Kartagener syndrome)	
	Surfactant protein deficiency	
Chronic respiratory diseases	Asthma	Considered if one previous inpatient admission in the last 12 months with asthma OR ever been intubated with asthma
	Bronchiectasis/chronic suppurative lung disease	
	Chronic lung disease/ Bronchopulmonary dysplasia	
	Pulmonary fibrosis	
	Restrictive lung disease	
Respiratory surgery	Prior lobectomy	
Neurologic/Neuromuscular		
Brain and spinal malformations	Malformations of the brain	Anencephaly, Holoprosencephaly, Encephalocoele, Microcephaly, Hydrocephalus, Chiari malformation, Lissencephaly,
	Malformations of the spinal cord	Syringomyelia, Spina bifida, Tethered cord

Category	Subcategory	Examples, further notes
	Malformations of the nervous system	
	Familial dysautonomia	
CNS: Central storage disorders	Mucopolysaccharidoses	Hunter / Hurler / Scheie / Sanfillipo / Morquio / Maroteaux-Lamy / Sly / Hyaluronidase deficiency
	Sphingolipidoses	GM1 / Tay-Sachs / Fabry / Gaucher / Niemann-Pick / Krabbe / metachromatic lecodystrophy
	Other central storage disease	
CNS: Ataxias	Hereditary ataxia	
	Cerebellar ataxia	
CNS: Other	Any other neurodegenerative disease	Leigh syndrome
	Spinal muscular atrophy	
	Tuberous sclerosis	
	Rett syndrome	
	Malignant neuroleptic syndrome	
	Global developmental delay	
	Cerebral palsy	All types
	Intellectual disability	
Epilepsy	Any form of known epilepsy with status epilepticus	
	Any form of known epilepsy that is intractable	Intractable if failure of adequate trials of two tolerated and appropriately chosen and used AED schedules (whether as monotherapies or in combination) to achieve sustained seizure freedom (Kwan, Epilepsia 2009;51:1069–1077). Also: Dravet syndrome, Lennox Gastaut syndrome, West syndrome, Otahara syndrome
CNS: Demyelination	Central pontine myelinolysis	
	Transverse myelitis	
	Other demyelinating disease of CNS	Multiple sclerosis, Devic's disease, ADEM, Acute haemorrhagic leucoencephalitis
CNS: Paralysis	Hemiplegia	
	Paraplegia	
	Quadriplegia	
	Locked in Syndrome	
	Paralytic syndromes	
	Hypoxic brain injury	
	Brain compression	
	Persistent vegetative state	
CNS: CSF shunt	Ventricle to atrium, pleura, peritoneum	Any CSF shunt, regardless of type or site
	Spinal canal to pleura, peritoneum	
CNS: Surgery	Hemispherectomy	Any type, any approach
	Cerebral venous thrombosis	

Category	Subcategory	Examples, further notes
Occlusion of cerebral vessels	Cerebral infarction	
	Cerebral haemorrhage	
Muscular dystrophies/myopathies	Any primary muscular dystrophy	Classical Duchenne, Becker, Fascioscapulohumeral, Limb-girdle and Myotonic
	Any myotonic disorder	
	Any primary disorder of muscle	Congenital myopathies including mitochondrial
	Myasthenia gravis	
Movement disorders	Any dystonia	
	Any chronic ataxia	Cerebellar ataxia, Hereditary ataxia, Congenital ataxia
	Any parkinsonian syndrome	
	Any extrapyramidal or movement disorder	Sydenham's chorea
	Huntington's chorea	
	SMA all types	
	Myoclonus	Any type
	Others	Restless legs syndrome, Stiff man syndrome, Any extrapyramidal movement disorder
	Hallevorden-Spatz syndrome	Any other basal ganglia degenerative disease
Gastrointestinal		
Congenital anomalies	Oesophagus	Oesophageal atresia with or without tracheo oesophageal fistula, Tracheo oesophageal fistula without atresia (H-type), Congenital stenosis or stricture, web
	Small intestine: congenital absence, atresia, stenosis	Duodenal, Ileal, Jejunal atresia/stenosis
	Large intestine: congenital absence, atresia, stenosis	Anal atresia/stenosis with and without fistula
	Other congenital malformations of intestine	Hirschsprung's disease, malrotation, intestinal duplication
	Congenital malformations of gallbladder, bile ducts and liver	Biliary atresia, Choledochal cyst
	Other congenital malformations of digestive system	Agenesis/aplasia/hypoplasia of pancreas
Chronic liver disease and cirrhosis		Chronic hepatitis, Cirrhosis and fibrosis, Autoimmune hepatitis, Central haemorrhagic necrosis of liver, Liver infarction, Hepatic veno occlusive disease
Other liver		Fatty liver, Chronic passive congestion of liver, Hepatopulmonary syndrome
Portal hypertension	With/without varices	
	Budd-Chiari syndrome	
Inflammatory bowel diseases		Crohn's disease and ulcerative colitis

Category	Subcategory	Examples, further notes
Chronic vascular disorders of intestine		Chronic ischemic entero/colitis; Chronic mesenteric ischemia; Chronic vascular insufficiency of intestine,
Volvulus		
Megacolon, not elsewhere classified		Megacolon, toxic megacolon
Acquired absence of stomach [or part of], or other parts of digestive tract	Small intestine or large intestine	Short gut syndrome, colectomy, hemicolectomy, ileal resection
Surgical resections		Tongue, Oesophagus, Stomach, Small intestine, Duodenum, Large intestine, Liver, Pancreas, NEC requiring surgical intervention
Dilatations and gastrointestinal intraluminal devices		Into oesophagus, Small intestine, Large intestine (stents)
Gastrostomy, Ileostomy, Colostomy & other artificial openings	Includes complications of these	
Oesophageal bypass procedures		Oesophagus to cutaneous, Oesophagus to stomach, intestine
Stomach bypass procedure		Stomach to cutaneous, stomach to intestine
Bypass other bowel		Ileum to cutaneous, Caecum to cutaneous, Colon to cutaneous
Renal/Urologic		
Congenital	Congenital malformations of the kidney or urinary system	Renal dysplasia, Renal agenesis, Any cystic Kidney disease, Other renal/urinary malformations, Congenital obstruction of renal pelvis, Posterior urethral valves
Chronic	Chronic renal failure/chronic kidney disease	
Bladder	Neuromuscular functional bladder problem	Neurogenic bladder, Neuropathic bladder
Acquired	Acquired absence of kidney	Traumatic or surgical nephrectomy
	Acquired absence of other urinary tract	Traumatic loss, surgical removal or bypass of other part of urinary tract
	Artificial urinary tract opening	Nephrostomy, Vesicostomy, Cystostomy, Appendicovesicostomy
Metabolic		
Amino Acid Metabolism	Classical phenylketonuria	PKU
	Other disorders of aromatic amino-acid metabolism	Disorders of phenylalanine or tyrosine but not PKU: Alkaptonuria, Tyrosinaemia, Albinism
	Maple-syrup-urine disease	
	Disorder of branched-chain amino-acid metabolism, unspecified	Methylmalonic acidaemia, Propionic acidaemia, Isovaleric acidaemia

Category	Subcategory	Examples, further notes
	Disorders of fatty-acid metabolism	Medium-chain acyl-coenzyme A dehydrogenase (MCAD) deficiency, Long-chain 3-hydroxyacyl-coenzyme A dehydrogenase (LCHAD) deficiency, Very long-chain acyl-coenzyme A dehydrogenase (VLCAD) deficiency
	Disorders of carnitine metabolism	Carnitine transport protein
	Peroxisomal disorders	Adrenoleukodystrophy, Refsum disease
	Disorders of amino-acid transport	Cysteinuria
	Disorders of urea cycle metabolism	OTC deficiency (orthinine transcarbamylase deficiency), Citrullinaemia, Argininosuccinic aciduria, Carbamoyl phosphate synthetase deficiency
	Disorder of amino-acid metabolism, unspecified	
Carbohydrate Metabolism	Glycogen storage disease	Pompe's disease, von Gierke's disease, McArdle disease
	Disorders of fructose metabolism	
	Disorders of galactose metabolism	Galactosemia (there are several enzymes that may be deficient)
	Disorders of pyruvate metabolism and gluconeogenesis	Pyruvate dehydrogenase deficiency, pyruvate carboxylase deficiency
	Other specified disorders of carbohydrate metabolism	
	Disorder of carbohydrate metabolism, unspecified	
Lipid Metabolism	Disorders of sphingolipid metabolism and other lipid storage disorders	GM1-gangliosidosis, GM2-gangliosidosis (infantile form =Tay-Sachs disease), Fabry disease, Gaucher disease, Metachromatic leukodystrophy, Krabbe disease, Niemann-Pick disease
	Hyperlipidaemia, unspecified	
	Lipodystrophy, not elsewhere classified	
Storage Disorder	Mucopolysaccharidosis, any type	Hurler syndrome, Hunter syndrome, Sanfilippo Morquio Maroteaux Lamy, Scheie, Sly, Hyaluronidase deficiency
Other Metabolic Disorders	Disorders of bilirubin excretion	Gilbert syndrome, Crigler-Najjar syndrome, Dubin Johnson syndrome
	Lesch-Nyhan syndrome	
	Other disorders of purine and pyrimidine metabolism	
	Other disorders of bilirubin metabolism	
	Disorder of bilirubin metabolism, unspecified	
	Disorders of copper metabolism	Menkes' syndrome, Wilson's disease
	Disorders of iron metabolism	

Category	Subcategory	Examples, further notes
	Multiple Carboxylase Deficiency, unspecified	Biotinidase deficiency
	Hypoglycaemia, unspecified	
	Disorders of mitochondrial oxidative phosphorylation, unspecified	MELAS (mitochondrial encephalopathy lactic acidosis and stroke-like episodes), Kearns-Sayre syndrome, Myoclonic epilepsy with ragged-red fibers (MERRF), Lebers optic neuropathy,
	Disorders of neurotransmitter metabolism, unspecified	
	Haemochromatosis, unspecified	
	Other and unspecified metabolic disorders	
Endocrine Disorders	Adrenocortical insufficiency, unspecified	
	Hypopituitarism	
	Diabetes insipidus	
	Syndrome of inappropriate secretion of antidiuretic hormone	
	Hypothalamic dysfunction, not elsewhere classified	
	Disorder of pituitary gland, unspecified	
	Drug-induced Cushing's syndrome	
	Cushing's syndrome, unspecified	
	Congenital adrenogenital disorders associated with enzyme deficiency	
	Adrenogenital disorder, unspecified	
	Congenial adrenal hyperplasia	
	Adrenal medullary dysfunction	
	Hypothyroidism	
	Thyroid disorder, unspecified	
	Diabetes mellitus, insulin dependent	
	Hypoparathyroidism	
Transplantation *(Notes: If transplant is regarded as curative, and ICU admission is post-transplant, then transplant only to be considered a chronic condition. If transplant does not cure the underlying disease (e.g. BMT for tyrosine kinase deficiency), then both transplant and underlying disease can be considered as chronic conditions.)*		
Transplantation - cardiac	Heart transplantation	
Transplantation - respiratory	Lung transplantation (lobe, single or double lung)	
Transplantation - renal	Kidney transplantation (related, unrelated)	
Transplantation - gastrointestinal	Liver transplantation (related, unrelated)	
	Intestinal transplantation (large, small)	

Category	Subcategory	Examples, further notes
	Pancreatic transplantation (non-autologous, autologous islet cell via any route)	
Transplantation - haematological	Marrow, Cord blood, Haemopoietic stem cells (autologous or non-autologous)	
Transplantation - miscellaneous	Transplant miscellaneous (e.g. splenic or other tissue/organ not listed)	
Technology Dependency *(Note: Must be considered chronic together with the system affected)*		
Neuro	CSF drainage device	
	Implanted neurostimulator lead	
	Synthetic substitute to ventricle or CSF drainage pathways (e.g., aqueductal stent placement)	
	Baclofen pump	
Cardiac	Prosthetic, bioprosthetic or biological heart valve	
	Conduit (prosthetic or biological)	
	Cardiac pacemaker (implantable) or contractility modulation device (delivers a biphasic signal to RV septum during absolute refractory period)	
	Automatic (implantable) cardiac defibrillator	
	Intravascular device including stents and implants	
	Heart assist device (BiVAD, LVAD, RVAD) or fully implantable artificial heart	
	Long-term vascular access device	
Respiratory	Tracheostomy	
	Tracheal/airway stent	
	Dependence on aspirator (vacuum) to remove airway secretions	
	Diaphragmatic pacemaker	
	Home CPAP or BIPAP	
	Home oxygen therapy	
	Home ventilation	
	Dependence on supplemental oxygen	
Renal	Dependence on renal dialysis (hemo or PD)	
	Cystostomy, vesicostomy, nephrostomy, ureterostomy, urethrostomy	
	Kidney pelvis or ureter to bladder bypass	

Category	Subcategory	Examples, further notes
	Arteriovenous fistula	
	Long-term vascular access device	
Gastro	Gastrostomy/PEG/other long-term feeding tube (e.g., NG or TPT)	
	Jejunostomy, Ileostomy, Colostomy, Any gut ostomy	
	Gastric lap band or similar	
	Oesophageal stent	
	Bypass oesophagus/upper oesophagus (e.g., gastric transposition or colon interposition for long seg oesophageal atresia)	
	Bypass stomach	
	Long-term vascular access device	
Metabolic	Pump external or internal for hormone infusion (e.g., insulin)	
Miscellaneous	Other internal orthopaedic devices, implants, and grafts	
	Spinal fusion of any type	
	External osteogenesis devices	Distraction osteogenesis (mandible, leg etc.)
	Dependence on supplemental oxygen	
Mental Health/Behavioural *(Notes: Include if the disorder is chronic (likely to last at least 12 months), and requires ongoing treatment (pharmacological/psychological/psychiatric))*		
Psychoactive substance use	Drug dependence (alcohol, amphetamines etc.)	
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	Schizophrenia (any form), or other non-mood psychotic disorder	
Mood (affective) disorders	Bipolar disorder	
	Depression	
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	Anxiety or panic disorder	
	Post-traumatic stress disorder (PTSD)	
	Obsessive compulsive disorder (OCD)	
Behavioural syndromes associated with physiological disturbances and physical factors	Eating disorder (Anorexia nervosa, Bulimia)	
Disorders of personality and behaviour	Gender identity disorder	
Intellectual disabilities	Intellectual disability; any kind	
Pervasive and specific developmental disorders	Autism, Autism spectrum disorder, Asperger's syndrome	

Category	Subcategory	Examples, further notes
	Global developmental delay	
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Attention deficit hyperactivity disorder (ADHD)	
	Oppositional defiant disorder (ODD)	
	Tourette's syndrome, Tic disorders	
	Behavioural and emotional disorder, other	