CHRONIC DISEASE CARE RECORD SHEETS

CODING CONVENTIONS

NOTES:

1   Where applicable the information should be clearly printed in full or the actual numeric value should be entered.

2   Where non-standard abbreviations or alphabetic codes are used that are not detailed here, its meaning/code should be entered on the back of the page.

3   In other situations unless otherwise stated problems and diseases should be coded as follows:

absent/nil/normal/good	0
mild	1
moderate	2
severe	3
very severe	4

Health and well-being should be coded similarly as follows:

excellent	0
mildly inadequate	1
moderately inadequate	2
severely inadequate	3
very severely inadequate	4

4   Alpha-numeric entries combine conventions 2 and 3.

5   Treat a plus sign (+) as a code meaning presence or for treatment meaning advised, prescribed or given. It usually requires elaboration on the back of the page. A minus sign (-) means that information was deliberately not sought or treatment not advised, prescribed or given. A blank block means that the coder forgot to collect or enter information.

6   In the rows (top) add a date where relevant and possible eg:

PTB present from July 1991 is coded as PTB 7/91.

7   The cell/block should be shaded if the information is awaited, e.g. bloods have been taken and the results are awaited or MedicAlert disc has been ordered and disc-number is awaited.

8   Use a pen for the entries in the first 3 lines and a pencil for the rest. Pencil entries can be easily erased in case of error.

9	Complete all the rows across the top at the first two visits whenever a page is started. These rows provide the demographic data and the clinical history and when a new page is started they provide an opportunity for an up-date/review.

10	Every page 1 has a space for the past (history) to be entered. Enter the symbol for the most severe episode in the *past* column. Put a date against it (the occurrence) in the *when* column.

11	Two variables are sometimes listed next to each other separated by a stroke. Both should be coded and the codes should be separated by a stroke. In the example below the patient complains of severe headache and mild dizziness.

	headache/dizziness	3/1

12	Enter the exact type of work done for OCCUPATION. Also enter the address and telephone number of present occupation.

13	A space has been provided to enter change of address. Old addresses should never be erased.

14	The entries in the columns refers to what happened since the previous visit. If the patient has been away for some time and/or has attended elsewhere (as an in-patient or an out-patient) use a column/s before the current entries to record the data.

15	Initially a 4-page record sheet was used. It made provision for the entry of test results and their interpretation or code in columns in the body of the record sheet according to the date of the tests.

	In the abbreviated 1-page version the dates and results are entered on the back of the record sheet and the codes in an allotted space in the top rows.

	A separate sheet for test results could be used if preferred, but the codes should still be cross-referenced to the rows in the record sheet

DETAILS OF CODES

VARIABLE NAME	VARIABLE VALUE	CODE
sex	female	F
	male	M
date of birth	day/month/year	DD/MM/YY
year of onset	when the sickness started not when it was first diagnosed	YYYY
sloth/exercise	according to the type and amount of physical activity or exercise:	
type:	dynamic exercises, strenuous sports and aerobic exercises, running, jogging, very heavy work such as loading and carting	submaximal
	as sub-maximal, but less strenuous exercise like swimming, heavy work	taxing
	brisk walking, gardening, sports like golf, bowls, social tennis, gentle aerobic exercises	moderate
	walking on level ground, light exercise, domestic work	little
	sedentary life, no domestic work	nil

codes:

type	frequency/week	code
submaximal	5 - 7	0
submaximal	3 - 4	1
submaximal	1 - 2	2
taxing	5 - 7	1
taxing	3 - 4	2
taxing	1 - 2	3
moderate	5 - 7	2
moderate	3 - 4	3
moderate	1 - 2	4
little	7	3
little	< 7	4

IBM	ideal body mass (acceptable weight)	note 1

For most practical purposes a simple formula which does not depend on tables is sufficient. If the value 100 is subtracted from a person's height in cm, the resulting value is a fair approximation in kg of the upper level of what that person should weigh. For example, if the person is 160 cm tall, s/he should not weigh more than 60 kg.

CHRONIC OBSTRUCTIVE LUNG DISEASE (COLD)

<u>causes and triggers of COLD</u>   notes 3, 5, 6 +

tobacco	mainstream (MSS) personal smoke; alphanumeric + note 6 alphabetic code =	
	filter cigarettes	FC
	plain cigarettes	PC
	rolled cigarettes	RC
	cigars	C
	pipe	P
	numeric code = number/day	

drugs	indicate drug and see notes 3, 5, 6	
	B-blocker	B
	NSAID (non-steroidal anti-inflammatory drug)	N

<u>types and complications of COLD</u>   notes 5, 6

severity	alphabetic code:	
	asthma (reversible bronchospasm)	A
	acute bronchitis	AB
	hyper-secretory chronic bronchitis (daily cough with sputum for 3 months a year for at least 2 consecutive years)	SB
	obstructive chronic bronchitis	OB
	emphysema	E

+ a disease-specific numeric code; otherwise note 3:

1   asthma attacks

The following figures are added up and then divided by 3 to make it comparable with the 0 - 4 scoring used here.

symptoms	bronchodilator use	% PFV
4 = waking at night	4 = > 4 times/day	4 = > 25%
3 = daily, night OK	3 = 1 - 4 times/day	3 = 15 - 25%
2 = < daily - > 1/week	2 = < daily	2 = 10 - 15%
1 = < 1/week or only with exercise	1 = < 1/week	1 = 6 - 10%
0 = nil for 3 months	0 = nil for 3 months	0 = < 6%

Percentage peak expiratory flow (PEF) variability (%PFV) is calculated with the following formula:

(best PEF minus worst PEF) X 100
divided by the best PEF

2   hyper-secretory chronic bronchitis

The numeric score depends on the amount of sputum/day:

20 ml	1
40 ml	2
60 ml	3
80 ml	4

3   obstructive chronic bronchitis and emphysema

The numeric score depends on the ratio (%) of observed to expected peak expiratory flow:

90 +	0
70 - 90	1
60 - 69	2
40 - 59	3
< 40	4

4   non-specific chronic bronchitis and acute bronchitis   note 3

<u>the rest of COLD</u>   notes 1, 2, 3

DIABETES

risk factors for diabetes

drugs   indicate drug and see notes 3, 5, 6

diuretics		D
steroids		C

obesity   variation from ideal body mass (IBM)

nil - very thin:	20+% below IBM	-2
nil - thin:	10 - 19% below IBM	-1
nil - normal:	9% below - 4% above IBM	0
a bit (mildly) fat:	5 - 9% above IBM	1
moderately fat:	10 - 19% above IBM	2
obese:	21 - 39% above IBM	3
grossly obese:	40 + % above IBM	4

sugars   amount of sugars (all - including fructose) in food:

no sugars at all no fruit	0
no sugar-sweetened food or drinks no sugar-containing packaged foods sweet ripe fruit ≤3/week sweet taste disliked	1
no sugar-sweetened foods may use a little sugar in tea and coffee sugar-containing processed food 1-2/day sweet ripe fruit 1-2/day may taste the sugar in shop bread	2
sugar-sweetened beverages (SSB) 1-2/day sugar in tea and coffee 2-3 tea-spoons/cup sugar-containing processed food 2-3/day sweet ripe fruit 2-3/day sweet taste enjoyed	3
sweet foods eaten often, sugar in tea and coffee >3 tea-spoons/cup sugar-containing processed food >3/day sweet ripe fruit >3/day sweet taste craved/desired	4

| infection | as a cause of/risk factor for diabetes | note 5 |

<u>complications of diabetes</u>   notes 2, 3, 5, 6

| hypo- | hypoglycaemic attacks according to severity and frequency: | |

severity:	hunger pains, mild anxiety	mild
	palpitations, sweating, yawning	moderate
	restlessness, aggression, confusion	severe
	coma, convulsions	very severe

severity	frequency/month	code
nil		0
mild	1 - 4	1
mild	5 +	2
moderate	1 - 4	2
moderate	5 +	3
severe	1 - 3	3
severe	4 +	4
very severe	1 +	4

| hyper | hyperglycaemic attacks | frequency/month |

retina	alphabetic code:	D
	no changes	0
	venous dilatation, increased tortuosity	1
	retinal oedema with glazed appearance, reduction in vessel calibre and number	2
	dot and blot haemorrhages, cotton-wool spots and fatty exudates	3
	new vessel formation, haemorrhages and fibrosis, retinal detachment	4

cataracts		notes 3, 5
	if removed	4/0
	add date of operation	note 6

| UTI | urinary tract infection number of episodes | n |

| caries | number affected | n |
| | or DMF (decayed, missing or filled) number | n/n/n |

neuropathy

peripheral	peripheral neuropathy; alphanumeric note 3 + alphabetic code:	
	numbness	N
	cramps (often nocturnal)	C
	paraesthesia	P
	mono-neuritis	M
	painful muscle weakness and wasting	W
	limited joint mobility (hands)	LJM
autonomic	autonomic neuropathy; alphanumeric note 3 + alphabetic code:	
	impotence	I
	postural hypotension	H
	nocturnal diarrhoea	D
	urinary retention	UR

<u>other findings in diabetes</u>   note 3

ketosis	number of times noted	n
coma	number of times noted	n

coma should be further characterised:

hypoglycaemic coma	O
hyperglycaemic keto-acidotic coma	K
hyperglycaemic hyper-osmolar non-ketotic coma	G
lactic acidotic coma	L

and the code is alphanumeric example:

K2   = 2 episodes of hyperglycaemic keto-acidotic coma in current year
O5/G1   = 5 episodes of hypoglycaemic coma and 1 episode of
                  hyperglycaemic hyper-osmolar non-ketotic coma in current year

<u>type of diabetes:</u>

insulin dependent diabetes	IDD
non-insulin dependent diabetes	NIDD
non-insulin dependent diabetes in the young (< 40 years)	NIDDY
insulin requiring diabetes	IRD

EPILEPSY

Some people suffer from only one type of seizure, others may suffer from two types at the same time or at different times and others start with one type of seizure and then change to have only another type.

Brief description of some types of seizures:

PARTIAL   only a part of the body is affected.

simple   without loss of consciousness

                    may move their eyes or head to one side
                    shake a part of the body, pull faces or
                    move the corner of their eye or mouth
                    may feel frightened or dizzy or
                    see or smell something that is not there

                    know a little of what is going on.
                    do not remember anything afterwards.
                    do not fall down.

complex   as above but with loss of consciousness

becoming generalized   partial at onset; whole body affected later

other   myoclonic, tonic, clonic, atonic, atypical

GENERALISED   the whole body affected at onset

grand mal or tonic-clonic seizures

                    body first goes stiff and patient falls
                    may scream and bite tongue
                    face goes blue and spit may dribble from mouth
                    may wet or soil themselves

                    = tonic (stiff) phase

                    after a short time the body starts to shake all over

                    = clonic (convulsive) phase.

                    now unconscious
                    gradually regain consciousness.
                    may be confused afterwards or
                    have headache and feel sore all over

petit mal or absence seizures

        loss of consciousness lasting a few seconds.
        do not fall down
        usually only children are affected.

other   myoclonic, tonic, clonic, atonic, atypical

hysterical   not true epilepsy, attention seeking, bizarre

<u>causes of epilepsy</u>

	alphanumeric +	notes 3, 5, 6
	and alphabetic code =	
familial	as for hypertension	
congenital	syphilis	S
	AIDS	HIV
	other infections	I
	tobacco	T
	alcohol	A
	other chemical poisons	C
infections	measles	M
	other encephalitis	E
	TB meningitis	TB
	other meningitis	M
	tapeworm cysticercosis	C
(head) injury	birth trauma	B
	motor vehicle accident	MVA
	other accident	A
	assault (possibly deliberate)	D
vascular	cerebral thrombosis	T
	cerebral haemorrhage	H
	cerebral embolus	E
other	brain tumour	T
	all others	O

<u>level of control of epilepsy</u>

less than 1 seizure in 3 months	0
about 1 seizure in 3 months	1
about 1 seizure in 1 month	2
about 1 seizure in 1 week	3

	more than 1 seizure in 1 week	4

The following are completed subjectively with information from the patient, the family and from general observation.

retarded	mental retardation	note 3
psychotic	suffering from psychosis	note 3
disabled	physically disabled	note 3
stressed	psycho-social stress	note 3

use this cell to indicate ability to cope and function at a personal level

HYPERTENSION

risk factors for hypertension

family	number of parents and siblings affected; alphanumeric where the alphabetic code is:	
	mother	M
	father	P
	sister	S
	brother	B

obesity		see page 6

alcohol	derived from codes on habitual intake:	
	very occasionally or nil	0
	about 1 unit/week	1
	less than 7 units/week	2
	about 14 units/week	3
	more than 14 units/week	4

drugs	indicate drug +	notes 3, 5, 6
	NSAID (non-steroidal anti-inflammatory drugs)	N
	sympatheticomimetics	S
	alkalinisers and antacids	A
	oestrogens	O
	steroids	C

sugars		see page 6

sodium	amount of sodium (as in table salt) in food:	
	no salt at all	0
	no salty foods, no salt in cooking, salt sometimes added after tasting salty food disliked	1
	no salty foods, a little salt in cooking salt often added after tasting may taste the salt in shop bread	2
	some salty foods, food cooked with salt, salt often added before tasting salty taste enjoyed	3
	salty foods eaten often, food cooked with salt, salt usually added before tasting salty taste craved/desired	4

complications of hypertension

IRF	impaired renal (kidney) function:	
	nocturia < 2, no proteinuria and creatinine < 120umol/l	0
	nocturia 2, occasional proteinuria or creatinine 120 - 149 umol/l	1
	nocturia 3, persistent proteinuria or creatinine 150 - 179 umol/l	2
	creatinine 180 - 259 umol/l	3
	creatinine 260 + umol/l	4

retina	retinal vascular changes; alphanumeric: alphabetic code =	
	atherosclerosis	A
	hypertension	H

numeric code for atherosclerosis is:

no changes	0
thickening of arterioles, copper wiring	1
arteriolar/venous (a/v) nipping	2
increased arteriolar tortuosity	3
sheathed vessels, retinal vein occlusion	4

numeric code for hypertension is:

no changes	0
narrowing of terminal arterioles	1
widespread, severe narrowing with distal dilatation of arterioles	2
striate haemorrhages, soft exudates, deep lipid exudates near macula (stars)	3
papilloedema	4

LVH	apex within or in mid-clavicular line	0
	apex between 0 and 2	1
	apex in anterior axillary line	2
	apex between 2 and 4	3
	apex in mid-axillary line	4

severity of hypertension:

normal/absent	SBP/ DBP	< 140/90	0
borderline	SBP/DBP	140 -159/90 - 94	1
mild	SBP/DBP	160 - 179/95 - 104	2
moderate	SBP/DBP	180 - 209/105 - 119	3
severe	SBP/DBP	210 +/120 +	4
accelerated	SBP/DBP	210 +/120 + headache = 4	4 +
malignant	SBP/DBP	any BP + retina = 4	4++

CODES FOR VISIT COLUMNS

Block 1

visit number	each page starts at 1	
date	when	MM/YY
attendant	care provider's identification	initials

Block 2	symptoms – in alphabetic order	notes 1 - 5
aura	a feeling before an epileptic fit starts	note 5

date of LMP	LMP = last menstrual period	
	if the woman is still menstruating	DD/MM
	if the woman is post-menopausal	MM/YY or YY
early morning dip		
	asthma attacks very early in the morning (about 0400 hours) number of mornings/week	n
night time asthma		
	asthma attacks that disturb sleep number of nights/week	n
nocturia	how many times subjects wake up from sleep to pass water but excluding the time just before getting up	n
polyuria	the number of times urine is passed during the day	note 3
post-ictal (fit) state		
	alphanumeric and alphabetic code =	notes 3, 5, 6
	aggressive	A
	confused	C
	drowsy	D
	restless	R
sputum	alphanumeric where alphabetic code =	
	watery	W
	sticky/mucoid	M
	purulent	P
	and numeric code =	see page 4
Block 3	signs – in alphabetic order	notes 1 - 4
injury	part of body injured +	note 3
skin/feet	alphanumeric + and alphabetic code for skin =	notes 3, 5, 6
	blothy	B
	cool/cold	C
	hot/warm	H

	infected	I
	scarred	S

and alphabetic code for feet =

	as for skin +	
	amputated toes etc	A
	pulseless	P

teeth DMF	number decayed, missing and filled	n/n/n

time BP measured	hhmm	

Block 4

Block 4	tests	
	when tests ordered	note 7
	when results available:	

urine tests - all	if menstruating, add	M
urine protein	nil	0
	trace	1
	+	2
	++	3
	+++	4

other urine test	as for urine protein	

time blood sugar taken		hhmm

peak flow		note 1

blood tests	alphanumeric where alphabetic code =	

	creatinine	C
	cholesterol - total (as for lipid)	L
	cholesterol - HDL	H
	glucose	S
	PCV (as for anaemia)	A
	potassium	K
	uric acid (SUA)	U

numeric code = standard deviation from average at 0

creatinine	< 120umol/l	0
	120 - 149 umol/l	1
	150 - 179 umol/l	2
	180 - 259 umol/l	3
	260 + umol/l	4

cholesterol - total	< 2.6 mmol/l	L
	2.6 - 4.2 mmol/l	0
	4.3 - 5.1 mmol/l	1
	5.2 - 6.0 mmol/l	2
	6.1 - 7.0 mmol/l	3
	> 7.0 mmol/l	4

cholesterol - HDL	> 2.0 mmol/l	H
	1.55 - 2.0 mmol/l	0
	1.37 - 1.54 mmol/l	1
	1.21 - 1.36 mmol/l	2
	1.03 - 1.20 mmol/l	3
	< 1.03 mmol/l	4

glucose	1 - 2 hours after a meal	
	< 3.0 mmol/l	H
	3.0 - 7.9 mmol/l	0
	8.0 -11.0 mmol/l	IGT
	> 11.0 mmol/l	DM

glucose	fasting or more than 2 hours after a meal	
	< 3 mmol/l	H
	3.0 - 6.9 mmol/l	0
	7.0 + mmol/l	DM

PCV (packed cell volume)

	> 50 %	H
	40 - 50 %	0
	37 - 39 %	1
	34 - 36 %	2
	29 - 33 %	3
	< 29 %	4

potassium	> 5.1 mmol/l	E
	4.4 - 5.1 mmol/l	0
	4.0 - 4.3 mmol/l	1
	3.6 - 3.9 mmol/l	2
	3.3 - 3.5 mmol/l	3
	< 3.3 mmol/l	4

uric acid	< 0.17 mmol/l	L
	0.17 - 0.29 mmol/l	0
	0.30 - 0.34 mmol/l	1
	0.35 - 0.40 mmol/l	2
	0.41 - 0.47 mmol/l	3
	> 0.47 mmol/l	4

Enter code in the column of the date when the test was performed

Block 5   diet and habits

time last meal (or snack)	hhmm
sugar/salt	note 3
all other food items - times/week	n

> Tinned food includes all packaged food – whether in bottles, plastic containers, cardboard, cellophane, tin, aluminium foil ...

alcohol   alphanumeric sum of habitual alcohol intake
where alphabetic code =

occasionally/sometimes	S
weekends only	W
daily	D

and n = number of units per week where
1 unit of alcohol = about 10g alcohol and =

mkomboti	scale	500 ml
beer	mug	350 ml
wine	standard table glass	120 ml
port and sherry	sherry glass	60 ml
spirits	metric tot	25 ml
except: dry martini	glass	4 units

tobacco	see page 4
exercise and general exercises	see page 3
chest exercises special expiratory exercises number of times/day	n
stress	note 3

dangerous activity

alphanumeric + and alphabetic code =	notes 3, 5, 6
working on heights as on ladders	H
driving a car	C
driving a kombi or bus	B
driving a truck	T
working with fire or boiling water, etc	F
working with open machines	M

Block 6 compliance

with attendance reason for non-punctual attendance
alphabetic where alphabetic code =

sick	S
family sick	F
had no money for transport/fees	M
job-related reason	J
going away	G
not here/away	A
no reason given	N

with treatment

K/Mg salt potassium/magnesium salt

if just enough or some over	note 3
if not enough/short	- n days

pill count in multiples of days' supply

if pills over/in hand	+ n
if pills not enough/short	- n

insulin dose total daily number insulin units taken note 1

inhaler as for K/Mg salt

time last dose taken hhmm

Block 7 treatment

K/Mg salt potassium/magnesium salt note 5

HCT 12.5mg hydrochlorothiazide 12.5mg/day note 5

reserpine 0.125mg
    reserpine 0.125mg/day note 5

other drugs examples of customised alphanumeric code
as used in HTDMC in 1985 =

amoxicillin	Am
gentian violet	GV
hydrochlorothiazide	HCT
metronidazole	F
paracetamol	P
penicillin	Pen
ung methyl salicylate	UMS

	and numeric code =	
	daily dose in mg	nnn.nn
	daily dose in g	n.nn g
named drugs	use above numeric code except	
insulin	short-acting soluble	A
	intermediate-acting	M
	mixed	P
	long-acting	U
inhalers	number of refills prescribed	n

Blocks 8 and 9

date next visit		DD/MM/YY
		DD/MM
occupation	specify in detail	note 1
	add dates (start - end)	MM/YY or YY
	add phone number (address if no telephone) where presently working	note 1
accomodation		note 1
type	brick house/townhouse	B
	block of flats - apartment	A
	room/s in back-yard	R
	hostel/compound	H
	mud hut/s	M
	container	C
	shack (made of scrap)	S
	tent	T
	veld - in the open	V
	nil - on the move	N

new contact details   If while using the current page of the record sheet the contact details change, enter new details here. Do not overwrite or erase details at the top of the page. Enter the new details at the top of the next record sheet page.