Reference Card 1

Glossary of Medical Abbreviations

Medicine Form

Amp. = Ampules (elongated glass container of liquid medication)
Cap. = Capsules (gel caps, time release caps, solid caplets)
Elix. = Elixir (liquid)
hypo. = hypodermically (injection)
I.D. = intradermal (injection in skin)
I.M. = intramuscular (injection in muscle)
inf. = infusion (I.V. infusion)
Inhalant = medication administered per nose and/or mouth via mist
I.V. = intravenously (in vein)
patche = skin cover for medication or for test
per os/P.O. = by mouth
P.R. = per rectum
Pulv = powder
S.L. = Sublingual (under the tongue)
s.q./subq/S.C. = subcutaneous (under the skin)
syr = syrup
Tab = Tablet
tr = tincture
ung = ointment
vial = container (small) of sealed liquid medication usually for injections

When or How Often a Medicine is Administered

a.c. = before meals
ad. lib = as desired
b.d. = twice a day
b.i.d. = twice a day
b.i.n. = twice a night
H. = hour
h.s. = at bedtime
non rep. = don't repeat
noxt. = at night
p.c. = after food (after meals)
p.r.n. = as needed (as desired)
q.h. = every hour
q = every
q 2h = every 2 hours
q.d. = every day
q.i.d = four times a day
q.o.d. = every other day
rep. = let it be repeated
stat. = immediately
t.i.d. = three times a day

Dosage or Strength of a Medicine

cc. = cubic centimeter (injections and liquid medications are measured in cc.)
dr. = drams 27 gr = 1 dram 8 drams = 1 oz.
fl. oz. = fluid ounce
gm or g = gram
gr = grain
gtt = drops
Kg = Kilogram
M^2 = square meter
mEq = milliequivalent (weight of substance in 1 milliliter)
mg = milligram 1000 mg = 1 gm
mcq = microgram
ml = milliliter 1000 ml = 1 Liter
mm = millimeter 1000 mm = 1 meter
L. = Liter 1.0567 quarters = 1 Liter

Commonly used Medical Abbreviations

a or aa = of each
AP = apical pulse
aq. = water
ASAP = as soon as possible
$\underline{C}$ = centigrade
$\overline{c}$ = with
CO_2 = carbon dioxide
comp = compound
dil = dilute
et = and
F = Fahrenheit
Fx = fracture
G = gauge
GI = gastrointestinal
I.O. = intake and output
lavage = to wash out cavities (wounds)
Na = sodium
NG tube = nasal gastric tube for feeding [sizes in French (i.e., French 18]
NS/NA C1 = normal saline (Sodium Chloride Solution)
O_2 = oxygen
o.d. = right eye
o.s. = left eye
o.u. = both eyes
pads = sterile or non-sterile coverings
$\overline{s}$ = without
S.O.B. = short of breath
sp. gr. = specific gravity
ss = half
$\dot{T}$ = one tablet
T = temperature
T.O. = telephone order
$\dot{T}\dot{T}$ = two tablets

Medical Chart Abbreviations and Symbols

A	-	assessment
AB, Ab	-	abortion
Abd	-	Abdomen, abdominal
ABG	-	arterial blood gases
Abx	-	antibiotics
AFB	-	acid fast baccili (tuberculosis culture)
AIDS	-	acquired immune deficiency syndrome
AP	-	anteroposterior
A/P	-	assessment, plan
ARC	-	AIDS related complex
Asx	-	asymptomatic
AMA	-	against medical advice
A&P	-	auscultation and percussion
Ax	-	axillary (armpit)
Appt	-	appointment
AZT	-	azidodideoxythymidine
B	-	black race
BC	-	blood culture; birth control (pills)
BM	-	bowel movement, brain mass
bid	-	two times a day
BOM	-	bilateral otitis media (earache)
BP, B/P	-	blood pressure
BUN	-	blood urea nitrogen (blood chemistry test for kidney function)
BS	-	breath sounds (chest exam); bowel sounds (abdominal exam)
Bx	-	biopsy
$\bar{c}$	-	with
C	-	Caucasian race
Ca	-	cancer
CAT	-	computerized axial tomography
CBC	-	complete blood count
CC, C/C	-	chief complaint
CCE	-	clubbing, cyanosis, edema (extremities)
CHD	-	congenital heart disease
CHF	-	congestive heart failure
chr	-	chronic
cl	-	clear
CIS	-	carcinoma in situ
C-section	-	cesarean section
cm	-	centimeter
CMV	-	cytomegalovirus
CN	-	cranial nerve
CNS	-	central nervous system
COR	-	coronary
CP	-	chest pain; cerebral palsy
C&S	-	culture and sensitivity
CSF	-	cerebrospinal fluid
CT	-	computed tomography
CTA, CTAP	-	clear to auscultation, percussion (lungs)

CV	-	cardiovascular
CVA	-	cerebrovascular accident (stroke); costovertebral angle (abdomen)
cx	-	cervical (nodes)
CXR	-	chest x-ray
D	-	dorsal spine
D&C	-	dilation and curettage (uterus)
D/C	-	discharge
dc/dc'd	-	discontinue, discontinued
def	-	deficit
Dig	-	Digoxin (used in treatment of congestive heart failure and other heart disorders)
DKA	-	diabetic ketoacidosis
DM	-	diabetes mellitus
DNR	-	do not resuscitate
DOA	-	data of admission; dead on arrival
DOB	-	date of birth
DOE	-	dyspnea on exertion (shortness of breath)
DPT	-	diphtheria, pertussis, tetanus immunization
DTR	-	deep tendon reflexes
Dx	-	diagnosis
ECG, EKG	-	electrocardiogram
ECHO	-	echocardiogram
EEG	-	electroencephalogram
EENT	-	eye, ear, nose, and throat
EMT	-	emergency medical technician
ENT	-	ear, nose, and throat
EOM, EOMI	-	extraocular movement, intact (eye exam)
ER	-	emergency room
Ext	-	extremity
ETOH	-	ethanol (alcohol)
F	-	female
FAS	-	fetal alcohol syndrome
FBS, FS	-	fasting blood sugar, fasting sugar
FE	-	iron
FH	-	family history
FT	-	fluorescent titer antibody (syphilis test)
F/U	-	followup
FUO	-	fever of unknown origin
Fx	-	fracture
GB	-	gallbladder
GC	-	gonococcus (organism causing gonorrhea)
GI	-	gastrointestinal
GU	-	genitourinary
GYN	-	gynecology
HA	-	headache; health assessment
HCM	-	health care maintenance
Hct	-	hematocrit
HD	-	heart disease
Hgb	-	hemoglobin
HEENT	-	head, eyes, ears, nose, throat
HBP	-	high blood pressure
H&P	-	history and physical

H - Hispanic
HMO - health maintenance organization
HSM - hepatosplenomegaly
HIV - human immunodeficiency virus
H/O, h/o - history of
HPI - history of present illness
HPV - human papilloma virus
HR - heart rate
H/S megaly - hepatosplenomegaly
HSV - herpes simplex virus
Ht - heart, height
HTN - hypertension
Hx, hx - history
ICD - International Classification of Diseases
ICU - intensive care unit
ID - identification
IDDM - insulin dependent diabetes mellitus
imm-UTD - immunization up-to-date
Inf - infection
INH - isonicotine hydrazine (drug for tuberculosis)
IP - inpatient
IV - intravenous
IVDA - intravenous drug abuse
IVDU - intravenous drug user
IVP - intravenous pyelogram (x-ray exam of kidneys)
IUP - intrauterine pregnancy
JVD - jugular vein distension
KS - Kaposi's sarcoma
L, (L) - left
LAD - left axial deviation; left anterior descending
LAS - lymphadenopathy syndrome
lat - lateral
LLL - left lower lobe (lung)
LLQ - left lower quadrant (abdomen)
LMP - last menstrual period
LN - lymph nodes
LNMP - last normal menstrual period
LP - lumbar puncture
LS - lumbosacral (spine)
LUE - left upper extremity
LUQ - left upper quadrant (abdomen)
(m) - murmur (heart)
M - male
meds - medications
ml - milliliter
mm - millimeter
MAR - Medicine Administration Record
MPAF - Medicare PPS Assessment Form
MR - medical record
MRI - magnetic resonance imaging
NAD - no apparent distress

NC - no complaints
NEG, neg - negative
NIDDM - noninsulin dependent diabetes mellitus
NKA, NKDA - no known allergies; no known drug allergies
nl - normal
NPH - a type of insulin (Isophone)
NPO - nothing by mouth
NSR - normal sinus rhythm (heart)
NT - not tender (abdomen)
NV, N/V - nausea & vomiting
NVD - nausea, vomiting, diarrhea
∩ - without
O - objective
OB - obstetrics
occ - occasional
OD - right eye
OM - otitis media
O-P - oral pharynx
O+P - ova and parasites
OP - outpatient
OPD - outpatient department
OR - operating room
OS - left eye
OT - oral thrush
ITC - over the counter
p - after; following
p - pulse; plan
PA - posteroanterior
PAP - Papanicolaou smear
Path - pathology
PCP - pneumocystis carinii pneumonia
PE, Pex - physical examination
Pen - penicillin
PERRLA - pupils equal, round, react to light and accommodation
PGL - progressive generalized lymphadenopathy
PID - pelvic inflammatory disease
PLH - pulmonary lymphoid hyperplasia
PMH - past medical history
PMI - point of maximum intensity (heart)
PML - progressive multifocal leukoencephalopathy
po - by mouth
PPD - tuberculosis skin test
PPS - Prospective Payment System
prn - as needed
pt - patient
PT - physical therapy
PTA - prior to admission
PUD - peptic ulcer disease
pul - pulmonary
q, Q - every

qd, QD	-	every day
qid, QID	-	four times a day
q4h	-	every four hours
R, Ⓡ	-	right, respiration
RBC	-	red blood cells
RCM	-	right coastal margin
RF	-	rheumatic fever
RHD	-	rheumatic heart disease
RLE	-	right lower extremity
RLL	-	right lower lobe (lung)
RLQ	-	right lower quadrant (abdomen)
RO, R/O	-	rule out
ROM	-	range of motion (extremities)
ROS	-	review of systems
RPR	-	syphilis test
RRR	-	regular rhythm & rate
RTI	-	respiratory tract infection
RUE	-	right upper extremity
RUL	-	right upper lobe (lung)
RUQ	-	right upper quadrant (abdomen)
Rx	-	prescription
s	-	without
S	-	subjective
S_1, S_2	-	first, second heart sound
SBE	-	subacute bacterial endocarditis
sen	-	sensory
SH	-	social history
sl	-	slight
SOB	-	short of breath
SP, S/P	-	status post
STD	-	sexually transmitted disease
STS	-	serology test for syphilis
SW	-	social worker
Sx	-	symptom
syst	-	systolic (blood pressure, murmur)
T	-	temperature
TB, TBC	-	tuberculosis
TM	-	tympanic membrane (ear)
TOXO	-	toxoplasmosis
TPR	-	temperature, pulse, respiration
Tx, Tx'ed	-	treat, treated
UA, U/A	-	urinalysis
URI	-	upper respiratory infection
UTI	-	urinary tract infection
VDRL	-	lab test for syphilis
VN, VNA	-	visiting nurse, visiting nurse association
VS, V/S	-	vital signs; versus
w/	-	with
W	-	white
WBC	-	white blood cells
W&D	-	warm and dry (skin)

WDWN	-	well developed, well nourished
WNL	-	within normal limits
wt	-	weight
x	-	times
yo	-	years old
♀	-	female
♂	-	male
⊕, (+), +	-	positive, plus, present
⊖, (-), -	-	negative, absent
⊂	-	heart
Δ	-	change
□	-	no, none
<	-	less than, caused by
>	-	greater than
↓	-	down, decreased
↑	-	up, increased
→	-	shows, results
1°	-	primary; first degree
2°	-	secondary; second degree
/	-	slash mark signifying per, and, with (can be mistaken for "1" or "I")

Reference Card 2

Example of Medical Records Order

Tabs	Forms
Patient Care Plans:	MDS, Trigger Sheet Patient Care Plan Discharge Plan
Nurses Notes:	Vital Sign Flow Sheet I&O (Intake & Output) Sheet Weight Record Nurses Notes Nursing Assessment
Doctors Orders:	Physician Orders
Progress Notes:	Physician Progress Notes
H & P:	History & Physical Discharge Summary Transfer Form
Lab:	X-ray Reports Laboratory Reports
Dietary:	Dietary Notes
Activities:	Activity Notes, Assessment, Plan of Care
Social Services:	Social Service Notes
Rehabilitation:	Physical Therapy Speech Therapy Occupational Therapy
Medication:	Medication Record Treatment Record PRN Medical Record
Nursing Assistance:	ADL Records
Miscellaneous:	Personal Possession Record
Admission:	Face Sheet/Admission Record
In Front/Back of Chart:	Legal Representative Record Living Will Advance Directives

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Reference Card 3

MCBS Guide to Patient Records

Questionnaire Section	Type of Patient Record (Reminder: Information may not be in only one place.)
Facility Questionnaire (FQ)	Must be completed with facility administrator or other knowledgeable respondent.
Residence History (RH)	Admission Record Discharge or Death Summary Face Sheet Final Nurses Notes or Progress Notes Patient Transfer Form
Background (BQ)	Admission Record Social History
Health Insurance (IN)	Medicare number and limited information about other health insurance coverage can be found on forms completed at the time of admission (e.g., Admission Record). Otherwise, this section will require a respondent in the business/billing office.
Health Status (HS)	Admission/Discharge Summary from the hospital Admission History and Physical ADL Records Doctor orders Nursing Assessment Sheet Nurses' Notes Patient Transfer Form Progress Notes Resident Basic Needs Assessment Form Minimum Data Set, or MDS
Prescribed Medicnes (PM)	Medication Record/Chart PRN Medical Record Treatment Records
Expenditures (EX)	Admission Record Records from the business office
Use (US)	Consultation Reports Doctors Orders Lab and Specialists' Reports Patient Care Plan Physician Progress Notes Nurses' Notes Rehabilitation and Therapy Reports Treatment Logs Xray Reports

Reference Card 4

Reference Card for Medical Specialty

1. DENTIST/DENTAL PROVIDER
2. MEDICAL DOCTOR
3. AUDIOLOGIST
4. CHIROPRACTOR
5. CLINICAL SOCIAL WORKER
6. DIETITIAN-NUTRITIONIST
7. HEARING THERAPIST
8. HOME HEALTH/HEALTH AIDE
9. HOMEMAKER
10. HOSPICE WORKER
11. I.V. THERAPIST
12. NURSE (RN)
13. NURSE PRACTITIONER
14. NURSE'S AIDE
15. OCCUPATIONAL THERAPIST (OT)
16. OPTOMETRIST
17. OSTEOPATH (DO)
18. PARAMEDIC
19. PHYSICAL THERAPIST (PT)
20. PHYSICIAN'S ASSISTANT
21. PODIATRIST (FOOT DOCTOR)
22. PSYCHOLOGIST
23. RESPIRATORY THERAPIST
24. SOCIAL/CASE WORKER
25. SPEECH THERAPIST
26. THERAPIST (MENTAL HEALTH)
27. X-RAY TECHNICIAN
28. LICENSED PRACTICAL NURSE (LPN)
91. OTHER MEDICAL PROVIDER SPECIALTY (NON-MD)

SPECIFY

EXAMPLES OF TYPES OF MEDICAL DOCTORS

ALLERGIST
ANESTHESIOLOGIST
CARDIOLOGIST
DERMATOLOGIST
ENDOCRINOLOGIST
GASTROENTEROLOGIST
GERIATRIC DOCTOR
GYNECOLOGIST
HEMATOLOGIST
INTERNAL MD/INTERNIST
NEPHROLOGIST
NEUROLOGIST
ONCOLOGIST
OPHTHALMOLOGIST
ORTHOPEDIST
PATHOLOGIST
PROCTOLOGIST
PULMONOLOGIST
PSYCHIATRIST
RADIOLOGIST
RHEUMATOLOGIST
SURGEON:
- CARDIOVASCULAR
- COLON/RECTAL
- EYE
- GENERAL
- HAND
- NEUROLOGICAL
- ORTHOPEDIC
- PLASTIC
- THORACIC
- VASCULAR

UROLOGIST

1/13/05

Reference Card 5

MCBS Facility Special Keys and Functions

SPECIAL KEY	FUNCTIONS
Enter	Tells the computer to move the cursor to the next field or Select a choice on a roster or select a button within a box
Esc	Moves you out of any box, for example, COMMENTS, PM LOOK UP. Stores and returns cursor to answer space.
Backspace	Erases previous character(s) on line where cursor is located.
Delete	Deletes a field value when highlighted.
F9	Calls up a comment window and moves cursor there so a comment can be entered.
F6	Stores a "refused" response in the data file.
F5	Stores a "don't know" response in the data file.
F1	Used to access help screens.
Space Bar	Adds a dash between values in a “Select All That Apply” field. Adds spaces in a text field.
Up Arrow	Takes you to the previous field entered.
TAB	Moves cursor to next field, or button within a box.
END	Moves cursor to last field entered.
S	Suppresses a soft error message and returns the cursor to next field.
C	Closes an error message and returns cursor to answer space.
G	Closes an error message and returns cursor to the highlighted “Question Involved” within the error message.
Ctrl/R	Add or Edit an entry to Person Roster.
Ctrl/S	Takes you to the Stay Report.
Ctrl/B	Takes you to the Break Off screen.
Ctrl/E	Escapes from Break Off screen, Person Roster, or Stay Report. (Interview can be started again in the instrument at the same place the Ctrl/E was entered.
[	Takes you to “PM DRUG NAME/STRENGTH NOT LISTED” on the prescribed medicines Look Up feature.
NOTE: When CTRL key is used -- hold the CTRL key down then press the appropriate key.	

5/13/12

Reference Card 6

State Abbreviations

Alabama	AL	Montana	MT
Alaska	AK	Nebraska	NE
Arizona	AZ	Nevada	NV
Arkansas	AR	New Hampshire	NH
California	CA	New Jersey	NJ
Colorado	CO	New Mexico	NM
Connecticut	CT	New York	NY
Delaware	DE	North Carolina	NC
District of Columbia	DC	North Dakota	ND
Florida	FL	Ohio	OH
Georgia	GA	Oklahoma	OK
Hawaii	HI	Oregon	OR
Idaho	ID	Pennsylvania	PA
Illinois	IL	Puerto Rico	PR
Indiana	IN	Rhode Island	RI
Iowa	IA	South Carolina	SC
Kansas	KS	South Dakota	SD
Kentucky	KY	Tennessee	TN
Louisiana	LA	Texas	TX
Maine	ME	Utah	UT
Maryland	MD	Vermont	VT
Massachusetts	MA	Virginia	VA
Michigan	MI	Washington	WA
Minnesota	MN	West Virginia	WV
Mississippi	MS	Wisconsin	WI
Missouri	MO	Wyoming	WY

Reference Card 7

Identifying Special Facility Cases

We continue to need your help in identifying these special facility cases. When the cases are fielded, review each of your facility cases with the following questions:

- Is this a Group/Adult/Family Care Home setting?
- Are all of the Group Homes on one campus? If yes, we still consider this one facility.

If you identify a Group/Adult/Family Care Home setting, do not complete the case; follow these steps:

1. Call the facility and find out the name, address, phone number, and contact person for the Group Home. Obtain the following information for every SP residing in the facility:
   - The physical address of the Group Home and,
   - The contact address where you will go to talk to the contact person.
2. Does the Group Home have three or more beds? If it does not, the case is not eligible for the Facility Component and will be crossed over to the Community Component.
3. Write an e-mail to your supervisor explaining the situation, making sure to include all necessary information:
   - SP ID #
   - The facility ID# of the case as originally fielded in the current round.
   - Do residents reside in the Facility where the case was fielded?
   - The name, address, and phone # of new Facility (Group Home).
   - The main contact name (the person you will contact to make an appointment).

Once all the details are worked out, the case will be resent to you electronically with the new Facility ID# and the "old" Facility will be deleted from your computer.

Facility Questionnaire Procedures for Group/Adult/Family Care Home Facilities

1. An interviewer instruction and additional response categories are included in FQ1. These direct and allow you to avoid asking this question in the Group/Adult/Family Care Home situations. The intent of this question is to confirm that we have the correct address for the group home location(where the SP resides).
2. For interviewing purposes, we treat the respondent for the FQ as the administrator at FQ3 (select response category - RESPONDENT CONSIDERED ADMINISTRATOR).
3. You are to collect the address of the FQ respondent at FQ4.
4. Verify the phone number at the Group Home location at FQ5. It would be best if this is done from previously obtained information; don't read this question aloud.
5. At FA12 (NUMBER OF FACILITY BEDS), probe for and enter the number of beds at the SP's physical location only.
6. **Finally, If this is a newly identified Group/Adult/Family Care Home. Be sure to enter the admission date that appears on the case folder label at RH2A.**

Reference Card 8

Guidelines For Making Comments in the Facility Questionnaires

When entering comments remember to include the following:

FQ: Add a PLACE or UNIT

- Place name.
- Type of place.
- Number of beds.
- Bed Certification: Medicare, Medicaid, ICF.

RH: Add a STAY

- Dates: begin and end.
- Name of the place.
- Type of STAY (hospital, home, facility or "other" facility) *See showcard FA1*.
- If the place is not already listed on the Place Roster also add the address and phone number of the place.

RH: Need to Change SP Disposition

[For example: case was coded complete in the facility and the SP was really discharged or deceased.]

- Name of the place the SP was discharged to or where the SP died.
- If SP was discharged or deceased in a new place, (not included on the Place Roster), also include the address and phone number of the new place.
- Date of discharge or death.
- Include any missing charges, payments and Sources of Payment through the date of death or discharge.

EX: Adding a Billing Period or Additional Charge Information

- Billing Period Date(s): begin and end.
- How many days were billed during each period.
- Total amount charged to the SP.
- Total amount paid.
- ALL Sources of Payment.

IN: Medicaid Coverage

[For example: "No" is entered at IN1 {Has SP ever been covered by Medicaid} and Medicaid is listed as a SOP in EX.]

- The year the SP was first covered by Medicaid.
- The Medicaid #.

PM: Adding Missed Medicine(s)

- The month(s) it was administered in.
- Name of the prescribed medicine.
- The form (tab/liquid/etc.) and strength (number and unit(MG/CC/etc.) - the single dosage.*
- How often the dosage was administered (QD/PRN/etc.)*
- The total number of times it was administered for that month.

***Use your prescribed medicine reference showcards**

General

Identify what questionnaire you are in and which question you are referring to. Then identify the problem and what action you think needs to be taken.

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Reference Card 9	MCBS - Missing Data Reference Guide

Sections with missing data may remain open for you to access and make corrections in certain situations. These sections are eventually locked to protect the data and a missing data section is activated. While it is preferable to go back into the original section to correct the missing data, you must use the MD section once the original section is locked. Below are items in each section that trigger the MD sections.

FACILITY QUESTIONNAIRE (FQ)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

QUESTION #	QUESTION TOPIC
FQ1A	IS FACILITY'S NAME CORRECT?
FQ2	IS FACILITY'S ADDRESS CORRECT?
FQ4	IS FACILITY'S MAILING ADDRESS CORRECT?
FQ3	IS FACILITY'S ADMINISTRATOR CORRECT?
FQ5	IS FACILITY'S PHONE NUMBER CORRECT?
FA1	WHAT IS THE TYPE OF PLACE FOR FACILITY?
FA12	WHAT IS THE NUMBER OF BEDS IN FACILITY?
FA13	IS THERE MEDICAID CERTIFICATION FOR FACILITY?
FA14	IS THERE MEDICARE CERTIFICATION FOR FACILITY?
FA15	IS THERE MEDICAID-ICF/MR CERTIFICATION FOR FACILITY?
FA16	IS THERE STATE DEPARTMENT LICENSING FOR FACILITY?
FA18	IS THERE NON-NURSING LICENSING FOR FACILITY?

RESIDENCE HISTORY (RH)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

QUESTION #	QUESTION TOPIC
RH7	IS SP ALIVE?
RH8	WHAT IS SP'S DATE OF DEATH?
RH13	WHAT ARE THE DATES FOR PLACE (SP) WAS IN (CURRENT YEAR)?

BACKGROUND QUESTIONNAIRE (BQ)

If any of the following questions are answered "don't know" or "refused", the section will be coded MD.

QUESTION #	QUESTION TOPIC
BQ11A	WHAT IS SP'S RACE?
BQ13	WHAT IS SP'S MARITAL STATUS?

Reference Card 9	MCBS - Missing Data Reference Guide (cont.)

HEALTH INSURANCE (IN)
NO MISSING DATA QUESTIONS

HEALTH STATUS (HS)
NO MISSING DATA QUESTIONS

PRESCRIBED MEDICINE (PM)

If PM data is missing for any month within the reference period, the section will be coded MD.

EXPENDITURE (EX)
NO MISSING DATA QUESTIONS

USE (US)
NO MISSING DATA QUESTIONS