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Patient Registration Information (*Record for every contact)*						
Field Name	**Code Options**				**Format**	**Notes**
Organisation ID	ODS code to identify service provider https://odsportal.digital.nhs.uk/ (Alternatively access codes here: https://digital.nhs.uk/organisation-data-service) (From 01/04/2020 new codes will be 5 characters)				Mandatory Length an3	This must be a valid code issued by the ODS If you do not know your Organisation Identifier code, contact Exeter.helpdesk@nhs.net If you do not know your Organisation Site Identifier code, contact Exeter.helpdesk@nhs.net
Clinic ID	ODS code to identify clinic or site http://odsportal.hscic.gov.uk/				Mandatory Length an5	
Patient ID	Local patient ID used to uniquely identify a patient within a SRH service.				Mandatory Length an10 (max)	Local patient Identifier or can be assigned automatically by the IT system. This field MUST NOT contain any information which could directly identify the patient such as NHS Number, name, address, postcode or date of birth. A warning will result if an NHS number is used. An error will result if a date or postcode format is used.
Gender	**1**	Male	9	Indeterminate (unable to be classified as male or female)	Mandatory Length an1	A self-defined classification of the current sex of a person, or inferred by observation for those unable to declare their gender. Some contraception codes, main methods and SRH Care Activities are gender specific.

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	2	Female	X	Not Known		For Transgender patients code 9.
Age	Enter date of birth and the software system will generate their age at attendance. Age at attendance date in years.				Mandatory Length an3	Not known = 999 A warning will result for patients under 11 and over 80. An error will result if patient is recorded as zero or blank

Field Name	Code Options		Format	Notes
Ethnicity	**White** A British B Irish C Any other White background **Mixed** D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background **Asian or Asian British** H Indian J Pakistani K Bangladeshi L Any other Asian background	**Black or Black British** M Caribbean N African P Any other Black background Other Ethnic Groups R Chinese S Any other ethnic group Z Not stated 99 Unknown	Mandatory Length an2	Patients select their own ethnic category. Ethnicity should not be defined by clinic staff. National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known
Lower Super Output Area (LSOA) of Residence	England codes begin with E01 Wales codes begin with W01 Scotland codes begin with S01 Northern Ireland codes begin with 95	L99999999 = Channel Islands M99999999 = Isle of Man X99999998 = Outside the UK X99999999 = Not known Please note that all LSOA codes are 9 digits except Northern Ireland which are 8 digits	Mandatory Length an9	LSOA of residence should be generated from patient postcode. The latest postcode mapping file (postcode directory is available from the Office for National Statistics at https://data.gov.uk/dataset/national-statistics-postcode-lookupuk

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Local Authority (LA) of Residence	There is an LA for each postcode in the UK (or equivalent – as defined by ONS). Records where the patient's postcode has not been provided to generate LA of residence should be allocated to 'not known' and coded "X99999999". Postcodes outside the UK (overseas visitors) should be allocated to 'not applicable' and coded as "X99999998" LA codes are 9 digits except Northern Ireland (DCA) which were recently updated from 3 digits to 9 digits. 3 digit Northern Ireland codes are still accepted until further notice or update from NHS Data Dictionary	Mandatory Length min an3 / max an9	LA of residence should be generated from patient postcode. The latest postcode mapping file (postcode directory is available from the Office for National Statistics at https://data.gov.uk/dataset/national-statistics-postcode-lookupuk

Field Name	Code Options		Format	Notes
GP Practice Code	https://odsportal.digital.nhs.uk/	Enter the patient's registered GP details; the system≠ should generate the GP Practice code.	Mandatory Length an6	Your system supplier is responsible for keeping the list of codes up to date in your system. A warning will result if an inactive code is entered. An error will result if an incorrect code is entered.
Attendance Information *(Record for every contact)*				
Date of Attendance	CCYY-MM-DD e.g. 2016-11-18		Mandatory Length an10	Enter date patient attended/received service. The date entered must be within the reporting year

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Initial Contact	**Y**	Yes	**N**	No	Mandatory Length a1	Identifies patient's first ever contact at this service. Any subsequent visits (regardless of time gap) should be coded as N. Dates of attendance are used in the validation for this field. Initial Contact can only be 'Yes' on an individual patient's first record. All subsequent records must be recorded as 'No'.
Consultation Medium Used	**01** **02** **03** **04**	Face to face communication Telephone Telemedicine web camera Talk type for a PERSON unable to speak	**05** **06** **98**	Email Short Messaging Service (SMS) – Text Messaging Other	Mandatory Length n2	Telephone contacts solely for informing PATIENTS of results are excluded. Identifies the communication mechanism used to relay information between the care professional and the patient. Code 01 must be entered if location type code is B01.

Field Name	Code Options	Format	Notes

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Location Type	**A01** **B01** **L99**	Patient's Home Health Centre Educational Premises	**M01** **N01** **X01**	Prison Street or Other Public Space Other	Mandatory Length an3	Identifies the physical location where patients are seen using the options shown. Where the consultation medium was not face to face, the location of the patient should be recorded, rather than the location of the care professional.
Contraception Information - *Whenever the reason for the patient's contact with the service is related to contraception care or advice on contraception methods then it must be recorded here*						
Contraception Method Status	**1**	**New** is where the patient is not currently using a main method of contraception and who receives a method following the consultation for the first time or receives a method for the first time after a time lapse of one month or greater.	**3**	**Maintain** is where the patient receives care by attending the service (or are seen by the service at another location) with respect to their current main method of contraception (e.g. a repeat supply of pills or adjustment of a long acting contraception method) regardless, of where the current method was first obtained, e.g. GP or another SRH service. This includes where contraception advice is given in relation to an existing method.	Length an1	• **This field can be left blank if there is no contraception activity** • If leaving blank then data **must** be recorded in Contraception Method Post Coital 1 & 2 **OR** in the SRH Care Activity • If entering 1,2, or 3 then data **must** be entered in Contraception Main Method • If entering 4 or left blank, the Contraception Main Method and Other Contraception Method 1 & 2 **must** be blank.

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	2	**Change** is where a patient changes from one main method of contraception to another, regardless of where the main method currently in use was obtained, e.g. GP or another SRH service. Only the new method is recorded in the [Contraception Main Method] field. This is where the actual method changes and not merely where a device is changed.	**4**	**Pre-Contraception Advice** only is where the patient receives advice on contraception prior to receiving a method e.g. on the range of methods of contraception available, without (yet) receiving a non-emergency method of contraception.		• Code 4 should be used if contraception advice is given but no contraception main method is given at this consultation AND the patient is not using any contraception at the time of the consultation. Providing contraception advice does not need recording in all other instances as it is presumed that it forms part of every consultation wherever necessary. **Figure 1 of the main SRHAD guidance document further illustrates how method status should be captured.**

Field Name	**Code Options**				**Format**	**Notes**
Contraception Main Method	**01**	Injectable Contraception	**08**	POP	Length an2	• **This field can be left blank if there is no contraception activity** • Only complete if Contraception Method Status is 1,2 or 3 • If entering 03 IUD or 04 IUS then SRH Care Activity **must not** be 22 or 23 as these codes are for non-contraception only. 22 Insertion is not recorded when used for contraception purposes as it is **implied** by codes 01, 02 and 03 in Contraception Method Status. 23 Check does not need to be recorded when used for contraception purposes as it is **implied** by using code 02 or 03 in Contraception Method Status.
	02	Implant	**09**	Cap/Diaphragm		
	03	IUD	**10**	Spermicides		
	04	IUS	**11**	Natural Family Planning		
	05	Vaginal Ring	**12**	Condom (Male)		
	06	Contraception Patch	**13**	Condom (Female)		
	07	Combined Pill				

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						• If entering codes 01 to 09 then gender **must** not be coded as Male (1)
Contraception Other Method 1 & 2	As Contraception Main Method				Length an2	Record up to two additional methods of contraception given to patient. The same validation rules and requirements as Contraception Main Method
Contraception Method Post Coital 1& 2	1	Emergency Oral	2	Emergency IUD	Length an1	• Gender must not be Male (1) • If entering data for Post Coital 2 then data must be completed for Post Coital 1

Sexual & Reproductive Health Activity Information	Length an2	
Field Name	**Code Options**	**Notes**

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SRH Care Activity	01– Sexual Health Advice 02 – Pregnancy Test 03 – Pregnancy Advice &/or Pregnancy Options Information 04 – Abortion Assessment 05 – Pre Abortion Counselling 06 – Abortion Medical Procedure 07 – Abortion Surgical Procedure 08 – Abortion Aftercare 09 – Abortion Referral (with advice) 10 – Post Abortion Counselling 11 – Cervical Screening 12 – Psychosexual Therapy 13 – Psychosexual Referral (with advice) 14 – Sterilisation/Vasectomy Assessment 15 - Sterilisation/Vasectomy Treatment (including Procedure) 16 – Sterilisation/Vasectomy Aftercare 17 – Sterilisation/Vasectomy Referral (with advice) 18 – PMS Treatment 19 – Implant Removal 20 – IUS Removal 21 – IUD Removal	22 – IUS Insertion (non-contraception) 23 – IUS Check (non-contraception) 24 – Menopause Management & Treatment (excluding IUS insertion/check) 25 – Colposcopy Treatment 26 – Colposcopy referral (with advice) 27 – Ultra Sound Scan 28 – Sub Fertility Treatment & Care 29 – Other Gynaecology Treatment & Care 30 – Alcohol Brief Intervention 31 – Safeguarding Children Referral 32 – CAF Referral 33 – Other Referral 34 – STI Related Care 35 – Complex LARC Procedures 36 – Complex Contraception 37 – Medical Gynaecology 38 – Care of Prostatitis 39 – Genital Dermatoses 40 – Sexual Assault (acute presentation) 41 – Sexual Assault (non-acute presentation)	Records other services received by the patient. • The following codes cannot be used for males **02, 04, 06, 07, 08, 09, 11, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 35, 36, 37** • Code **38** cannot be used for females • Codes **06 and 07** cannot be used on the same attendance. • Codes **06 and 09** cannot be on the same attendance. • Codes **07 and 09** cannot be on the same attendance. • Codes **15 and 16** cannot be on the same attendance. • Codes **15 and 17** cannot be on the same attendance. • Codes **12 and 13** cannot be on the same attendance • Codes **20 and 21** (IUS/IUD removal)should be used when IUS /IUS main method is being maintained (code 3 in Method status) and the device is being replaced with a new one • Codes **22 and 23** should not be used when IUS is being used for contraception and is indicated in Contraception Main Method fields. • Codes **25 and 26** cannot be on the same attendance • If the IUS insertion is to provide contraception then record under '**04** Contraception Main Method'. However if the IUS is for menorrhagia purposes only including to support menopause treatment and care then record as '**22** SRH Care Activity' • Record '**01** Sexual Health Advice' only if advice is NOT for 'CMS 4 Contraception Advice' or NOT for '03 Pregnancy

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			Options' and is not an inherent part of and separate to a SRH care activity you are also recording at the patient's attendance. • Up to six codes can be entered per patient, but must be entered consecutively with no gaps.

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