an ciste náisiúnta um cheannach cóireála
the national treatment purchase fund

Radiology Waiting List Minimum Data Set

V1.0

Contents

Document Revision History

Date	Author	Version	Change Reference
2024/10/15	Conor Lynch	0.1	Initial draft
2025/01/06	Conor Lynch	0.2	Feedback from internal meeting
2025/01/10	Conor Lynch	0.3	Updated based on feedback from WLR Team
2025/01/30	Conor Lynch	0.4	Updated after consultation with NIMIS and NTPF IT Team
2025/04/10	Conor Lynch	0.5	Updated after meetings with NIMIS and WLR Team.
2025/06/16	Conor Lynch	1.0	Small adjustments to field descriptions.

Introduction

The purpose of this document is to provide information to hospitals to aid them in producing the Radiology Waiting List extract files for subsequent weekly upload to, and processing by, the NTPF.

Producing Extract Files

The extract should contain a complete set of data as described and have no dependencies on previously submitted extract files.

A record comprising of certain data items is required for every qualifying patient referral, as defined below. Each record **must** contain 78 fields, as defined in the Minimum Data Set (MDS) hereunder and **in the order defined in the MDS.**

Extract data should be relation to only the following sets of patients:

- Outpatient referrals
- Other Outpatient services
- GP referrals
- Primary care referrals
- Community services referrals
- Patients awaiting a Planned Examination

The following patient **should NOT** be included:

- Interventional Radiology
- Emergency Department
- Inpatient Referrals
- National Screening Services (Breast Check)
- Private Patients
- Private Waiting Lists
- GP access to community diagnostic scheme

The extract should be a snapshot of the Radiology Waiting List data containing a single record for each referral. Records should remain on the extract for exactly four weeks after the referral has been removed (i.e. the appointment has taken place or the referral entry is removed as a result of Clinical Prioritisation (Vetting) outcome (rejected)). If a referral has been given an appointment data it should be included as a valid WL entry, even though in some systems it may be flagged as "Resolved".

An extract file should be produced and submitted weekly. The files will be submitted by SFTP via the National Health Network (NHN).

Naming Extract Files

The naming convention with respect to extract file names is as follows:

There should be four items of information within the extract file name, each separated by an underline character:

- "RAD25"
- The Hospital HIPE Code (including the leading zero if applicable)
- The Waiting List Extract Date (formatted as "yyyyMMdd")
- The file set sequence number (only required if there are multiple extract files and the above items to not provide a unique file name)

A typical extract file name might be: RAD25_0908_20241015_1.csv

Multiple Extract Files per Week

There is no mechanism by which the NTPF can know that all Radiology entries for a particular organisation are included in a particular extract file. It is the responsibility of each providing organisation to ensure that all available Radiology episode information is included within the extract file submitted.

On the occasion that multiple files are submitted in a given week, only the latest version of the file will be processed. Files submitted after the archive deadline **cannot** be processed retrospectively.

Extract File Structure

The extract file should be structured using simple "commas separated value" formatting, as is the case for the IDPP and OPWL Waiting List files currently produced and submitted.

Header Record

The first line within an extract should be a header record. The header record will contain five fields and be structured according to the following table:

Field No	Field Name	Description	Data Type	Max Length	Mandatory
1	Extract Type	Text denoting that it's a Radiology extract file: "RAD25"	String	4	Y
2	Hospital HIPE	ESRI identifier (HIPE code) of the hospital (including the leading zero if applicable)	String	4	Y
3	File Date	Effective date of the data contained in this extract file (normally the date that the extract file is produced)	Date	10	Y
4	File Set Sequence Number	Identifier used to differentiate between multiple extract files from the same	String	20	Y

		source organisation for the same effective date			
5	Record Count	The number of records within this extract file, excluding the header record	Integer	-	Y

A typical header file record might look like: “RAD25”,”0908”,”15/10/2024”,”1”,”1076”

Radiology Minimum Data Set Details

The following table lists the data items that need to be provided by hospitals. All records should be submitted weekly up to 4 weeks after being removed.

When no data exists for a non-mandatory field, then the field can be null within the record. This is represented by two consecutive double-quote characters between the commas: “”

Date Format

Unless otherwise specified, all dates should be provided in dd/MM/yyyy format. Datetimes should be provided in dd/MM/yyyy hh:mm:ss format.

Field No	Field Name	Description	Data Type	Max Length	Mandatory
1	Hospital HIPE	The HIPE code of the hospital	Numeric string	4	Y
2	IHI Number	The full, 18-digit, IHI identifier. Return blank if not available. (Should start with 539)	string	50	N
3	PPSN	For future use.	string	10	Please leave blank for now.
4	MRN	Unique identifier for the patient as allocated by the hospital.	string	50	Y
5	PAS Account Number/Episode Number	Unique identifier for the case that the Radiology Examination is associated with as allocated and used by the hospital.	string	50	Y, where exists
6	Order Number	Unique identifier for this request as	string	50	Y

		allocated and used by the hospital.			
7	Accession Number	Unique identifier for this particular accession as allocated and used by the hospital.	string	50	Y
8	Patient Forename 1	Patient's first name	string	50	Y
9	Patient Forename 2	Patient's middle name or initial(s)	string	50	N
10	Patient Surname	Patient's surname	string	50	Y
11	Patient Sex	Male, Female or Unknown Note: This is the biological sex of the patient, distinct from their gender identity.	string	1 – See Code Table 1	Y
12	Patient Date of Birth	Date of patient's birth	date	10	Y
13	Patient Address Line 1	Address line 1 of primary residence	string	50	Y
14	Patient Address Line 2	Address line 2 of primary residence	string	50	N
15	Patient Address Line 3	Address line 3 of primary residence	string	50	N
16	Patient Address Line 4	Address line 4 of primary residence	string	50	N
17	Patient Address Line 5	Address line 5 of primary residence	string	50	N
18	Patient Area of Residence Code	The area of residence (as allocated by ESRI for HIPE returns)	string	4 – See Code Table 2	N
19	Eircode	The patient's Eircode	string	7	N
20	Patient Telephone Number	Daytime telephone number used to contact patient	numeric string	50	N
21	Patient Mobile Telephone Number	Mobile telephone number used to contact patient	numeric string	50	N
22	Patient Email Address	Email Address used to contact patient	string	50	N
23	Patient Type	Inpatient/Outpatient	integer	See Code Table 3	Y

24	Patient Class	The patient class as defined by the NRQI programme definitions.	integer	See Code Table 4	Y
25	Ambulatory Status	The ambulatory status of the patient.	integer	See Code table 5	Y
26	Modality	Description of the form of imaging been requested.	integer	See Code Table 6	Y
27	Exam Code	The code for the exam to be carried out	string	50	Y
28	Exam Description	The full text description of the exam to be carried out	string	150	Y
29	Order Location	The location where the order was created	string	150	Y
30	Exam Location	The room or site where the exam will take place. May also be called “Resource”.	string	150	N
31	Referral Date	The date and time of the referral letter	date	10	N
32	Referrer’s Priority	The priority as assigned by the referral source	integer	See Code Table 7	Y
33	Referral Received Date	Date the referral letter was received by the hospital	date	10	Y
34	File Date	Effective date of the data contained in this extract file (normally the date that the extract file is produced)	date	10	Y
35	Entering User Forename	First name of the user who created the entry in the system, excluding title (e.g. “Dr.”)	string	50	Y
36	Entering User Surname	Surname of the user who created the entry in the system	string	50	N (If name is stored in one field on your system you may leave this blank

					and fill full name into previous field)
37	Order Date/Time	The date and time the referral request was placed on the hospital RIS or ordering system	datetime	19	Y
38	Scheduled Status	If request is scheduled or not scheduled	integer	See Code Table 8	Y
39	Scheduled Date/Time	Scheduled appointment date and time	datetime	19	Dependent on value of field 37
40	Arrived Date/Time	The date and time that the patient arrived in the radiology department	datetime	19	N
41	Started Date/Time	The date and time that the exam started	datetime	19	N
42	Filmed Date/Time	The date and time the patient successfully completed their radiology examination	datetime	19	N
43	Signed Date/Time	Date and time at which radiology reports are made available for internal referrers to view	datetime	19	N
44	Discharge Date/Time	Date and time patient was discharged	datetime	19	N
45	Cancellation Date	Date the appointment was last cancelled (for any reason). If a new appointment date has been given since the cancellation, then this field should return to NULL.	date	10	N
46	Cancellation Reason	Reason for the most recent cancellation	integer	See Code Table 9	Mandatory if 44 is provided

47	Most Recent Patient Appointment Cancellation Date	Date of the last cancellation with "Cancelled by Patient/Guardian (for non-clinical reasons)" (code value 22) given as the reason in field 33. If a new appointment date has been given since the cancellation, Then this field **SHOULD NOT** return to NULL. See the full note at the end of this section.	date	10	N
48	Most Recent Patient DNA Date	Date of the last cancellation with "Patient Did Not Attend (DNA)" (code value 12) given as the reason in field 33. If a new appointment date has been given since the cancellation, Then this field **SHOULD NOT** return to NULL. See the full note at the end of this section.	date	10	N
49	Made Available for Clinical Prioritisation (Vetting) Date	Date the referral was made available for clinical prioritisation (Vetting) This may be the same as the Order Date	date	10	Mandatory if 52 is supplied

50	Clinical Prioritisation (Vetting) Date	Date that the patient was vetted	date	10	Mandatory if 52 is supplied
51	Clinical Prioritisation (Vetting) Status	The vetting status of the patient	integer	See Code Table 10	Mandatory if 50 is supplied
52	Clinical Prioritisation (Vetting) Category	The urgency level assigned to the referral at Clinical Prioritisation (Vetting)	integer	See Code Table 7	Y
53	Vetted By Forename	The first name of the person who vetted this patient, excluding title (e.g. “Dr.”)	string	50	Mandatory if patient has been vetted
54	Vetted By Surname	The surname of the person who vetted this patient	string	50	N (If name is stored in one field on your system you may leave this blank and fill full name into previous field)
55	Requesting Physician Forename	The requesting physician’s first name, excluding title (e.g. “Dr.”)	string	50	Y
56	Requesting Physician Surname	The requesting physician’s surname	string	50	N (If name is stored in one field on your system you may leave this blank and fill full name into previous field)
57	Requesting Physician Medical Title	Medical title of the requesting physician	string	16	Y
58	Requesting Physician Specialty	HIPE code of the requesting physician’s specialty	string	4	N
59	Requesting Physician HIPE	Requesting physician’s HIPE code	numeric string	4 – See code table 11	N, but if not provided then IMC must be provided below

60	Requesting Physician IMC	Requesting physician's IMC code	string	10 – See code table 12	N, but if not provided then HIPE must be provided above
61	Attending Physician Forename	The attending physician's first name, excluding title (e.g. "Dr.")	string	50	Y
62	Attending Physician Surname	The attending physician's surname	string	50	N (If name is stored in one field on your system you may leave this blank and fill full name into previous field)
63	Attending Physician Medical Title	Medical title of the attending physician	string	16	Y
64	Attending Physician Specialty HIPE	HIPE code of the attending physician's specialty	string	4	Y
65	Attending Physician HIPE	Attending physician's HIPE code	numeric string	4 – See code table 11	N, but if not provided then IMC must be provided below
66	Attending Physician IMC	Attending physician's IMC code	string	10 – See code table 12	N, but if not provided then HIPE must be provided above
67	GP Forename	GP's first name, excluding title (e.g. "Dr.")	string	50	N
68	GP Surname	GP's surname	string	50	N (If name is stored in one field on your system you may leave this blank and fill full name into previous field)
69	GP Code	GP's local hospital code, if exists	string	12	N

70	GP IMC	GP's Medical Council No.	string	10 – See code table 13	N
71	GP Address Line 1	Address line 1 of GP's practice	string	50	N
72	GP Address Line 2	Address line 2 of GP's practice	string	50	N
73	GP Address Line 3	Address line 3 of GP's practice	string	50	N
74	GP Address Line 4	Address line 4 of GP's practice	string	50	N
75	GP Address Line 5	Address line 5 of GP's practice	string	50	N
76	GP Eircode	Eircode of GP's practice	string	7	N
77	GP Email Address	GP's email address	string	50	N
78	High Clinical and/or Social Needs	Is this a high clinical and/or social needs patient (as determined by clinician)	integer	See code table 14	N

Notes

- Where a patient cancels their appointment for non-clinical reasons (code value 22 in field 46), the cancel date should be populated into both fields 45 and 47. The date in field 32 should be returned to NULL when the patient is issued a new appointment date. The date in field 46 should persist for the duration of the patient's wait time, or until it is replaced by another patient requested cancellation date for non-clinical reasons.
- Where there has been a patient DNA incident (code value 12 in field 46), the DNA date should be populated into both fields 45 and 48. The date in field 32 should be returned to NULL when the patient is issued a new appointment date. The date in field 47 should persist for the duration of the patient's wait time, or until it is replaced by another patient requested cancellation date for non-clinical reasons.

Code Tables

Many of the data files in the MDS need coded values. Each of such data fields has a corresponding table below that either explains what valid codes are available or refers to an established source where the valid codes may be found.

Table 1 – Patient Sex (Field 11)

Description	Code Value
Male	M
Female	F
Unknown	U

Table 2 – Patient Area of Residence Code (Field 18)

Description	Code Value
Carlow	0500
Cavan	2900
Clare	1600
Cork (City)	1101
Cork (County)	1200
Donegal	2800
Dublin 1	0101
Dublin 2	0202
Dublin 3	0103
Dublin 4	0204
Dublin 5	0105
Dublin 6	0206
Dublin 7	0107
Dublin 8	0208
Dublin 9	0109
Dublin 10	0210
Dublin 11	0111
Dublin 12	0212
Dublin 13	0113
Dublin 14	0214
Dublin 15	0115
Dublin 16	0216
Dublin 17	0117
Dublin 18	0218
Dublin 20	0220
Dublin 22	0222
Dublin 24	0224
Dun Laoghaire Borough	0217
Galway (City)	1801
Galway (County)	1900

Kerry	1300
Kildare	0300
Kilkenny	0700
Laois	2500
Leitrim	2600
Limerick (city)	1401
Limerick (County)	1500
Longford	2200
Louth	3100
Mayo	2100
Meath	3200
Monaghan	3000
North Dublin City & County	0100
Northern Ireland	3310
Offaly	2400
Roscommon	2000
Sligo	2700
South Dublin City & County	0200
Tipperary (North)	1700
Tipperary (South)	0800
Waterford (City)	0901
Waterford (County)	1000
Westmeath	2300
Wexford	0600
Wicklow	0400

Table 3 – Patient Type (Field 23)

Description	Code Value
Inpatient	1
Outpatient	2

Table 4 – Patient Class (Field 24)

Description	Code Value
Radiology Inpatient Referral	1
Radiology Outpatient Referral	2
External Radiology Referral	3

Table 5 – Ambulatory Status (Field 25)

Description	Code Value
Bed	1
Trolley	2
Walking	3

Wheelchair	4
Cot	5
Incubator	6
Needs Assistance	7
Pregnant	8
Pacemaker (For MRI Only)	9
Baby	10

Table 6 – Modality (Field 26)

Modality	Description	Code Value
AR	Arthroscopy	1
CI	Cardiac Investigation	2
CS	Cross Site Requesting	3
CTR	CT Radiotherapy Planning	4
CUS	Cardiac Echo	5
DXA	Dexa	6
ECG	ECG	7
ES	Endoscopy	8
EUS	Endoscopic Ultrasound	9
EV	Endovascular	10
FL	Flouroscopy Screening	11
IC	Interventional Cardiology	12
IM	Image Management	13
IO	Dental Intra Oral	14
IR	Interventional Radiology	15
MDM	Multi-Disciplinary Meeting	16
MG	Mammography	17
MR	Magnetic Resonance Imaging	18
MRR	MR RADIOTHERAPY PLANNING	19
NM	NUCLEAR MEDICINE	20
OUS	OBSTETRICAL ULTRASOUND	21
PET	POSITRON EMISSION TOMOGRAPHY	22
PFT	PULMONARY FUNCTION INVESTIGATIONS	23
PSG	SLEEP DIAGNOSTIC INVESTIGATIONS	24
TH	THEATRE	25
US	ULTRASOUND	26
VUS	VASCULAR ULTRASOUND	27
CT	CT SCAN	28
XR	X RAY	29

Table 7 – Referrer's Priority/Clinical Prioritisation (Vetting) Category (Field 32/52)

Description	Code Value
Urgent	1
Non-Urgent	2

Semi-Urgent	3
Specified Date – 3 Months	6
Specified Date – 6 Months	7
Specified Date – 9 Months	8
Specified Date – 12 Months	9
Specified Date – 18 Months	10
Specified Date – 24 Months	11
Specified Date – 36 Months	12
Specified Date – 36+ Months	13

Table 8 – Scheduled Status (Field 38)

Description	Code Value
Scheduled	1
Not Scheduled	2

Table 9 – Cancellation Reason (Field 46)

Description	Hospital/ Patient	Code Value
Cancelled no bed	H	1
Patient is Deceased	H	11
Patient DNA	P	12
Cancelled by Patient/Guardian (for non-clinical reasons)	P	22
Cancelled by Patient/Guardian – Short Notice Appointment (<2 weeks)	P	29
Patient Unfit	H	30
Correction of Clerical Error	H	90
Unable to Contact Patient	H	109
Cancelled by Hospital	H	110
Equipment Service/Failure	H	111
Already had exam externally	H	112
Rescheduled by Patient	P	113
Rescheduled by Hospital	H	114
Not Justified	H	115
No Longer Required	H	116
Patient is/may be Pregnant	H	117
Outside LMP Range	H	118
Patient Discharged	H	119

Table 10 – Clinical Prioritisation (Vetting) Status (Field 51)

Description	Code Value
Ordered/Not Vetted	1
Vetted	2
On Hold/Needs Information	3

Table 11 – Consultant HIPE (Field 59/68)

Description	Code Value
The consultant code that the patient is being referred under as defined by ESRI for HIPE returns	4 digit numeric code as per ESRI code table

Table 12 – Consultant IMC (Field 60/69)

Description	Code Value
The consultant code that the patient is being referred under as assigned by the Irish Medical Council	The consultant's Irish Medical Council number

Table 13 – GP IMC (Field 70)

Description	Code Value
The GP code that the patient is being referred under as assigned by the Irish Medical Council	The GP's Irish Medical Council number

Table 14 – High Clinical and/or Social Needs (Field 78)

Description	Code Value
No	0
Yes	1