QUESTIONNAIRE ON
ICD-10 TRAINING MATERIALS

Please complete one of these questionnaires for each set/type/package of ICD-10 training materials (including those for national versions or clinical modifications) known or used.

Name of WHO Regional Office or Collaborating Centre, IFHRO Member Country, or educational institution: ______________________________________

Person completing the questionnaire: ____________________________________________
(Please include contact information at the end.)

Name of training product (if available): ______________________________________

Who is the author/developer of the training product? (name and contact details)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Who owns the training product? (name and contact details)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is there a copyright on the training product?

_____ No

_____ Yes

Is it necessary to obtain a license to use the training product?

_____ No

_____ Yes (please indicate the cost involved and any limitations imposed)
________________________________________________________________________
1. **Purpose of training product** (please tick all that apply):

   ____ ICD-10 mortality coding training – underlying cause, basic
   ____ ICD-10 mortality coding training – underlying cause, advanced
   ____ ICD-10 mortality coding training – multiple cause, basic
   ____ ICD-10 mortality coding training – multiple cause, advanced
   ____ ICD-10 morbidity coding training – learn to code (if the materials relate to a national version or clinical modification, please specify the name of the classification: ____________________________________________________)
   ____ ICD-10 morbidity coding training – update from ICD-8/ICD-9 to ICD-10
   ____ Orientation to ICD-10 (basic introduction to the classification and its uses, e.g., for doctors, medical/paramedical students, statisticians, other data users)
   ____ Awareness building for ICD-10 (advocacy materials, relationship of classification to planning and management, e.g. for high level management)
   ____ Other (please specify) ______________________________________________

2. **Target audience** (please tick all that apply)

   ____ Trainers of coders
   ____ Coders
   ____ Clinicians/doctors
   ____ Health record/information students
   ____ Medical students
   ____ Paramedical students
   ____ Statisticians/epidemiologists
   ____ Health information analysts
   ____ Health information managers/medical record personnel
   ____ Health planners and managers
_____ High-level decision makers

_____ Others (please specify) __________________________________________

3. What language/s is this training package available in? ______________

_________________________________________________________________

4. Is it possible to obtain translation rights?

_____ No

_____ Yes (please describe the procedure involved, cost, etc.) ______________

_________________________________________________________________

5. Are there any pre-requisites (e.g. for minimum educational level, experience, etc.) required of students using this training product?

_____ No

_____ Yes (please describe)____________________________________________

_________________________________________________________________

6. What media is used for the training product?

_____ Paper-based

_____ Computer-based

_____ Web-based

_____ Other (please specify)___________________________________________

7. Are there plans for additional media to be used for this training product?

_____ No
Yes (please describe the media planned to be used and the expected date of availability)

__________________________________________________________________

8. **What is the usual duration of courses (in hours, days, weeks or months) for which this training product is used?**

__________________________________________________________________

9. **Is there an examination associated with the training product?**

_____ No

_____ Yes (please describe)

__________________________________________________________________

10. **How is the training product used?** (please tick all that apply)

_____ face-to-face courses

_____ self-education/learning – distance education (no face to face instructor)

_____ self-education/learning – on site (access to instructor)

_____ Other (please specify)

11. **Is this product available to the public?**

_____ No

_____ Yes (please tick all that apply)

_____ through a distribution centre

_____ on the internet

_____ from the author/producer

_____ from the Collaborating Centre

_____ other (please specify)
12. **Is there a charge for the training product?**

   _____ No

   _____ Yes (please specify amount and currency)

13. **Are there provisions/mechanisms for updating the training product to reflect changes in ICD-10?**

   _____ No

   _____ Yes (please describe provisions/mechanisms as completely as possible)

   _____________________________________________________________

   _____________________________________________________________

   _____________________________________________________________

   _____________________________________________________________

Person Completing the Questionnaire

Name: __________________________________________________________

Designation: ____________________________________________________

Organization: ____________________________________________________

Address: ________________________________________________________

   _____________________________________________________________

   _____________________________________________________________

   _____________________________________________________________

   _____________________________________________________________

Telephone no: ____________________________________________________

Fax no: __________________________________________________________

E-mail address: ____________________________________________________

Role in ICD implementation: ________________________________________

*Return completed questionnaire to: American Health Information Management Association, Attention: Yvette Apura, 233 North Michigan Avenue, 21st Floor, Chicago, Illinois, 60601, USA. Thank you.*