Queensland Perinatal Data Collection

File Format

Statistical Collections and Integration

2015-2016

Queensland Government

Queensland Perinatal Data Collection File Format

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An electronic version of this document is available at http://www.health.qld.gov.au/hsu

Version 1.31 Revision

Ver	Date	Revision History	Author	Effective Date
1.31	16/3/2015	Add new item 'Antenatal Screening performed for Edinburgh Depression Score and range' to Mother file Add new item 'Antenatal Screening performed for Domestic Violence' to Mother file Add new item 'Antenatal Screening performed for Alcohol Use' to Mother file Add new item 'Antenatal Screening performed for Illicit Drug Use' to Mother file Add new item 'Immunisation for Influenza received during this pregnancy' to Mother file Add new item 'Influenza immunisation received at gestation' to Mother Code file Add new item 'Immunisation for Pertussis received during this pregnancy' to Mother file Add new item 'Pertussis immunisation received at gestation' to Mother Code file Add 'Frozen Embryo Transfer/Embryo Transfer' to Mother Code file (Code Type C) Add 'Main Reason for Induction' in Baby File Add 'Reason for Induction Additional 1' to Baby File Add 'Reason for Induction Additional 2' to Baby File Replace 'Reason for Induction' with a blank filler in Baby File Remove Baby Code Type E =RI Reason for Induction Add Baby Code Type E =IM Main Reason for Induction Add Baby Code Type E =IO Reason for Induction Additional 1 Add Baby Code Type E =IT Reason for Induction Additional 2 Add validation rule to 'Neonatal Treatment' in Baby Code Add validation rule to 'Type of fluid baby received from birth to discharge' in Baby Code Add validation rule to 'Type of fluid baby received in the 24 hours prior to discharge/transfer/death' in Baby Code	Joanne Ellerington	1/7/2015

Queensland Perinatal Data Collection (QPDC)
File Format 2015-2016 Collection Year

Introduction

This document specifies the file format for the electronic submission of perinatal data by facilities (providing maternity services) to the Health Statistics Branch, Queensland Department of Health for the Perinatal Data Collection for births occurring from 1 July 2015 (inclusive).

A record must be provided for each birth that meets the scope of the QPDC.

This document describes the Electronic file format for perinatal data for use in public and private hospitals.

Record types

The data will be contained in a single file containing a number of different record types. The record types are:

File Header	Record Type 'F' This contains information related to the file such as the file's extract period. There is one of these records in the file and it should be the first record in the file.
Type Details	Record Type 'T' This record contains counts of New, Amend and Delete record types that occur in the file. There will be one of these records for each of the record types Mother's Details, Mother's Code, Baby's Birth Details and Baby's Birth Code. A Data Type field on a Type Details record identifies the record type that the counts relate to. The Data Types are: Data Type 'M' - Mother's Details Data Type 'C' - Mother's Code Data Type 'B' - Baby's Birth Details Data Type 'D' - Baby's Birth Code These records should occur at the end of the file in the above order.
Mother's Details	Record Type 'M' This record contains the data related to the mother in a particular confinement. The data values that uniquely identify a particular confinement are the mother's UR Number and the date of confinement. There is one mother detail record per confinement.
Mother's Code	Record Type 'C'

Mother's Code records are used to contain the multiple codes that relate to the mother in a confinement such as medical condition codes or conception method codes. The Mother's UR Number and Date of Confinement fields on the record identify the confinement it is associated with and the Code Type field identifies the particular code involved. The Code Types are:

Code Type 'C' - Conception Method
Code Type 'T' - Reason for Transfer
Code Type 'M' - Medical Condition
Code Type 'P' - Pregnancy Complication
Code Type 'O' - Procedure/Operation
Code Type 'L' - Method of Delivery of Last Birth
Code Type 'A' - Antenatal Care Type
Code Type 'E' - Extra Text

For each particular confinement and Code Type, there can be multiple code values and thus multiple records. However, a particular code value can only occur once for a particular confinement and Code Type. An example of this for a particular confinement is as follows:

Code Type 'C', Code Value 02
Code Type 'C', Code Value 19
Code Type 'M', Code Value B373
Code Type 'M', Code Value E669
Code Type 'P', Code Value O440
Code Type 'P', Code Value O16

Note that for example, another instance of Code Type 'C', Code value 02 for the same confinement is not valid.

Baby's Birth Details

Record Type 'B'

These records contain the details relating to each birth of a baby for a confinement. A baby's birth is uniquely identified by the Mother's UR Number, the Date of Confinement and the Baby Number which is the birth order of the baby e.g. 1=twin 1, 2=twin 2, 1=singleton. There is one of these records per birth per confinement **and therefore there can be more than one Baby's Birth Detail record for each Mother Detail Record**.

Baby's Birth Code

Record Type 'D'

Baby's Birth Code records are used to contain the multiple codes that relate to a baby's birth in a confinement such as analgesia codes or congenital anomaly codes. The Mother's UR Number, Date of Confinement and Baby Number fields on the record identify the baby's birth it is associated with and the Code Type field identifies the particular code involved. The Code Types are:

Code Type 'I' - Induction/Augmentation
Code Type 'A' - Pharmacological Analgesia
Code Type 'S' - Anaesthesia

Code Type ‘R’ -	Resuscitation
Code Type ‘T’ -	Neonatal Treatment
Code Type ‘C’ -	Congenital Anomaly
Code Type ‘L’ -	Labour & Delivery Complication
Code Type ‘M’ -	Neonatal Morbidity
Code Type ‘P’ -	Puerperium Complication
Code Type ‘N’ -	Non-Pharmacological Analgesia
Code Type ‘F’ -	Type of fluid received in 24 hours prior to discharge
Code Type ‘D’ -	Type of fluid received at anytime during the birth Episode
Code Type ‘E’ -	Extra Text
Code Type ‘B’ -	Alternative Feeding Method code
Code Type ‘G’ -	Thromboprophylaxis code
Code Type ‘V’ -	Perineal Status Code

For each particular baby’s birth and Code Type, there can be multiple code values and thus multiple records. However, a particular code value can only occur once for a particular baby’s birth and Code Type. This is similar to the Mother’s Code records above.

Ordering of records

The File Header record is the first record in the file and there must be only one file header record.

Following the File Header are the sets of records for each confinement. The confinement sets are ordered by increasing confinement date and within confinement date by increasing UR No. Each set of records for a confinement is made up in the following way:

- The Mother's Detail record is the first record in a confinement set. There must be only one Mother's Detail record per confinement set.

- Following the Mother's Detail record are the Mother's Code records if applicable. There can be zero to several records per code type and the records for each code type are grouped together. The ordering of the code types is C, T, M, P, O, L, A, E. Each group of records for a code type need not have any particular record order.

- Following the Mother's Code records (if any) are Baby's Birth record sets. There must be at least one Baby's Birth record set per confinement set**, with the number of Baby's Birth records matching the number of babies in the confinement**. These sets are ordered by increasing Baby Number. These sets are made up in the following way:

    - The Baby's Birth Detail record is the first record in the set. There is only one Baby's Birth Detail record per Baby's Birth set.

    - Following the Baby's Birth Detail record are the Baby's Birth Code records if there are any. There can be zero to several records per code type and the records for each code type are grouped together. The ordering of these types is I, A, S, R, T, C, L, M, P**,** N, F, D, E**,** B, G**,** V**.** Each group of records for a code type need not have any particular record order.

The last four rows of the file will contain the Type Detail records. These will show the counts of New, Amend and Delete records contained within the file. There is one of these records per each Data Type and the ordering of the Data Types is M, C, B, D.

Example of file structure

Below is an example layout of a small file to demonstrate the ordering of records.

Note: The character '|' is a field separator to enhance readability of the example. It does not appear in a real file. The character '~' represents a space. Not all data fields are shown.

```
F|00003|20150701|20150731|20150901|201507|
M|N|00102374|20150701|.........
C|N|00102374|20150701|C|02~~~|
C|N|00102374|20150701|C|19~~~|
C|N|00102374|20150701|M|B373~~~|
C|N|00102374|20150701|M|E669~~~|
C|N|00102374|20150701|P|O440~~~|
C|N|00102374|20150701|P|O16~~~~|
C|N|00102374|20150701|L|03|
C|N|00102374|20150701|A|06|
C|N|00102374|20150701|E|ATDOCTOR UNAVAILABLE|
B|N|00102374|20150701|1|..........
D|N|00102374|20150701|1|I|1~~~~|
D|N|00102374|20150701|1|A|05~~~|
D|N|00102374|20150701|1|F|1|
D|N|00102374|20150701|1|D|1|
D|N|00102374|20150701|1|B|02|
D|N|00102374|20150701|1|G|1|
M|N|00102381|20150701|.........
C|N|00102381|20150701|M|0212~~~|
C|N|00102381|20150701|O|1370601|
B|N|00102381|20150701|1|..........
D|N|00102381|20150701|1|M|D649~|
D|N|00102381|20150701|1|P|O721~|
D|N|00102381|20150701|1|F|1|
D|N|00102381|20150701|1|D|1|
D|N|00102381|20150701|1|V|02|
B|N|00102381|20150701|2|..........
D|N|00102381|20150701|2|C|Q3511322|
D|N|00102381|20150701|2|M|P288~|
D|N|00102381|20150701|2|N|04|
D|N|00102381|20150701|2|F|1|
D|N|00102381|20150701|2|D|1|
D|N|00102381|20150701|2|D|2|
D|N|00102381|20150701|2|E|CALADD'S BANDS|
D|N|00102381|20150701|2|B|01|
D|N|00102381|20150701|2|V|02|
D|N|00102381|20150701|2|V|03|
T|M|00002|00000|00000|
T|C|00011|00000|00000|
T|B|00003|00000|00000|
T|D|00018|00000|00000|
```

Transaction type

The initial version of the Perinatal Electronic Load system will only use New transaction type records, therefore the Transaction Type field of all records will be 'N'. Amendments and deletions will be handled manually in the initial version. In future versions the other transaction types of Amendment and Deletion will be accepted. For Mother's Detail records and Baby's Birth detail records, amendments will require the complete set of data for the record including both amended and non-amended fields. For these records deletions will only require the Record Type, Transaction Type, Mother's UR Number, Date of Confinement and, for Baby Birth records, Baby No. - the remaining fields can be truncated from the record. Deleting a detail record results in the deletion of subsidiary dependent records from the database. Deleting a Mother's detail record causes the deletion of associated Mother's Code records, Baby's Birth Detail records and Baby's Birth Code records. Deleting a Baby's Birth Detail record causes the deletion of associated Baby's Birth Code records.

For Mother's Code records and Baby's Birth Code records, amendments will not be used. In order to amend code values, a deletion transaction must be supplied to delete the complete code value set for the particular confinement or baby birth and the code type involved. A set of new Code records is then supplied including amended and non-amended code values. The deletion transaction requires only that the fields up to and including the Code type be supplied. The Code Value field can be truncated. The particular group of code values will be deleted.

The above assumes that the system supplying the data file can keep track of changes to its source data at the required level of detail. An alternative is, that when any change is made to a particular confinement's data set, to supply a deletion for the Mother's Detail which deletes all associated data and then resupply the complete set of confinement data as New transactions.

Physical format

The file will be an ASCII text file with records terminated by the ASCII character no. 10 (Line Feed). Records are variable length and do not require padding by spaces to a fixed length except where noted. All alphabetic characters in the file should be uppercase.

File naming, file header and logistics

The name of the file will be FFFFFYYYYMM.PDC where FFFFF is the facility no. relating to the data in the file, YYYY is the year of data in the file and MM is the month of data in the file. The file will be named in this way by the supplying facility and not by the Perinatal Data Collections. The extract period dates contained in the file header are considered to refer to the date of input completion (or date of amendment when amendments are in use) of any particular confinement data set and not the date of confinement. This ensures that the facility can extract mutually exclusive contiguous sets of data at any time, will allow flexibility for the facility in the inclusion of data in the file and flexibility for the future in that amendments may occur in a later time period than the original data. The extract period can be checked in the load process to ensure previous periods do not overlap.

It is envisaged that files will be supplied to Perinatal Data Collections on a monthly basis. In connection with this the nominal monthly period in the file header will assist in keeping track of the data.

An example of this is that the file for July 2015 is being prepared. The extract period is selected as occurring from 01/07/2015 to 31/07/2015, and the nominal monthly period for the File Header should be input as 201507 (July 2015). Any confinements where the baby has been discharged in July, or if not yet discharged, where the baby has reached 28 days old in July, should be selected for the file. Exceptions to this rule include where babies of a multiple birth are born across different months, all details for the confinement should be included with the “slowest” baby, ie. in the month the last baby is discharged, or turns 28 days old, whichever occurs first. Confinements that have been entered for a previous time period and not previously extracted should also be included in this file, however, it should not include any confinements occurring after the extract period. It is suggested that the creating system also performs similar checks as above such as checking the extract period and nominal monthly period.

Once created, the file can be transferred to the perinatal unit using the Queensland Health approved secure file transfer application. For details on how to access this, contact the PDC. A sizing study indicates that the total data for the largest hospital would be about 200 Kbytes and on average 11 Kbytes.

File Header Record

Data item	Format	Description	Validations
Record Type	1 char	F	
Place of delivery	5 num Right adjusted and zero filled from left	Facility number	Must be a valid facility number Must not be blank
Extract period start date	8 date YYYYMMDD	Date at which extract period starts	Must be a valid date Must not be blank Must be less than or equal to Extract Period End Date
Extract period end date	8 date YYYYMMDD	Date at which extract period ends	Must be a valid date Must not be blank Must be greater than or equal to Extract Period Start Date
Extract date	8 date YYYYMMDD	Date data extracted	Must be a valid date Must not be blank Must be greater than Extract Period End Date
Nominal Monthly Period	6 date YYYYMM	Nominal Month of the data	Must be a valid date Must not be blank Must not be greater than Extract Period End Date's period

Type Detail Record

Data item	Format	Description	Validations
Record type	1 char	T	
Data type	1 char	Code to identify data type M Mother's details C Mother's Code B Baby's birth details D Baby's birth Code	Must be a valid Data Type (M,C,B,D) Must not be blank
Number of new records	5 num. Right adjusted and zero filled from left	Number of new records. Zero if none.	Must not be blank
Number of records for amendment	5 num. Right adjusted and zero filled from left	Number of records for amendment. Zero if none.	Must not be blank
Number of records for deletion	5 num. Right adjusted and zero filled from left	Number of records for deletion. Zero if none.	Must not be blank

Mother's Details Record

Data item	Format	Description	Validations
Record Type	1 char	M	
Transaction Type	1 char	N=new, A=amendment, D=deletion	Must be a valid value (N, A or D) Must not be blank
Mothers UR number	8 char Right adjusted and zero filled from left	Unique number assigned by the facility to identify the mother (e.g. Unit record number within the facility).	Must not be blank Must be unique for each patient within a facility
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby in multiple births)	Must not be blank Must be a valid date Must be after the date of LMP Must be after the mother's date of birth Must equal the date of birth of the baby (or first baby of a multiple birth)
Mother's country of birth	4 num Right adjusted and zero filled from left	4 digit ASCCSS country code for mother's country of birth.	Validated against ASCCSS country codes Must not be blank
Mother's date of birth	8 Date YYYYMMDD	Date of birth of the mother	Must not be blank Must be a valid date Must not be more than 60 years prior to

			admission date Must be greater than 10 years prior to admission date Must not be in the future Must not be after the admission date or LMP date
Indigenous status (Mother)	1 num	Indigenous status of the mother. 1=Aboriginal 2=Torres Strait Islander 3=Both Aust. Aboriginal and T.S. Islander 4=Neither Aust. Aboriginal nor T.S. Islander 9=Not stated/unknown	Validated against list of indigenous status codes Must not be blank
Marital status	1 num	Marital status of the mother. 1=never married 2=married/defacto 3=widowed 4=divorced 5=separated 9=not stated/unknown	Validated against list of marital status codes Must not be blank
Accommodation status of mother	1 num	The chargeable status elected by the mother. 1=public 4=private 9=not stated/unknown	Validated against list of accommodation status codes Must not be blank
Postcode of usual residence	4 num Right adjusted and zero filled from left	4 digit Australian postcode of the usual residential address of mother (corresponding to the National Localities Index- NLI). Supplementary codes: 9301=Papua New Guinea	Validated against list of postcodes and supplementary codes Must not be blank

		9302=New Zealand 9399=overseas 9799=at sea 9989=no fixed address 0989=not stated/unknown	
Locality of usual residence	40 char Left adjusted	Name of suburb or town of usual residence of mother (localities corresponding to the NLI). If patient's usual residence is overseas, insert the country of usual residence. If not stated or unknown then record 'NOT STATED OR UNKNOWN'.	Validated against National Localities Index localities or equal to 'NOT STATED OR UNKNOWN'. Must not be blank
State of usual residence	1 num	State of usual residence of the mother. 0=Overseas 1=New South Wales 2=Victoria 3=Queensland 4=South Australia 5=Western Australia 6=Tasmania 7=Northern Territory 8=Australian Capital Territory 9=Not stated/unknown/no fixed address/at sea	Validated against list of state codes Must not be blank
Filler (previously previous Statistical Local Area)	4	Blank	Must be blank
Transferred antenatally flag	1 num	Patient transferred antenatally including transfers from planned home births to hospital, birthing centre to acute care etc.	Must be 1, 2 or 9 Must not be blank

		1=not transferred antenatally 2=transferred antenatally 9=not stated or unknown	
Hospital transferred from	5 num Right adjusted and zero filled from left	5 digit facility number corresponding to the facility the mother was transferred from antenatally plus supplementary codes. Birthing centres: 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 00988=Gold Coast University Hospital 00998=planned homebirths 00999=emergency/unknown May be blank.	Validated against list of facility codes and supplementary codes if not blank Must not be blank if transferred antenatally=2 Must be blank if transferred antenatally=1 or 9
Time of transfer	1 num	Time of antenatal transfer in relation to labour. 1=prior to onset of labour 2=during labour 9=not stated/unknown May be blank.	Validated against list of time of transfer codes Must not be blank if transferred antenatally=2 Must be blank if transferred antenatally=1 or 9
Date of admission	8 Date YYYYMMDD	Date of admission for this confinement.	Must not be blank Must be a valid date Must not be in the future (ie past current date) Must not be before date of birth of the mother Must not be after the separation date

Previous pregnancies	1 num	Indicates any previous pregnancies 1=none 2=one or more previous pregnancies 9=not stated/unknown	Must not be blank Must be 1, 2 or 9 If previous pregnancy=2, total number of previous pregnancies must be greater than 0
Filler (previously previous livebirths)	2	Blank	Must be blank
Filler (previously previous stillbirths)	1	Blank	Must be blank
Filler (previously previous abortion/ miscarriage)	2	Blank	Must be blank
Last menstrual period	8 Date YYYYMMDD	Date of the first day of LMP. May be blank.	May be blank Otherwise must be a valid date
Estimated date of confinement	8 Date YYYYMMDD	EDC as indicated by ultrasound scan, dates or clinical assessment. If only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. May be blank.	May be blank Otherwise must be a valid date
Filler (previously antenatal care)	1	Blank	Must be blank
Filler (previously Number of antenatal visits)	1	Blank	Must be blank

Medical conditions flag	1 num	Medical conditions in mother affecting this pregnancy or its management. 1=no current medical conditions affecting this pregnancy 2=one or more medical conditions 9=no conditions stated/known	Must be 1,2 or 9 Must not be blank
Pregnancy complications flag	1 num	Any complications of this pregnancy. 1=no pregnancy complications 2=one or more pregnancy complications 9=no complications stated/known	Must be 1,2 or 9 Must not be blank
Procedures and operations flag	1 num	Any procedures or operations the mother had during this pregnancy. 1=no procedures or operations 2=one or more procedures or operations 9=no procedures or operations stated/known	Must be 1,2 or 9 Must not be blank
Filler (previously Ultrasound scan)	1	Blank	Must be blank
Assisted conception flag	1 num	Whether this pregnancy was the result of assisted conception. 1=no assisted conception 2=assisted conception 9=not stated/unknown	Must be 1,2 or 9 Must not be blank
Separation type - mother	1 num	Separation type of mother. 1=discharged 2=transferred 3=died 4=remaining in	Validated against list of separation types Must not be blank

		9=not stated/unknown	
Mother transferred to	5 num Right adjusted and zero filled from left	5 digit facility code for the facility mother was transferred to after the birth plus supplementary codes. Birthing centres: 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 00988=Gold Coast University 00999=not stated/unknown May be blank.	Must be a valid facility number or 00999 Must not be blank if separation type-mother=2 Must be blank if separation type-mother=1,3, 4 or 9
Date discharged - mother	8 Date YYYYMMDD	Date mother discharged from hospital. May be blank.	Must be a valid date if not blank Blank if separation type-mother=4 Must not be blank if separation type-mother=1, 2 or 3 Must not be in the future (i.e. past current date) Must be on or after the date of admission
Method of delivery of last birth flag	1 num	Indicates any methods of delivery of last birth. 1=no methods of delivery of last birth/not applicable 2=one or more methods of delivery of last birth 9=not stated/not known May be blank.	Must not be blank if previous pregnancies=2 Blank if previous pregnancies=1 or 9

Number of previous caesareans	2 num Right adjusted and zero filled from left	Number of previous caesareans. 99=not stated/unknown May be blank.	Must be an integer 00-15 or 99 Must be >=1 if 04,05 exists in method of delivery of last birth Blank if previous pregnancies=1 or 9
Number of ultrasound scans	2 num Right adjusted and zero filled from left	Number of ultrasound scans performed during this pregnancy. 99=not stated/unknown	Must be an integer 00-50 or 99 Must not be blank

Early discharge program	1 num	Indicates whether mother discharged through an early discharge program. 1=no 2=yes	Validated against list of early discharge program codes Must not be blank
Estimation flag for Last Menstrual Period	1 char	Indicates whether the date of the mother's Last Menstrual Period was estimated. E=estimated N=not estimated	Validated against list of estimation flag for last menstrual period codes Must not be blank
Estimation flag for Estimated Date of Confinement	1 char	Indicates whether the mother's Estimated Date of Confinement was estimated. E=estimated N=not estimated	Validated against list of estimation flag for estimated date of confinement codes Must not be blank
Filler (previously Cigarette Smoking indicator)	1 num	blank	Must be blank
Filler (previously Average number of cigarettes smoked)	1 num	blank	Must be blank
Mother's Family Name (previously Surname)	24 char	First 24 characters of surname of the mother	Must not be blank
Mother's First Given Name (previously First Name)	15 char	First 15 characters of first given name of the mother	May be blank

Mother's Second Given Name (previously Second Name)	15 char	First 15 characters of second given name of the mother	May be blank
Address of usual residence	40 char	Number and street of usual residential address of patient. Note: Post office box numbers, property names (with no other details, eg include access road name with the property name), or mail service numbers should NOT be recorded.	May be blank
Number of previous pregnancies resulting in all livebirths	2 num Right adjusted and zero filled from left	Number of previous pregnancies where all outcomes were livebirths. Valid range 0-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in all stillbirths	2 num Right adjusted and zero filled from left	Number of previous pregnancies where all outcomes were stillbirths (of at least 20 weeks gestation or at least 400 g). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in all abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left	Number of previous pregnancies where all outcomes were abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 0-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2

Number of previous pregnancies resulting in livebirths and stillbirths	2 num Right adjusted and zero filled from left	Number of previous pregnancies where outcomes were a combination of livebirths and stillbirths (of at least 20 weeks gestation or at least 400 grams). Valid range 0-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in livebirths and abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left	Number of previous pregnancies where outcomes were a combination of livebirths and abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 0-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in stillbirths and abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left	Number of previous pregnancies where outcomes were a combination of stillbirths (of at least 20 weeks gestation or at least 400 grams) and abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 0-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in livebirths, stillbirths and abortion/ miscarriage/ ectopic/ hydatiform	2 num Right adjusted and zero filled from left	Number of previous pregnancies where outcomes was at least one livebirth and at least one stillbirth (of at least 20 weeks gestation or at least 400 grams) and at least one abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2

moles		grams). Valid range 0-20, 99 99=not stated/unknown May be blank.	

Total number of previous pregnancies	2 num Right adjusted and zero filled from left	Total number of previous pregnancies. Valid range 01-20, 99 99=not stated/unknown May be blank	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2 Must equal total number of pregnancies reported in the above seven fields
Mother's height	3 num Right adjusted and zero filled from left	Height in total number of centimetres of the Mother – self reported at conception Valid range 100-250 999=not stated/unknown	Must not be blank
Mother's weight – Self reported at conception	3 num Right adjusted and zero filled from left	Weight in total number of kilograms of the Mother – self reported at conception Valid range 35-200 999=not stated/unknown	Must not be blank
Antenatal Care Flag	1 num	Antenatal care received for this pregnancy 1=no antenatal care 2=antenatal care 9=no antenatal care stated/known	Must be 1,2 or 9 Must not be blank
Nuchal translucency ultrasound	1 char	Indicates whether mother had a nuchal translucency ultrasound performed 1=no nuchal translucency ultrasound performed 2=nuchal translucency ultrasound performed 9=no nuchal translucency ultrasound stated/unknown	Validated against list of nuchal translucency ultrasound codes Must not be blank
Morphology ultrasound	1 char	Indicates whether mother had a morphology ultrasound performed	Validated against list of morphology ultrasound codes

		1=no morphology ultrasound performed 2=morphology ultrasound performed 9=no morphology ultrasound stated/unknown	Must not be blank
Assessment for chorionicity ultrasound	1 char	Indicates whether mother had an assessment for chorionicity ultrasound performed 1=no assessment for chorionicity performed 2=assessment for chorionicity performed 9=no assessment for chorionicity stated/unknown	Validated against list of assessment for chorionicity ultrasound codes Must not be blank
Smoking cessation advice during the first 20 weeks	1 num	Indicates whether the mother was offered smoking cessation advice by a health care provider during the first 20 weeks of pregnancy 1=No 2=Yes 9=not stated/unknown	Must not be blank if cigarette smoking indicator during the first 20 weeks flag=2 Must be blank if cigarette smoking indicator during the first 20 weeks =1 or 9
Extra text flag	1 num	Indicates if there is extra text fields as a result of 'Other please specify' fields 1=No 2=Yes	Validated against list of Extra text flag codes Must not be blank
Cigarette Smoking Indicator during the first 20 weeks	1 num	Indicates whether cigarettes were smoked during the first 20 weeks of pregnancy 1=No 2=Yes 9=not stated/unknown	Must be 1,2 or 9 Must not be blank
Number of cigarettes smoked each day during the first 20 weeks	3 num Right adjusted and zero filled from left	The number of cigarettes smoked each day during the first 20 weeks of pregnancy 998= Occasional smoking (less than one) 999=not stated/unknown	Must not be blank if cigarette smoking indicator during the first 20 weeks flag = 2 Blank if cigarette smoking indicator during the first 20 weeks = 1 or 9

Cigarette Smoking Indicator after 20 weeks	1 num	Indicates whether cigarettes were smoked after 20 weeks of pregnancy 1=No 2=Yes 9=not stated/unknown	Must be 1,2 or 9 Must not be blank
Number of cigarettes smoked each day after 20 weeks	3 num Right adjusted and zero filled from left	The number of cigarettes smoked each day after 20 weeks of pregnancy 998=Occasional smoking (less than one) 999=not stated/unknown	Must not be blank if cigarette smoking indicator after 20 weeks flag = 2 Blank if cigarette smoking indicator after 20 weeks = 1 or 9
Smoking cessation advice after 20 weeks	1 num	Indicates whether the mother was offered smoking cessation advice by a health care provider after 20 weeks of pregnancy 1=No 2=Yes 9=not stated/unknown	Must not be blank if cigarette smoking indicator after 20 weeks flag=2 Blank if cigarette smoking indicator after 20 weeks =1 or 9
Gestation at first antenatal visit	2 num Right adjusted and zero filled from left	The gestational age, in completed weeks, at first contact for antenatal care 99=not stated/unknown	Must be blank if Antenatal Care Flag = 1 Must not be blank if Antenatal Care Flag = 2 or 9 and must be less than 46 or 99
Estimation flag for Mother's Date of Birth	1 char	Indicates whether the Mother's date of birth was estimated E=estimated N=not estimated	Must be E or N Must not be blank
Total number of antenatal visits	3 num Right adjusted and zero filled from left	The total number of antenatal visits the mother has received during her pregnancy. 999 =not stated/unknown	Must be blank if Antenatal Care Flag = 1 Must not be blank if Antenatal Care Flag = 2 or 9 and must be between 001 and 999

Antenatal Screening performed for Edinburgh Depression Score and range	**1 num**	**Indicates whether antenatal screening was performed for Edinburgh Depression Score and range** **1=Not done** **2=Score less than 10** **3=Score 10 or above** **9=not stated/unknown**	**Must be equal to 1, 2,3 or 9** **Must be equal to 1 if antenatal care flag = 1** **Must not be null**
Antenatal Screening performed for Domestic Violence	**1 num**	**Indicates whether antenatal screening was performed for Domestic Violence** **1=No** **2=Yes** **9=not stated/unknown**	**Must be equal to 1, 2, or 9** **Must be equal to 1 if antenatal care flag = 1** **Must not be null**
Antenatal Screening performed for Alcohol Use	**1 num**	**Indicates whether antenatal screening was performed for Alcohol Use** **1=No** **2=Yes** **9=not stated/unknown**	**Must be equal to 1, 2, or 9** **Must be equal to 1 if antenatal care flag = 1** **Must not be null**
Antenatal Screening performed for Illicit Drug Use	**1 num**	**Indicates whether antenatal screening was performed for Illicit Drug Use** **1=No** **2=Yes** **9=not stated/unknown**	**Must be equal to 1, 2, or 9** **Must be equal to 1 if antenatal care flag = 1** **Must not be null**
Immunisation for influenza received during this pregnancy	**1 num**	**Indicates whether immunisation for Influenza received during this pregnancy** **1=No** **2=Yes** **9=not stated/unknown**	**Must be equal to 1, 2 or 9** **Must not be null**

Influenza immunisation received at gestation weeks	**2 num Right adjusted and zero filled from left**	**Gestational age in completed weeks when Influenza immunisation received 99=not stated/unknown**	**Must not be null if Immunisation for influenza received during this pregnancy = 2 and must be less than 46 completed weeks or 99 Must be blank if Immunisation for influenza received during this pregnancy = 1 or 9**
Immunisation for pertussis received during this pregnancy	**1 num**	**Indicates whether immunisation for Pertussis received during this pregnancy 1=No 2=Yes 9=not stated/unknown**	**Must be equal to 1, 2 or 9 Must not be null**
Pertussis immunisation received at gestation	**2 num Right adjusted and zero filled from left**	**Gestational age in completed weeks when Pertussis immunisation received 99=not stated/unknown**	**Must not be null if Immunisation for pertussis received during this pregnancy = 2 and must be less than 46 completed weeks or 99 Must be blank if Immunisation for pertussis received during this pregnancy = 1 or 9**

Mother's Code Record

Data item	Format	Description	Validations
Record Type	1 char	C	
Transaction Type	1 char	N=new, D=deletion	Must be a valid value (N or D) Must not be blank
Mother's UR number	8 char Right adjusted and zero filled from left	A number unique within the facility to identify the patient. This number is not to be reused.	Must not be blank Must not be zero Must be unique for each patient within a facility
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby in multiple births)	Must not be blank Must be a valid date Must be after the date of LMP Must be after the mother's date of birth
Code Type	1 char	Identifies the type of code: C=conception method T=reason for antenatal transfer M=medical condition codes P=pregnancy complication codes O=procedure/operation codes L=method of delivery of last birth A=antenatal care type E=extra text	Must be C, T, M, P, O, L, A, E.
Mother's code	7 char Left adjusted and	If Code Type = T,M,P then an ICD-10-AM diagnosis code up to 5	If Code Type = T,M,P then Must be a valid ICD-10-AM diagnosis

	space filled from right.	characters (do not use punctuation).
		
		If Code Type = O then
		an ICD-10-AM procedure code of 7 characters (do not use punctuation).
			code
			
			If Code Type = T then
			Record must not exist if transferred antenatally flag=1 or 9
			Record must exist if transferred antenatally flag=2
			
			If Code Type = M then
			Record must not exist if medical conditions flag=1 or 9
			Record must exist if medical conditions flag=2
			
			If Code Type = P then
			Record must not exist if pregnancy complications flag=1 or 9
			Record must exist if pregnancy complications flag=2
			
			If Code Type = O then
			Must be a valid ICD-10-AM procedure code
			
			If Code Type = O then
			Record must not exist if procedures/operations flag=1 or 9
			Record must exist if procedures/operations flag=2

		If Code Type = C then
		a 2 digit conception method code:
		02=AIH/AID
		03=ovulation induction
		04=IVF
		05=GIFT
		07=ICSI
		08=donor egg
		09=FET/ET
		19=other methods
		99=not stated/unknown
		
		If Code Type = L then
		a 2 digit method of delivery of last birth code:
		10=vaginal non-instrumental
		02=forceps
		03=vacuum extractor
		04=LSCS
		05=Classical CS
		98 = Other methods
		99=not stated/unknown
			If Code Type = C then
			Validated against list of Conception Method codes
			Record must not exist if assisted conception flag=1 or 9
			Record must exist if assisted conception flag=2
			
			If Code Type = L then
			Validated against list of Method of Delivery of Last Birth codes
			Record must not exist if method of delivery of last birth flag=1 or 9
			Record must exist if method of delivery of last birth flag=2

		If Code Type = A then
		A 2 digit antenatal care type code:
		06=public hospital/clinic midwifery practitioner
		07=public hospital/clinic medical practitioner
		08=general practitioner
		03=private medical practitioner
		04=private midwifery practitioner
		99=not stated/unknown
		
		If Code Type = E then
		A 2 character extra text identifier
		followed by up to 120 characters of text
		Extra text identifiers:
		AT=Antenatal transfer
		MC=Medical condition
		PC=Pregnancy complication
		PO=Procedure/operation
			If Code Type = A then
			Validated against list of Antenatal Care Type codes
			Record must not exist if antenatal care flag= 1 or 9
			Record must exist if antenatal care flag=2
			
			If Code Type = E then
			First 2 letters validated against list of Extra Text identifiers
			Record must not exist if Extra Text flag =1
			Record must exist if Extra Text flag=2

Baby's Birth Detail Record

Data item	Format	Description	Validations
Record Type	1 char	B	
Transaction Type	1 char	N=new, A=amendment, D=deletion	Must be a valid value (N, A, D) Must not be blank
Mother's UR number	8 char Right adjusted and zero filled from left	A number unique within the facility to identify the mother. This number is not to be reused.	Must not be blank Must not be zero Must be unique for each patient within a facility
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby of a multiple birth)	Must not be blank Must be a valid date Must be after the date of LMP Must be after the mother's date of birth
Baby number	1 num	The birth order of this baby. eg 1=twin 1, 2=twin 2, 1=singleton.	Must not be blank Must be 1-8 Must be unique for each mother's UR number and date of confinement Must be consecutive numbers for each mother's UR number and date of confinement
Baby's UR number	8 char Right adjusted and zero filled from left	A number unique within the facility to identify the baby. This number is not to be reused.	Must not be blank Must be unique for each patient within a facility

Onset of labour	1 num	Indicates whether labour was spontaneous or induced. 1=spontaneous 2=induced 3=no labour (Caesarean section) 9=not stated/unknown	Validated against list of onset of labour codes Must not be blank
Induction/augmentation flag	1 num	Indicates whether induction or augmentation was used during labour for this baby 1= induction or augmentation not used 2= induction or augmentation used 9=not stated/unknown	Must be 1 or 2 if Onset of Labour=1 Must be 2 if Onset of Labour=2 Must be 1 if Onset of Labour=3 Must not be blank
Filler (previously reason for induction)	**5**	**Blank**	**Must be blank**
Presentation at birth	1 num	Presentation of baby at birth. 1=vertex 2=breech 4=face 5=brow 6=other cephalic 7=transverse/shoulder 8=other (e.g. oblique/hand etc.) 9=not stated/unknown	Validated against list of presentation codes Must not be blank
Filler (Previously analgesia flag)	1	Blank	Must be blank

Anaesthesia flag	1 num	Indicates whether anaesthesia was used for operative delivery of the baby (caesarean, forceps or vacuum extraction). 1=none 2=anaesthesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank
Method of birth	2 num	Method of birth. 10=Vaginal non-instrumental 02=forceps 03=vacuum extractor 04=LSCS (Inc. hysteroscopy) 05=classical CS 98=other methods 99=not stated/unknown	Validated against list of method of birth codes Must not be blank Must be 04 or 05 if onset of labour=3
Filler (Previously Reason for Caesarean)	5	Blank	Must be blank
Principal accoucheur	1 num	Principal accoucheur at delivery 1=obstetrician 2=other medical officer 3=registered midwife 4= midwife student 5=medical student 6=any other person 7=no attendant/self 9=not stated/unknown	Validated against list of principal accoucheur codes Must not be blank

Filler (previously Perineum)	1	blank	Must be blank
Filler (previously Episiotomy)	1	blank	Must be blank
Surgical repair	1 num	Indicates if surgical repair to perineum or vagina performed. 1=no repair performed 2=repair performed 9=not stated/unknown	Validated against list of surgical repair codes Must not be blank
Labour and delivery complications flag	1 num	Any labour or delivery complications this delivery. 1=no complications 2=one or more complications 9=no complications stated/unknown	Must be equal to 1,2 or 9 Must not be blank
Fetal scalp pH	1 num	Indicates if fetal scalp pH was measured 1=not taken/unknown 2=fetal scalp pH taken	Must be equal to 1 or 2 Must not be blank

Baby's date of birth	8 Date YYYYMMDD	Same as date of confinement if baby is a singleton or first baby of a multiple birth.	Must not be blank Must be a valid date Must be after date of LMP Must be the same as date of confinement if baby is a singleton or the first of a multiple birth Must be before or same as discharge date Must be more than 10 years after mother's date of birth Must be less than 60 years after mother's date of birth
Time of birth	4 num HHMM	Baby's time of birth. 24 hour clock 0000 (midnight)-2359. 9999=not stated/unknown	Must be a valid time or 9999 Must not be blank
Birthweight	4 num Right adjusted and zero filled from left	Baby's weight at birth (grams) (Note that stillbirths less than 400g and less than 20 weeks gestation are beyond the scope of this collection). 9999=not stated/unknown	If born alive = 2 (stillborn), baby must be > 399 if gestation <20 Must not be blank
Gestation weeks	2 num Right adjusted and zero filled from left	Gestational age of baby determined by clinical examination after birth (number of completed weeks). (Note that stillbirths less than 20 weeks and less than 400g birthweight are beyond the scope of this collection). 99=not stated/unknown	If born alive = 2 (stillborn), baby must be >19 if birthweight<400 Must not be blank
Plurality	1 num	Plurality of this pregnancy. 1=singleton	Must not be blank Must be less than 10

		2=twins 3=triplets etc. Valid range 1-8 9=not stated/unknown	Must not be less than the baby number
Baby's sex	1 num	Sex of the baby. 1=male 2=female 3=indeterminate 9=not stated/unknown	Validated against list of baby's sex codes Must not be blank
Born alive/stillborn	1 num	Indicates whether the baby was born alive or a still birth. 1=born alive 2=stillbirth 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank
Macerated	1 num	Indicates whether a baby was macerated if stillborn. 1=not macerated 2=macerated 9=not stated/unknown May be blank.	Must be 1, 2 or 9 Must be blank if born alive/stillborn=1 Must not be blank if born alive/stillborn=2
Vitamin K	1 num	Method of administering first dose of vitamin K to baby. 1=oral 2=IM 3=none 9=not stated/unknown	Validated against list of Vitamin K codes Must not be blank

Apgar score at 1 minute	2 num Right adjusted and zero filled from left	Total Apgar score at 1 minute 00-10 99=not stated/unknown	Must not be blank Must be less than 11 or 99 Must be 00 if born alive/stillborn=2
Apgar score at 5 minutes	2 num Right adjusted and zero filled from left	Total Apgar score at 5 minutes 00-10 99=not stated/unknown	Must not be blank Must be less than 11 or 99 Must be 00 if born alive/stillborn=2
Regular respirations	2 num Right adjusted and zero filled from left	Number of minutes to establish regular respirations for livebirths. 00=at birth 97=respirations not established 98=intubated 99=not stated/unknown May be blank	Must be less than 60 or equal to 97 or 98 or 99 Must not be blank if born alive/stillborn=1 Must be blank if born alive/stillborn=2
Cord pH	1 num	Indicates whether cord pH was measured. 1=not measured 2=measured	Must be equal to 1 or 2 Must not be blank
Resuscitation used flag	1 num	Indicates whether resuscitation was used for this baby. 1=no resuscitation used 2=resuscitation used for baby 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be blank
Neonatal morbidity flag	1 num	Indicates if any neonatal morbidity was present. 1=no neonatal morbidity 2=one or more neonatal morbidities 9=not stated/unknown	Must be equal to 1, 2, or 9 Must be 1 if born alive/stillborn=2 Must not be blank Must be 2 if Neonatal Treatment flag is 2

Neonatal treatment flag	1 num	Indicates whether any neonatal treatment was applied. 1=no neonatal treatment 2=neonatal treatment given 9=not stated/unknown	Must be equal to 1, 2 or 9 Must be 1 if born alive/stillborn=2 Must not be blank
Congenital anomaly flag	1 num	Indicates the presence of any congenital anomalies in the baby. 1=no congenital anomaly 2=congenital anomaly present 3=suspected congenital anomaly 9=not stated/unknown	Must be 1,2, 3 or 9 Must not be blank
Filler (previously Admitted to ICN/SCN)	3	Blank	
Puerperium complications flag	1 num	The presence of puerperium complications following delivery. 1=no puerperium complications 2=one or more puerperium complications 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be blank
Filler (previously Feeding method on discharge)	1	Blank	
Separation type - baby	1 num	The type of separation of the baby. 1=discharged 2=transferred 3=died 4=remaining in 9=not stated/unknown	Validated against a list of separation type-baby codes Must not be blank Must be 3 if born alive/stillborn=2 Must be 4 if date discharged-baby is blank

Baby transferred to	5 num Right adjusted and zero filled from left	5 digit facility code of the facility to which the baby was transferred plus supplementary codes. Birthing centres: 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 00988=Gold Coast University 00999=not stated/unknown May be blank.	Must be a valid facility number or 00999 if not blank Must not be blank if separation type-baby=2 Must be blank if separation type-baby=1,3, 4 or 9
Date discharged - baby	8 Date YYYYMMDD	Date of discharge, transfer or death of baby May be blank.	Must be a valid date if not blank Blank if separation type-baby=4 Must be on or after baby's date of birth Must be equal to baby's date of birth if born alive/ stillborn=2
Intended Place of Birth	1 num	The intended place of birth at the onset of labour. 1=Hospital 2=Birth centre, attached to hospital 3=Birth centre, free standing 4=Home 8=Other 9=not stated/unknown	Validated against list of Intended Place of Birth codes Must not be blank

Actual Place of Birth	1 num	The actual place where the birth occurred. 1=Hospital 2=Birth centre, attached to hospital 3=Birth centre, free standing 4=Home 8=Other 9=not stated/unknown	Validated against list of Actual Place of Birth codes Must not be blank
Membranes ruptured	5 num Right justified and zero filled from left	The number of hours before delivery the membranes ruptured. 99999=not stated/unknown	Must be an integer 00000-99999 Must not be blank
Length of first stage of labour	5 num Right justified and zero filled from left	The length of the first stage of labour (minutes). 00000=interrupted 99998=not measured 99999=not stated/unknown May be blank	Must be an integer 00000-99999 Must not be blank if onset of labour = 1,2 or 9 Must be blank if onset of labour=3
Length of second stage of labour	5 num Right justified and zero filled from left	The length of the second stage of labour (minutes). 00000=interrupted 99998=not measured 99999=not stated/unknown May be blank	Must be an integer 00000-99999 Must not be blank if onset of labour=1,2 or 9 Must be blank if onset of labour=3
Reason for forceps/vacuum	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for instrumental delivery. May be blank	Must be a valid ICD-10-AM diagnosis code Must be blank if method of birth =04,05,98,10 Must not be blank if method of birth =02 or 03
Cervical dilatation prior to caesarean	1 num	Cervical dilatation prior to caesarean 1=3cm or less	Validated against list of cervical dilatation codes

		2=more than 3cm 3=not measured May be blank	Must be blank if method of birth =02,03,10 Must not be blank if method of birth =04 or 05 May be blank
Head circumference at birth	(3,1) num Right adjusted and zero filled from left	Head circumference of baby at birth 99.8=not measured 99.9=not stated/unknown	Must be a number to one decimal place 00.0-99.9 Must not be blank Do not transmit the decimal point
Length at birth	(3,1) num Right adjusted and zero filled from left	Length of baby at birth 99.8=not measured 99.9=not stated/unknown	Must be a number to one decimal place 00.0-99.9 Must not be blank Do not transmit the decimal point
Admitted to ICN	3 num Right adjusted and zero filled from left	Number of whole days or part there of the baby was present in intensive care nursery. If baby in for less than 24 hours report this as 001. Valid range 000-998 999=not stated/unknown	Must be an integer 000-999 Must not be blank

Admitted to SCN	3 num Right adjusted and zero filled from left	Number of whole days or part there of the baby was present in special care nursery. If baby in for less than 24 hours report this as 001. Valid range 000-998 999=not stated/unknown	Must be an integer 000-999 Must not be blank
Reason for admission to ICN/SCN	5 char Left justified	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for admission to intensive/special care nursery. May be blank	Must be a valid ICD-10-AM diagnosis code Must not be blank if admitted to ICN is between 1 and 998 days or admitted to SCN is between 1 and 998 days
Hep B Vaccination	1 num	Whether baby was given birth dose of Hep B vaccination 1=not given vaccination 2=given vaccination 9=not stated/unknown	Must be 1,2,9 Must not be blank
CTG	1 num	Indicates if CTG was performed during labour 1=Not performed 2=CTG performed 9=not stated/unknown	Must be 1,2,9 Must not be blank
FSE	1 num	Indicates if FSE was performed during labour 1=Not performed 2=FSE performed 9=not stated/unknown	Must be 1,2,9 Must not be blank
Non-Pharmacological Analgesia flag	1 num	Indicates whether non-pharmacological analgesia was used during labour. 1=none 2=non-pharmacological analgesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank

Pharmacological Analgesia flag	1 num	Indicates whether pharmacological analgesia was used during labour. 1=none 2=pharmacological analgesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank
Fetal scalp pH result	(3,2) num left adjusted and zero filled from right	Fetal scalp pH result 9.99=not stated/unknown May be blank	Must be a valid number to two decimal places Valid range 6.49 – 7.50 If Fetal scalp pH flag = 2 then must not be blank If Fetal scalp pH flag =1 then must be blank Do not transmit the decimal point
Cord pH result	(3,2) num left adjusted and zero filled from right	Cord pH result 9.99=not stated/unknown May be blank	Must be a valid number to two decimal places Valid range 6.49 – 7.50 If Cord pH flag = 2 then must not be blank If Cord pH flag =1 then must be blank Do not transmit the decimal point
Water birth flag	1 num	Indicates whether this birth was a water birth. 1=no 2=yes 9=not stated/unknown	Must be 1,2 or 9 Must not be blank
Water birth intent	1 num	Indicates whether this water birth was planned or unplanned 1=unplanned 2=planned 9=not stated/unknown	If Water birth flag = 2 then must not be blank If Water birth flag = 1 then must be blank May be blank

		May be blank	
PPH volume	1 num	The volume of PPH loss 1=500–999mls 3=1000-1499mls 4=>1500mls 9 = not stated/unknown	Validated against list of PPH volume codes If Labour and Delivery complication code=O721 must not be blank If Labour and Delivery complication code <>O721 then must be blank
Fluid(s) the baby received in the 24 hours prior to discharge flag	1 num	Indicates whether the baby received fluid(s) in the 24 hours prior to discharge/transfer/death 1=no fluid 2=fluid received 9=not stated/unknown	Must be 1,2 or 9 if born alive/stillborn=1 Must be 1 if born alive/stillborn=2
Fluid(s) the baby received at any time from birth to discharge flag (previously during birth episode)	1 num	Indicates whether the baby received fluid(s) at any time from birth to discharge 1=no fluid 2=fluid received 9=not stated/unknown	Must be 1,2 or 9 if born alive/stillborn=1 Must be 1 if born alive/stillborn=2
Filler (Previously fed by a bottle)	1	Blank	Must be blank
Extra text flag	1 num	Indicates if there is extra text fields as a result of 'Other please specify' fields 1=No 2=Yes	Validated against list of Extra text flag codes Must not be blank
Fetal scalp lactate flag	1 num	Indicates if fetal scalp lactate was measured 1=not measured 2=measured	Must be equal to 1 or 2 Must not be blank

Fetal scalp lactate result	(3,1) num right adjusted and zero filled from left	Fetal scalp lactate result 99.9=not stated/unknown May be blank	Must be a valid number to one decimal place Valid range 00.0 – 30.9 Must not be blank if fetal scalp lactate flag = 2 Must be blank if fetal scalp lactate flag =1 Do not transmit the decimal point
Gestation days	1 num	Gestation days (used in conjunction with Gestation weeks) of baby determined by clinical examination after birth. (Note that stillbirths less than 20 weeks and less than 400g birthweight are beyond the scope of this collection). 9=not stated/unknown	Must be between 0 and 6 or 9 Must not be blank
Antibiotics received at time of caesarean section	1 num	Indicates whether antibiotics were received at time of caesarean section 1=No 2=Prophylactic antibiotics received 3=Antibiotics already received 9=Not stated/unknown May be blank	Must be equal to 1, 2, 3 or 9 if method of birth = 04, 05 Must be blank if method of birth = 10, 02, 03, 98, 99
Thromboprophylaxis received for caesarean section	1 num	Indicates whether thromboprophylaxis was received for caesarean section 1=No 2=Yes 9=Not stated/unknown	Must be equal to 1, 2 or 9 if method of birth = 04, 05 Must be blank if method of birth = 10, 02, 03, 98, 99

Alternative feeding method flag	1 num	Indicates whether the baby has ever been fed by an alternative feeding method 1=No 2=Yes 9=Not stated/unknown May be blank	Must be equal to 1,2 or 9 if born alive/stillborn = 1 Must be blank if born alive/stillborn = 2
Indigenous status (Baby)	1 num	Indicates the indigenous status of the baby 1=Aboriginal 2=Torres Strait Islander 3=Aboriginal and Torres Strait Islander 4=Neither Aboriginal nor Torres Strait Islander 9=Not stated/Unknown	Must be equal to 1, 2, 3, 4 or 9 Must not be blank
Hepatitis B Immunoglobulin	1 num	Whether baby was given Hepatitis B immunoglobulin 1=hepatitis B immunoglobulin not given 2= hepatitis B immunoglobulin given 9=not stated/unknown	Must be 1,2,9 Must not be blank
Perineal Damage flag	1 num	Indicates whether the perineum sustained any damage during birth 1=No (perineum intact) 2=Yes	Must be equal to 1 or 2 Must not be blank
Main Reason for Caesarean	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate main reason for Caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code Must be blank if method of birth =10,02,03,98,99 Must not be blank if method of birth =04 or 05 Validated against main reason for

			caesarean codes
Main Reason for Caesarean identifier	1 num	1=Previous shoulder dystocia 2=Previous perineal trauma/4th degree tear 3=Previous adverse fetal/neonatal outcome 8=Other	Must be blank if method of birth =10,02,03,98,99 May be blank if method of birth =04 or 05 Validated against list of main reason for caesarean identifier codes Must not be blank if main reason for caesarean code=Z352 Must be blank if main reason for caesarean code is not Z352
First Additional Reason for Caesarean	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate first additional reason for caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code Must be blank if method of birth =10,02,03,98,99 May be blank if method of birth =04 or 05 Must be blank if main reason for caesarean is blank Must not be blank if second additional reason for caesarean is not blank Validated against list of first reason for caesarean codes
First Additional Reason for Caesarean identifier	1 num	1=Previous shoulder dystocia 2=Previous perineal trauma/4th degree tear 3=Previous adverse fetal/neonatal outcome 8=Other	Must be blank if method of birth =10,02,03,98,99 May be blank if method of birth =04 or 05 Validated against list of first additional reason for caesarean identifier codes Must not be blank if first additional reason for caesarean code=Z352 Must be blank if first additional reason for caesarean code is not Z352

Second Additional Reason for Caesarean	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate second additional reason for caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code Must be blank if method of birth =10,02,03,98,99 May be blank if method of birth =04 or 05 Must be blank if main reason for caesarean is blank Must be blank if first additional reason for caesarean is blank Validated against list of second reason for caesarean codes
Second Additional Reason for Caesarean identifier	1 num	1=Previous shoulder dystocia 2=Previous perineal trauma/4th degree tear 3=Previous adverse fetal/neonatal outcome 8=Other	Must be blank if method of birth =10,02,03,98,99 May be blank if method of birth =04 or 05 Validated against list of second additional reason for caesarean identifier codes Must not be blank if second additional reason for caesarean code=Z352 Must be blank if second additional reason for caesarean code is not Z352
Main Reason for Induction	**5 char Left adjusted**	**An ICD-10-AM diagnosis code up to 5 characters to indicate main reason for induction. May be blank.**	**Must be a valid ICD-10-AM diagnosis code Must be blank if onset of labour =1,3,9 Must not be blank if onset of labour =2 Validated against main reason for induction codes**
Reason for Induction Additional 1	**5 char Left adjusted**	**An ICD-10-AM diagnosis code up to 5 characters to indicate reason for induction additional 1. May be blank.**	**Must be a valid ICD-10-AM diagnosis code Must be blank if onset of labour =1,3,9 May be blank if onset of labour =2 Must be blank if main reason for induction is blank**

			Must not be blank if reason for induction additional 2 is not blank **Validated against list of reason for additional 1 codes**
Reason for Induction Additional 2	**5 char** **Left adjusted**	**An ICD-10-AM diagnosis code up to 5 characters to indicate reason for induction additional 2.** **May be blank.**	**Must be a valid ICD-10-AM diagnosis code** **Must be blank if onset of labour =1,3,9** **May be blank if onset of labour =2** **Must be blank if main reason for induction is blank** **Must be blank if reason for induction additional 1 is blank** **Validated against list of reason for additional 2 codes**

Baby's Birth Code Record

Data item	Format	Description	Validations
Record Type	1 char	D	
Transaction Type	1 char	N=new, D=deletion	Must be a valid value (N, D) Must not be blank
Mother's UR number	8 char Right adjusted and zero filled from left	A number unique within the facility to identify the mother. This number is not to be reused.	Must not be blank Must not be zero Must be unique for each patient within a facility
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby of a multiple birth)	Must not be blank Must be a valid date Must be after the date of LMP Must be after the mother's date of birth
Baby number	1 num	The birth order of this baby eg 1=twin 1, 2=twin 2, 1=singleton.	Must not be blank Must be less than 10 Must be unique for each mother's UR number and date of confinement Must be consecutive numbers for each mother's UR number and date of confinement
Code Type	1 char	Identifies the type of code: I=Induction/Augmentation A=Pharmacological Analgesia S=Anaesthesia R=Resuscitation	Must be I, A, S, R, T, L, C, M, P, N, F, D, E, B, G, V

		T=Neonatal Treatment C=Congenital Anomaly L=Labour and Delivery Complication M=Neonatal Morbidity P=Puerperium Complication N=Non-pharmacological analgesia F=Type of fluid baby received in the 24 hours prior to discharge/transfer/death D=Type of fluid baby received at any time during the birth episode E=Extra text B=Alternative Feeding Method G=Thromboprophylaxis received for caesarean section V=Perineal Status Code	

Baby's birth code	5 char
	Left adjusted and space filled from right.
		If Code Type = L,P,M then
		an ICD-10-AM diagnosis code up to 5 characters
			If Code Type = L, P,M then
			Must be a valid ICD-10-AM diagnosis code
			
			If Code Type **=** L then
			Record must not exist if labour and delivery complication flag=1 or 9
			Record must exist if labour and delivery complication flag=2
			
			If Code Type **=** P then
			Record must not exist if puerperium complications flag=1 or 9
			Record must exist if puerperium

	8 char - made up of 5 char ICD-10-AM code left adjusted and space filled from right, 1 char identifying position, 1 char identifying status,
	1 char identifying diagnosed prior to birth indicator
		If Code Type = C then
		5 char - an ICD-10-AM diagnosis code up to 5 characters in range Q00 – Q999 or D181 or R294
		
		1 char – position – this is the position of the anomaly as collected by the NPSU
		1=right
		2=left
		3=bilateral
		4=Unilateral (unspecified)
		5=anterior
		6=posterior
		7=central/midline
		8=not applicable
		9=not stated
		
		1 char – status code – This is the current status of the anomaly
		1=suspected
		2=confirmed
		3=suspected and cannot confirm
		9=not stated/unknown
			complications flag=2
			
			If Code Type **=** M then
			Record must not exist if neonatal morbidity flag=1 or 9
			Record must exist if neonatal morbidity flag=2
			
			If Code Type = C then
			Record must not exist if congenital anomaly flag=1 or 9
			Record must exist if congenital anomaly flag=2 or 3
			Must be a valid ICD-10-AM diagnosis code in range Q00 – Q9999 or D181 or R294
			Must contain position and status following the ICD-10-AM code
			Must contain diagnosed prior to birth indicator code following the position and status

		1 char – diagnosed prior to birth indicator – This shows if the congenital anomaly was diagnosed prior to birth or not
		1=not diagnosed prior to birth
		2=diagnosed prior to birth
		9=not stated/unknown
		
		If Code Type = I then
		a 1 digit code for Method of induction or augmentation of labour:
		1=artificial rupture of membranes
		2=oxytocin
		3=prostaglandins
		8=other
		9=not stated/unknown
		
		If Code Type = A then
		a 2 digit code for pharmacological Analgesia:
		02=nitrous oxide
		08=systemic opioid (inc IM/IV narcotic)
		04=epidural
		05=spinal
		10=combined spinal-epidural
		07=caudal
		19=other
		99=not stated/unknown
		
		If Code Type = S then
			If Code Type = I then
			Validated against list of induction/augmentation codes
			Record must not exist if onset of labour=1 or 3
			Record must not exist if induction/augmentation flag=1 or 9
			Record must exist if onset of labour=2
			Record must exist if induction/augmentation flag=2
			
			If Code Type = A then
			Validated against list of pharmacological analgesia codes
			Record must not exist if pharmacological analgesia flag=1 or 9
			Record must exist if pharmacological analgesia flag=2
			
			If Code Type = S then

		a 2 digit code for Anaesthesia: 02=Local anaesthetic to perineum 03=pudendal 04=epidural 05=spinal 10=combined spinal-epidural 06=general anaesthesia 07=caudal 19=other 99=not stated/unknown	Validated against list of anaesthesia codes Record must not exist if anaesthesia flag=1 or 9 Record must exist if anaesthesia flag=2
		If Code Type = R then a 2 digit code for Resuscitation Method: 02=suction (oral, pharyngeal etc.) 03=suction of meconium (oral, pharyngeal etc.) 04=suction of meconium via ETT 05=facial O_2 (or head box) 06=bag and mask 07=IPPV via ETT 08=narcotic antagonist injection 09=external cardiac massage 11=adrenalin/sodium bic/calcium 12=other drugs 19=other stimulations 99=not stated/unknown	If Code Type = R then Validated against list of Resuscitation codes Record must not exist if resuscitation used flag=1 or 9 Record must exist if resuscitation used flag=2
		If Code Type = T then A 2 digit code for Neonatal Treatment: 02=oxygen for >4 hours	If Code Type = T then Validated against list of Neonatal treatment codes

		03=phototherapy
		04=IV/IM antibiotics
		05=IV fluid
		06=mechanical ventilation
		07=IA line
		08=exchange transfusion
		10=blood glucose monitoring
		11=CPAP
		12=oro/nasogastric feeds
		19=other
		99=not stated/unknown
		
		If Code Type = N then
		a 2 digit code for Non-pharmacological Analgesia:
		02=heat pack
		03=birth ball
		04=massage
		05=shower
		06=water immersion
		07=aromatherapy
		08=homoeopathy
		09=acupuncture
		10=TENS
		11=Water Injection
		98=other
		99=not stated/unknown
		
		If Code Type = F then
		A 1 digit code for the type of fluid the baby received during the 24 hours prior to
			Record must not exist if neonatal treatment flag=1 or 9
			Record must exist if neonatal treatment flag=2
			If treatment code not null or 99 then neonatal morbidity to indicate reason for treatment must be provided
			
			If Code Type = N then
			Validated against list of non-pharmacological analgesia codes
			Record must not exist if non-pharmacological analgesia flag=1 or 9
			Record must exist if non-pharmacological analgesia flag=2
			
			If Code Type = F then
			Validated against a list of type of fluid the baby received during 24 hours prior to

		discharge/transfer/death 1=Breast milk/colostrum 2=Infant formula 3=Water, fruit juice or water-based products 4=nil fluids by mouth 9=not stated/unknown	discharge/transfer/death codes if not blank Record must not exist if Fluid(s) the baby received in the 24 hours prior to discharge flag = 1 or 9 Record must exist if Fluid(s) the baby received in the 24 hours prior to discharge flag = 2 Must be blank if born alive/stillborn=2 Must not be blank if born alive/stillborn =1 **Must be blank if separation type – baby =4**
		If Code Type = D then A 1 digit code for the type of fluid the baby received at any time from birth to discharge 1=Breast milk/colostrum 2=Infant formula 3=Water, fruit juice or water-based products 4=nil fluids by mouth 9=not stated/unknown	If Code Type = D then Validated against a list of type of fluid the baby received at any time from birth to discharge if not blank Record must not exist if Fluid(s) the baby received at any time prior to discharge flag = 1 or 9 Record must exist if Fluid(s) the baby received at any time prior to discharge flag = 2 Must be blank if born alive/stillborn=2 Must not be blank if born alive/stillborn =1 **Must be blank if separation type – baby =4**

		If Code Type = E then
		A 2 character extra text identifier
		followed by up to 120 characters of text
		Extra text identifiers:
		~~**RI=Reason induction**~~
		IM=Main reason for induction
		IO=Reason for Induction Additional 1
		IT=Reason for Induction Additional 2
		FV=Reason forceps/vacuum
		CM=Main reason for caesarean
		CO= First Additional Reason for Caesarean
		CT= Second Additional Reason for Caesarean
		LD=Labour/Delivery complication
		PU=Puerperium complication
		NM=Neonatal morbidity
		CA=Congenital anomaly
		RN=Reason admission to ICN/SCN
		
		If Code Type = B then
		a 2 digit code for Alternative Feeding Method:
		02=bottle
		03=cup
		04=syringe
		98=other
			If Code Type = E then
			First 2 letters validated against list of Extra Text identifiers
			Record must not exist if Extra Text flag = 1
			Record must exist if Extra Text flag=2
			
			If Code Type = B then
			Validated against a list of Alternative Feeding Methods if not blank
			Record must not exist if Alternative Feeding Method flag = 1 or 9
			Record must exist if Alternative Feeding Method flag = 2

		99=not stated/unknown
		
		If Code Type = G then
		A 1 digit code for Thromboprophylaxis for caesarean section:
		2=Pharmacological thromboprophylaxis
		3=Intermittent calf compression
		4=TED Stockings
		8=Other thromboprophylaxis
		9=Not stated/Unknown
		
		If Code Type = V then
		A 2 digit code for Perineal Code:
		02=1st degree laceration/vaginal graze
		03=2nd degree laceration
		04=3rd degree laceration
		05=4th degree laceration
		06=episiotomy
		98= other
		99=Not stated/Unknown
			Must be blank if born alive/stillborn=2
			
			If Code Type = G then
			Validated against list of thromboprophylaxis codes
			Record must exist if thromboprophylaxis received for caesarean section = 2
			Record must not exist if thromboprophylaxis received for caesarean section =1 or 9
			
			If Code Type = V then
			Validated against list of Perineal Codes
			Record must exist if Perineal Status = 2
			Record must not exist if Perineal Status =1