1 JULY 2011 – 30 JUNE 2012

QUEENSLAND PERINATAL DATA COLLECTION (PDC)

Manual of Instructions for the completion and notification of births to the Perinatal Data Collection

DATA COLLECTIONS UNIT (DCU) QUEENSLAND HEALTH

LIST OF APPENDICES vi

GLOSSARY OF TERMS AND ABBREVIATIONS vii

1 THE MANUAL 101

1.1 PURPOSE 101
1.2 PAPER FORMS VS ELECTRONIC EXTRACT 101
1.3 MAINTENANCE OF THE MANUAL 101
1.4 ACKNOWLEDGMENTS 102

2 INTRODUCTION 201

2.1 BACKGROUND 201
2.2 REQUIREMENTS 201
2.3 AIMS OF THE PERINATAL DATA COLLECTION 201
2.4 CONFIDENTIALITY OF DATA 201
2.5 PERINATAL STATISTICS AND PUBLICATIONS 201
2.6 THE FORM 202
2.6.1 PERINATAL DATA COLLECTION FORM (MR63D) (SEE APPENDIX B) 202
2.7 DISPATCH OF FORMS 202
2.8 ELECTRONIC TRANSFER OF DATA 202

3 GENERAL INSTRUCTIONS 301

3.1 COMPLETING THE FORMS 301

4 MOTHER'S DETAILS 401

4.1 PLACE OF DELIVERY 401
4.2 DATE OF ADMISSION 401
4.3 MOTHER'S COUNTRY OF BIRTH 401
4.4 INDIGENOUS STATUS 402
4.5 MARITAL STATUS 403
4.6 ACCOMMODATION STATUS OF MOTHER 403
4.7 SEROLOGY* 404
4.8 MOTHER FAMILY NAME 404
4.9 GIVEN NAMES 404
4.10 UR NUMBER 405
4.11 DATE OF BIRTH (MOTHER) 405
4.12 ESTIMATED DATE OF BIRTH FLAG (MOTHER) 406
4.13 ADDRESS OF USUAL RESIDENCE 406
4.14 ANTENATAL TRANSFER 407

4.14.1 REASON FOR TRANSFER 407
4.14.2 TRANSFERRED FROM 407
4.14.3 TIME OF TRANSFER 407

5 PREVIOUS PREGNANCIES 501

5.1 PREVIOUS PREGNANCIES 501
5.2 NUMBER OF PREVIOUS PREGNANCIES 501
5.3 METHOD OF DELIVERY OF LAST BIRTH 502
5.4 NUMBER OF PREVIOUS CAESAREANS 503

6 PRESENT PREGNANCY 601

6.1 LMP 601
6.2 EDC 601
6.3 HEIGHT 602
6.4 WEIGHT 602
6.5 ANTENATAL CARE 602
6.6 DID THE SAME MIDWIFE(S) WHO PROVIDED ANTENATAL CARE ALSO PROVIDE THE WOMAN'S INTRAPARTUM AND POST-DISCHARGE CARE? (PERINATAL ONLINE HOSPITALS ONLY) 603
6.7 NUMBER OF VISITS 604
6.8 CURRENT MEDICAL CONDITIONS 605
6.9 GESTATION AT FIRST ANTENATAL VISIT 606
6.10 PREGNANCY COMPLICATIONS 606
6.11 SMOKING 607
6.12 PROCEDURES AND OPERATIONS 608
6.13 NUMBER OF ULTRASOUND SCANS 609
6.14 TYPES OF ULTRASOUND SCANS 609
6.15 ASSISTED CONCEPTION 610

7 LABOUR AND DELIVERY 701

7.1 INTENDED PLACE OF BIRTH AT ONSET OF LABOUR 701
7.2 ACTUAL PLACE OF BIRTH OF BABY 701
7.3 ONSET OF LABOUR 702
7.4 METHODS USED TO INDUCE LABOUR OR AUGMENT LABOUR? 703
7.5 REASON FOR INDUCTION 703
7.6 MEMBRANES RUPTURED 703
7.7 LENGTH OF 1ST AND 2ND STAGE OF LABOUR 704
7.8 PRESENTATION AT BIRTH 704
7.9 METHOD OF BIRTH 705
7.10 WATER BIRTH 706

7.11 REASON FOR FORCEPS/VACUUM 706
7.12 REASON FOR CAESAREAN 707
7.13 CAESAREAN SECTION – ANTIBIOTIC USAGE STATUS 707
7.14 CERVICAL DILATATION PRIOR TO CAESAREAN 707
7.15 PLACENTA/CORD* 709
7.16 PRINCIPAL ACCOUCHEUR 709
7.17 PERINEUM 710
7.18 OTHER GENITAL TRAUMA 711
7.19 SURGICAL REPAIROF THE VAGINA OR PERINEUM 711
7.20 NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY 711
7.21 PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY 712
7.22 LABOUR AND DELIVERY COMPLICATIONS 713
7.23 ANAESTHESIA FOR DELIVERY 714
7.23 CTG IN LABOUR 715
7.24 FSE IN LABOUR 715
7.25 FETAL SCALP pH AND RESULT 716
7.26 LACTATE AND RESULT 716

8 BABY 801

8.1 BABY'S UR NUMBER 801
8.2 INDIGENOUS STATUS – BABY 801
8.3 DATE OF BIRTH 801
8.4 TIME OF BIRTH 802
8.5 BIRTHWEIGHT 802
8.6 GESTATION 802
8.7 HEAD CIRCUMFERENCE AT BIRTH 802
8.8 LENGTH AT BIRTH 802
8.9 PLURALITY 803
8.10 SEX 803
8.11 BIRTH STATUS 803
8.12 APGAR SCORE 804
8.13 REGULAR RESPIRATION 805
8.14 RESUSCITATION 805
8.15 CORD Ph AND VALUE 806
8.16 VITAMIN K (FIRST DOSE) 807
8.17 HEPATITIS B VACCINATION (BIRTH DOSE) 807

9 POSTNATAL DETAILS 901

9.1 NEONATAL MORBIDITY 901

9.2 NEONATAL TREATMENT 902
9.3 ADMITTED TO ICN/SCN 902
9.4 MAIN REASON FOR ADMISSION TO ICN/SCN 903
9.5 CONGENITAL ANOMALY 904

10 DISCHARGE DETAILS 1001

10.1 DISCHARGE DETAILS OF THE MOTHER 1001
10.1.1 PUERPERIUM COMPLICATIONS 1001
10.1.2 PUERPERIUM THROMBOPROPHYLAXIS FOLLOWING CAESAREAN 1002
10.1.3 PUERPERIUM PROCEDURES AND OPERATIONS 1002
10.1.4 DISCHARGE DETAILS 1003
10.1.5 EARLY DISCHARGE PROGRAM 1003
10.2 DISCHARGE DETAILS OF THE BABY 1003
10.2.1 NEONATAL SCREENING 1003
10.2.2 DISCHARGE WEIGHT 1004
10.2.3 DISCHARGE DETAILS 1004
10.2.4 FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE 1004
10.2.5 FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE 1005
10.2.6 ALTERNATE FEEDING METHOD 1005

11 ADDITIONAL CONGENITAL ANOMALY DATA 1101

11.1 INDICATE BY SHADING OR MARKING THE APPROPRIATE DIAGRAM(S) 1101
11.2 ADDITIONAL CONGENITAL ANOMALY DESCRIPTION OR DETAILS 1101
11.3 MEDICAL PRACTITIONER’S SIGNATURE 1101
11.4 SURNAME 1101
11.5 DESIGNATION 1101
11.6 DATE 1101

LIST OF APPENDICES

Appendix	Description
A	Dispatch details
B	Perinatal Data Collection form
C	Electronic File Format
D	Examples of conditions to report
E	Registered Neonatal Intensive Care Units and Special Care Nurseries

GLOSSARY OF TERMS AND ABBREVIATIONS

AIHW	Australian Institute of Health and Welfare
CTG	Cardiotocography
CSCF	Clinical Services Capability Framework
DCU	Data Collections Unit
EDC	Estimated Date of Confinement
FSE	Fetal Scalp Electrode
HSC	Health Statistics Centre
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICN	Intensive Care Nursery
LMP	Last Menstrual Period
MR63D	Perinatal Data Collection Form
NHDD	National Health Data Dictionary
NPESU	National Perinatal Epidemiology and Statistics Unit
PDC	Perinatal Data Collection
PNO	Perinatal Online Form
QHDD	Queensland Health Data Dictionary
SCN	Special Care Nursery
SLA	Statistical Local Area
SOU	Statistical Output Unit
US	Ultrasound

1 THE MANUAL

1.1 PURPOSE

This Instruction Manual describes the data items that are collected as part of the Queensland Perinatal Data Collection (PDC). It is intended to be a reference for all public hospitals, private hospitals, and private midwifery or medical practitioners who deliver babies outside hospitals, as well as Health Service Districts and Division personnel who are involved in the collection and use of perinatal data.

1.2 PAPER FORMS VS ELECTRONIC EXTRACT

All data providers should use this manual, whether using the paper forms (MR63D), the Perinatal Online application (PNO) or providing an electronic extract.

For specific instructions on how to complete the PNO, refer to the Perinatal Online User manual or the Perinatal Online Administration manual.

Where differences occur between the electronic system used and Queensland Health's Data Collections Unit (DCU) requirements, the data extracted should be mapped or grouped to meet the DCU file format and requirements.

1.3 MAINTENANCE OF THE MANUAL

It is important that the information in this Manual is updated with any changes forwarded by the Data Collections Unit so that the Manual remains a relevant and up-to-date reference for contributors to and managers of the Collection, and for users of the data.

Amendments to the Collection form (MR63D) may need to be made to reflect changes in legislation, standards and policies, and therefore the Instruction Manual will also need to be updated accordingly. Any such changes are likely to occur each financial year.

If you have any queries or questions relating to this document or to the Perinatal Data Collection, please contact the Data Collection Coordinator (details below).

If you require any further copies of this Manual, also contact the Data Collection Coordinator.

Data Collection Liaison Officer
Perinatal Data Collection
Data Collections Unit
Health Statistics Centre
Queensland Health
GPO Box 48
Brisbane Qld 4001

Telephone: (07) 3235 4359
Facsimile: (07) 3234 0279

Email: perimail@health.qld.gov.au

1.4 ACKNOWLEDGMENTS

Definitions have been taken from the Queensland Health Data Dictionary (QHDD) and the National Health Data Dictionary (NHDD) as prepared by Queensland Health and the Australian Institute of Health and Welfare (AIHW) where applicable to this Collection.

We would like to thank all the midwives and medical practitioners who complete the Perinatal Data Collection (MR63D) form as well as input and submit data electronically using Perinatal Online Form or via other electronic systems.

2 INTRODUCTION

2.1 BACKGROUND

The *Health Act 1937–1988* was replaced by the *Public Health Act 2005*. Chapter 6, Part 1 - Perinatal Statistics includes a requirement that perinatal data be provided to the Chief Executive of Queensland Health for every baby born in Queensland. The Queensland Perinatal Data Collection commenced in November 1986.

2.2 REQUIREMENTS

The Perinatal Data Collection Form (MR63D) is required to be completed (or in the case of hospitals providing electronic extracts, an extract is required) by all public hospitals, private hospitals, and private midwifery or medical practitioners who deliver babies outside hospitals, for all births occurring in Queensland. The scope of the Collection includes all live births, and stillbirths of at least 20 weeks gestation and/or at least 400 grams in weight. Information relating to neonatal morbidity is collected up until the baby is discharged from the birth admission or up until the baby reaches 28 days of age.

The quality of information produced from the PDC depends on the accurate, consistent and timely completion of the forms. Completed forms and electronic extracts are validated and queries relating to missing, contradictory or ambiguous data are directed back to the hospital or independent practitioner.

2.3 AIMS OF THE PERINATAL DATA COLLECTION

The aims of the PDC are to monitor patterns of obstetric and neonatal practice in the State and to provide statistical information on specific topics within these fields to assist with the planning of Queensland Health services. It is also intended to be a basic source of information for research in obstetric and neonatal care and to be used in the education of students of midwifery and medicine.

In addition to information collected via the perinatal data forms and via electronic extracts, details from Certificates of Perinatal Death, Histopathology reports and post mortem reports supplement the Collection.

2.4 CONFIDENTIALITY OF DATA

All unit record information collected by Data Collections Unit is treated as strictly confidential. All information collected is used for statistical purposes only.

Data Collections Unit adheres to Information Standard IS42A which requires personal information to be managed in accordance with National Privacy Principals.

2.5 PERINATAL STATISTICS AND PUBLICATIONS

The Health Statistics Centre (HSC) releases an annual report presenting summary statistics based on the data collected via the PDC. This report is available on QHEPS:

- http://qheps.health.qld.gov.au/hic/products.htm#reports

or via the following website:

- http://www.health.qld.gov.au - use the search engine and the terms “health statistics centre” and follow the prompts to publications and then perinatal.

Through the National Perinatal Epidemiology and Statistics Unit (NPESU) of the AIHW, Queensland data is used in the compilation of Australia-wide figures and can be compared with perinatal statistics from other States and Territories.

Data is also available via request, on an adhoc or regular basis, from the Statistical Output Unit (SOU) within HSC. The release of data is governed by patient confidentiality legislation in the Public Health Act 2005. Requests for data should be made via e-mail to HlthStat@health.qld.gov.au or by phoning (07) 3234 1875. (Note that in some instances charges may apply – contact SOU for further details).

2.6 THE FORM

The form is designed to be an integral part of the obstetric record, both to reduce duplication of recording and to ensure optimum accuracy of data. The hospital copies can be used as a summary for the patient's chart and this includes some items which are not essential for the PDC but may be useful in hospitals. Items not needed specifically for the PDC but included for hospitals' use are not highlighted white on the hospital copies and have been marked with an asterisk (*) in this Manual.

Currently, there is no distinction in PNO between mandatory and non-mandatory fields.

2.6.1 PERINATAL DATA COLLECTION FORM (MR63D) (SEE APPENDIX B)

From 1 July 2007, the MR63D form is supplied as an A3 size sheet which will fold in half to A4 size for placement within the medical record. The MR66 Congenital Anomaly form has been subsumed into the MR63D form. This form consists of three sheets – an original and two duplicates:

- The original (green) must be retained for your own hospital records and should be referred to when clarifying or confirming queries.
- The first duplicate (green) may be placed in the baby's chart or forwarded to the private medical practitioner or Child Health Nurse. This is left to the discretion of individual hospitals.
- The second duplicate (white) is to be returned to Data Collections Unit within 35 days of the baby's birth.

2.7 DISPATCH OF FORMS

Instructions for the dispatch of the Data Collections Unit copies of the MR63D forms are included in Appendix A. These forms should be forwarded to the Data Collections Unit within 35 days of the birth of a baby. Hospitals should dispatch the returns on a fortnightly or monthly basis, with an accompanying Dispatch Cover Note (see Appendix A).

Facilities using PNO may refer to the Perinatal Online Administration manual for details on the extraction of data.

2.8 ELECTRONIC TRANSFER OF DATA

For facilities providing data via electronic extract, please contact PDC to obtain the most current file format required (see Appendix C for example file format, current at time of publication). Prior to providing an electronic extract of data to PDC, individual facilities should contact the Principal Data Collection Officer, Joanne Bunney, phone (07) 3237

1464 or via e-mail, joanne_bunney@health.qld.gov.au. Extracts are required within 35 days of the birth of a baby.

3 GENERAL INSTRUCTIONS

3.1 COMPLETING THE FORMS

- Please PRINT clearly using a ballpoint pen (not a felt pen) and press firmly.

- The paper has been carbonised so please take care not to write on paper placed over these forms, or place undue sharp pressure on the original.

- If an error is made on the form, it is preferable to cross through the incorrect response and rewrite the answer, rather than overwriting the original answer, as this is easier to read, and reduces errors in interpretation.

- Please enter the appropriate information in the areas provided, or tick the appropriate boxes. If the boxes do not provide the appropriate alternative, please specify details under ‘Other’ in the space provided.

- Using a question mark (?) on the form to indicate that a condition is suspected will always generate a query to confirm the suspected condition. Wherever possible please confirm prior to reporting. If the diagnosis can not be confirmed, indicate this also on the form by writing beside the condition ‘unable to be confirmed’.

- The forms should be as complete as possible. Do not leave any fields blank. If any details are unknown the best estimate should be used, or ‘not known’ written beside the missing item.

- In the case of multiple births, a separate form should be completed for each baby. For example, in the case of twins, two forms are to be completed, identifying each twin as Twin I and Twin II. The Data Collections Unit copies should be pinned together so that common information need not be completed on the second form. Details in the LABOUR AND DELIVERY, BABY, POSTNATAL and BABY DISCHARGE DETAILS sections are required for each baby.

- If the baby is transferred to another hospital after birth, please complete the form and document the transfer destination so that, if necessary, further enquires can be made about congenital anomalies.

- The items marked with an asterisk (*) are for hospital use only and do not form part of the information processed for the PDC. These items are not highlighted white on the hospital copies of the form.

- Currently, there is no distinction in PNO between mandatory and non-mandatory fields.

4 MOTHER'S DETAILS

All items contained in this section of the form must be completed clearly. Wherever possible, it is preferred that printed labels be used to provide maternal details and to identify the MR63D forms, however this is not mandatory.

If used on the original and duplicate copies, labels should be placed in the upper right hand corner, ensuring that no other information is obscured. If an identification label is used only on the hospital copies (and not the duplicates), DO NOT FORGET to complete MOTHER'S USUAL RESIDENCE, DATE OF BIRTH, NAMES and UR NUMBER on the second duplicate (i.e. the Data Collections Unit copy).

4.1 PLACE OF DELIVERY

PLACE OF DELIVERY ____________________

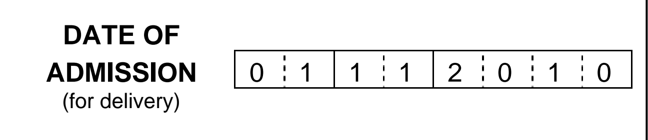
Enter the name of the hospital where the birth occurred. Where both public and private facilities exist please specify (eg Mater Mothers Public or Mater Mothers Private).

For births notified by a hospital but not delivered in the hospital (eg Born before arrival (BBA) or home birth), enter the name of the hospital completing the form. If a home birth is notified by the accoucheur, write 'Home' and complete the details on the reverse side of the Data Collections Unit copy.

This field allows the Data Collections Unit to follow up queries concerning missing or inconsistent data. It also enables individual hospitals to receive feedback on the data they record on the form.

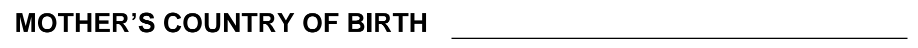
4.2 DATE OF ADMISSION

Enter the day, month and year of the date of admission of the mother for delivery using all boxes, eg 1 November 2010 should be entered as:


DATE OF ADMISSION (for delivery) 0 1 | 1 1 | 2 0 1 0

For this Collection, record the date of admission for the delivery to the facility where the delivery takes place. For planned home births where the baby is not admitted to a hospital, this field is not required.

4.3 MOTHER'S COUNTRY OF BIRTH


MOTHER'S COUNTRY OF BIRTH ____________________

Enter the country of birth of the mother. Be as specific as possible, eg. enter Zimbabwe rather than Africa.

Ethnicity is an important concept, both in the study of disease patterns and the need for and provision of services. Country of birth is the most easily collected and consistently

reported of possible ethnicity data items. It is recognised that country of birth is one of a number of surrogate measures for ethnicity.

4.4 INDIGENOUS STATUS

INDIGENOUS STATUS	
Aboriginal	☐
Torres Strait Islander	☐
Aborig. & Torres Str. Is.	☐
Neither Aboriginal nor Torres Str. Is.	☐

Tick the box (one box only) that corresponds to the Indigenous Status of the mother.

Note that a mother's indigenous status cannot be determined simply by observation and therefore this question must be asked of all mothers. For further information regarding determining Indigenous status, please refer to the 'Are you of Aboriginal or Torres Strait Islander origin?' pamphlet. If you require copies of this publication, please contact the National Centre for Aboriginal and Torres Strait Islander Statistics (Australian Bureau of Statistics) on the free call number 1800 633 216.

Definitions:
An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which she lives.

- **Aboriginal**
  Aboriginal but not Torres Strait Islander origin.

- **Torres Strait Islander**
  Torres Strait Islander but not Aboriginal origin.

- **Aboriginal and Torres Strait Islander**
  Both Aboriginal and Torres Strait Islander origin.

- **Neither Aboriginal nor Torres Strait Islander**
  Neither Aboriginal nor Torres Strait Islander origin.

Given the gross inequalities in health status between Indigenous and Non-indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on Indigenous status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health.

4.5 MARITAL STATUS

MARITAL STATUS	
Never Married	☐
Married/defacto	☐
Widowed	☐
Divorced	☐
Separated	☐

Tick the box (one box only) that corresponds to the marital status of the mother.

Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to facilitate analysis of the association of marital status with the need for and use of services and for epidemiological analysis.

4.6 ACCOMMODATION STATUS OF MOTHER

ACCOMMODATION STATUS OF MOTHER	
Public	☐
Private	☐

Tick the box (one box only) that corresponds to the type of ward accommodation the mother has elected to be accommodated in regardless of the method of payment for the hospital admission. This item does not indicate the insurance status of the mother.

For home births where the baby is not admitted to a hospital, this field is not required.

Definitions:

- **Public**
  A public patient is a person, eligible for Medicare, who, on admission to a recognised hospital or soon after:
  - receives a public hospital service free of charge; or
  - elects to be a public patient; or
  - whose treatment is contracted to a private hospital.

- **Private**
  A private patient is a person who, on admission to a recognised hospital or soon after:
  - elects to be a private patient treated by a medical practitioner of her own choice; or
  - elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical practitioner); or
  - a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical practitioner).

Note that ineligible and compensable patients who are chargeable but use public hospital doctors are classified as public. Those who use private doctors are to be classified as private.

4.7 SEROLOGY*

This field is not mandatory, however if results reported in this field affect the management of the pregnancy, please report the associated condition in Medical Conditions (see 6.5) or Pregnancy Complications (see 6.6).

SEROLOGY
RPR………..……..IgG………….…..
Rubella…………………………..…….
Hepatitis B……………….………...
Blood group……………….……….
Rh…………………………….…..….
Antibodies No ☐ Yes ☐
Other__________________________

RPR……IgG……	Enter 'Pos' or 'Neg' in both fields to show RPR and IgG status
Rubella	Enter immune or not immune
Hepatitis B	Enter 'Pos' or 'Neg'
Blood group	Enter blood group, eg 'O', 'A', 'B' or 'AB'
Rh	Enter the Rhesus factor (+ or -)
Antibodies	Tick the appropriate box for 'Yes' or 'No'

4.8 MOTHER FAMILY NAME

The mother's full family name should be recorded.
If family name is not known or cannot be established, record UNKNOWN.

Some people do not have a family name and a given name and they have only one name by which they are known. If the mother has only one name, record it as the family name.

FAMILY NAME ______________________
1ST GIVEN NAME ______________________
2ND GIVEN NAME ______________________

The use of hospital labels is the preferred method to identify forms, as long as they contain all of the relevant information, as it reduces errors in transcription of written information (such as UR numbers and Date of Birth).

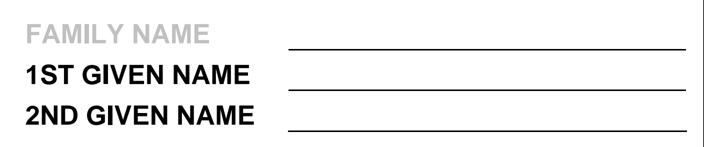
4.9 GIVEN NAMES

A mother may have more than one given name.

A mother's given name(s) should be recorded. Where applicable it is essential that the given names are recorded for the first two recorded given names of a mother.

If given name is not known or cannot be established, record UNKNOWN

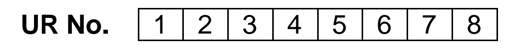
Some people do not have a family name and a given name and they have only one name by which they are known. If the mother has only one name, record it as the family name.


FAMILY NAME ____________
1ST GIVEN NAME ____________
2ND GIVEN NAME ____________

The use of hospital labels is the preferred method to identify forms, as long as they contain all of the relevant information, as it reduces errors in transcription of written information (such as UR numbers and Date of Birth).

4.10 UR NUMBER

Enter the Unit Record (UR) number assigned to the mother (if applicable).

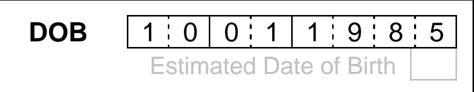

UR No. 1 2 3 4 5 6 7 8

For home births where the baby is not admitted to a hospital, this field is not required, however, if the private midwifery practitioner assigns a record number for administrative purposes it can be included.

Confidentiality of data is maintained through the storage of this data in a separate table by PDC, with limited access. PDC adhere to Queensland Health's confidentiality of data standards including IS42A.

4.11 DATE OF BIRTH (MOTHER)

Record the date of birth of the mother using the full date (ie. ddmmyyyy) and leading zeros where necessary. Example: 10 January 1985 should be entered as:


DOB 1 0 0 1 1 9 8 5
Estimated Date of Birth

If the day of birth is unknown, use 15.
If the month of birth is unknown, use 06.
If the year of birth is unknown, estimate the year from the age of the mother.
If the age of the mother is unknown and it is not possible to estimate an age and hence a year of birth (eg. for unconscious mothers, use the year 1900)

Example: If a mother is admitted in 2010 and does not know her exact date of birth but knows that she is 30 years of age, record the date of birth as follows:

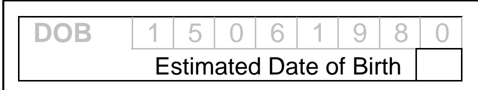
DOB 1 5 0 6 1 9 8 0
Estimated Date of Birth

Although provision is made for recording an unknown date of birth (using 15/06/1900), every effort should be made during the course of the admission to determine (and record) the mother's actual date of birth. The mother's date of birth is an important requirement for the correct identification of the individual.

4.12 ESTIMATED DATE OF BIRTH FLAG (MOTHER)

The Estimated Date of Birth box indicates whether the mother's date of birth has been estimated.

If an estimate has been used in place of either the day or the month or the year, then Estimated Date of Birth box must be ticked.



4.13 ADDRESS OF USUAL RESIDENCE

The collection of the address details of a mother is critical for patient follow up and as a means of reporting information about the geographic location of the residence of a mother. A mother may have one address or many addresses. The last known address should be recorded.

Enter the street number, street name, suburb/town and postcode where the mother usually resides (not postal address). For interstate mothers, enter the address and name of the State of the mother's usual residence.

USUAL RESIDENCE ______________________________

____

POSTCODE ☐☐☐☐ **STATE** ☐ **SLA** ☐☐☐☐

If the mother is not a resident of Australia or an Australian External Territory, or has no fixed address, use one of the following supplementary codes as the postcode of usual residence.

Code	Description
9301	Papua New Guinea
9302	New Zealand
9399	Overseas other (not PNG or NZ)
9799	At Sea
9989	No Fixed Address
0989	Not stated or unknown

Please note that it is particularly important to record the country of residence accurately for patients from Papua New Guinea and New Zealand.

For Australian External Territory addresses, the actual postcode and State ID is to be used from 1 July 2005, rather than a supplementary postcode and State ID. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, and Norfolk Island.

This information is used to determine the Statistical Local Area (SLA) of usual residence, enabling the comparison of the use of services by persons residing in different geographical areas, the characterisation of catchment areas and populations for facilities for planning purposes and the documentation of the provision of services to residents of States or Territories other than Queensland.

For those hospitals sending data electronically, please contact the CRDS Administrator on (07) 3836 0598 or via e-mail CRDS@health.qld.gov.au for a complete list of valid SLA codes.

4.14 ANTENATAL TRANSFER

ANTENATAL TRANSFER No ☐ Yes ☐
(include transfers from planned home birth to hospital, from birthing centre to acute areas etc.)
Reason for transfer ________________________
____
Transferred from ________________________

Time of Transfer
- prior to onset of labour ☐
- during labour ☐

Tick 'Yes' or 'No' to indicate whether the mother has been transferred from a different location. This includes transfers from home births to hospital, from birthing centre to acute care area.

4.14.1 REASON FOR TRANSFER

Enter the reason for the transfer of the mother from the initial location, eg 'unavailability of medical services', 'premature rupture of membranes'.

Reason for transfer ________________________
____

4.14.2 TRANSFERRED FROM

Enter the initial place of treatment that the mother has been transferred from. Enter the full name of the facility, including whether public or private where applicable, or where transferred from a home birth, enter 'Home'.

Transferred from ________________________

4.14.3 TIME OF TRANSFER

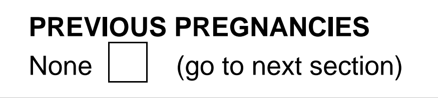
Tick whether the mother was transferred 'prior to onset of labour' or 'during labour'.

Time of Transfer
- prior to onset of labour ☐
- during labour ☐

5 PREVIOUS PREGNANCIES

Note: This section refers to all previous pregnancies and therefore excludes the current pregnancy.

5.1 PREVIOUS PREGNANCIES


PREVIOUS PREGNANCIES
None ☐ (go to next section)

If the mother has had no previous pregnancies, tick 'None' and go to the next section PRESENT PREGNANCY. **DO NOT** complete the remaining fields in this section.

If the mother has had previous pregnancies, complete all sections in Previous Pregnancies field (5.2 – 5.4).

5.2 NUMBER OF PREVIOUS PREGNANCIES

Number of **previous pregnancies** resulting in:	
Only livebirths	☐☐
Only stillbirths	☐☐
Only abortions/miscarriages/ectopic/hydatiform mole	☐☐
Livebirth & stillbirth	☐
Livebirth & abortion/miscarriage/ectopic/hydatiform mole	☐
Stillbirth & abortion/miscarriage/ectopic/hydatiform mole	☐
Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole	☐
TOTAL NUMBER of previous pregnancies	☐☐

Enter the number of previous pregnancies (not number of previous babies) resulting in each of:

- Only livebirths (Number of previous pregnancies resulting in livebirths only);
- Only stillbirths (Number of previous pregnancies resulting in stillbirths only);
- Only abortions/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in abortion/miscarriage/ectopic/hydatiform mole only);
- Livebirth & stillbirth (Number of previous pregnancies resulting in an outcome of livebirth and stillbirth in the same pregnancy);
- Livebirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of livebirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy);
- Stillbirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of stillbirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy);
- Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of livebirth and stillbirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy).

A tick or cross is not sufficient; the actual number of pregnancies must be recorded, even if that number is zero.

Note: This field refers to the number of pregnancies, not the number of babies born. Consequently, a pregnancy resulting in multiple births should be counted as only one pregnancy.

The total number of previous pregnancies should be entered at the bottom of the list of outcomes in the field provided. Note that the total number entered should be equal to the combined numbers entered as outcomes.

Definitions:

- **Live birth**
  The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

- **Stillbirth**
  A fetal death prior to the complete expulsion or extraction from its mother of a product or conception of 20 or more completed weeks of gestation and/or of 400 grams or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

- **Abortion/Miscarriage/Ectopic/Hydatiform mole**
  Includes spontaneous abortion (less than 20 weeks gestation and less than 400 grams birthweight); induced abortion (termination of pregnancy before 20 weeks gestation); ectopic pregnancy; or molar pregnancy.

Note, that in the case of medical abortion or termination of pregnancy where gestation is 20 weeks or greater and/or birthweight 400g or greater, the pregnancy should be recorded as determined by the outcome (i.e. live birth or stillbirth).

5.3 METHOD OF DELIVERY OF LAST BIRTH

METHOD OF DELIVERY OF LAST BIRTH

Vaginal non-instrumental ☐
Forceps ☐
Vacuum extractor ☐
LSCS ☐
Classical CS ☐
Other (specify) ☐

Tick the box(es) that correspond to the method of delivery of the last birth. If a previous multiple pregnancy resulted in two or more different outcomes (eg Vaginal non-instrumental and LSCS), tick both boxes. This should be further clarified by noting in this section that a multiple pregnancy occurred.

Note: This relates to the last birth, and therefore not necessarily the last pregnancy. For example, if the mother has had two previous pregnancies and the last pregnancy resulted in a spontaneous abortion while the pregnancy before that resulted in a lower segment caesarean birth then tick ‘LSCS’.

Method of delivery should only be provided for abortion/miscarriage when gestation is 20 weeks or greater and/or birthweight 400g or more.

(See Section 7.10 for definitions of Methods of Birth).

5.4 NUMBER OF PREVIOUS CAESAREANS

Number of previous caesareans	☐☐

Enter the number of previous caesarean sections the mother has had. Enter zero if the mother has had no previous caesarean sections.

6 PRESENT PREGNANCY

6.1 LMP

Enter the day, month and year of the first day of the mother's last menstrual period (LMP) using all boxes. For example, a LMP of 1 November 2009 should be entered as:

LMP	0	1	1	1	2	0	0	9

If the exact day is unknown, enter month and year as show below:

LMP	?	?	1	1	2	0	0	9

If the date of the LMP is unknown, enter '99 99 99' as shown below. This may occur in cases where there is a history of abnormal or irregular periods, or a delay of ovulation has occurred following the use of the contraceptive pill.

LMP	9	9	9	9	9	9	9	9

In the case of hospitals reporting this information electronically, if only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. The LMP Estimation Flag must be completed as an E for estimated. If the date is unknown, leave the field blank.

6.2 EDC

Enter the day, month and year of the best-estimated date of confinement (EDC) for this pregnancy using all boxes. For example, an EDC of 1 November 2010 should be entered as:

EDC	0	1	1	1	2	0	1	0

If the exact day is unknown, enter month and year as shown below:

EDC	?	?	1	1	2	0	1	0

Assessment

EDC	?	?	1	1	2	0	1	0

By US scan/dates/clinical assessment

Indicate how the EDC was determined by circling US scan, dates or clinical assessment.

If more than one EDC is available, (either by US scan, dates or clinical assessment), then record the one that has been deemed to be clinically the most reliable (i.e. the date used by the clinician, on which clinical decisions regarding the management of the pregnancy have been based).

In the case of hospitals reporting this information electronically, if only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. The EDC

Estimation Flag must be completed as an E for estimated. If the date is unknown, leave the field blank.

6.3 HEIGHT

HEIGHT	☐☐☐ cm

Record the mother's height in total centimetres. This can either be measured or self reported. Height will be used in conjunction with self-reported weight for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

6.4 WEIGHT

WEIGHT (self-reported at conception)	☐☐☐ kg

Record the mother's weight in total kilograms. This will be the self reported weight of the mother in the four to six weeks prior to or at conception. Weight will be used in conjunction with height for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

6.5 ANTENATAL CARE

ANTENATAL CARE (You may tick more than one box)	
No antenatal care	☐
Public hospital/clinic midwifery practitioner	☐
Public hospital/clinic medical practitioner	☐
General practitioner	☐
Private medical practitioner	☐
Private midwife practitioner	☐

Tick the box(es) that correspond to the antenatal care received for the current pregnancy. More than one box may be ticked. If the mother received no antenatal care, tick 'No antenatal care'.

Definitions are listed on the next page.

Definitions:

- **Public hospital/clinic midwifery practitioner**
  Includes public hospital clinics, hospital based midwifery clinics, and community based midwifery programs run by nursing staff.

- **Public hospital/clinical medical practitioner**
  Includes public hospitals and hospital based clinics attended by medical staff.

- **General practitioner**
  Includes a medical officer in general practice.

- **Private medical practitioner**
  Includes a private specialist medical practitioner in own private practice (for example a private obstetrician).

- **Private midwife practitioner**
  Registered midwife practising in the community.

6.6 DID THE SAME MIDWIFE(S) WHO PROVIDED ANTENATAL CARE ALSO PROVIDE THE WOMAN'S INTRAPARTUM AND POST-DISCHARGE CARE? (PERINATAL ONLINE HOSPITALS ONLY)

Did the same Midwife(s) who provided antenatal care also provide the woman's intrapartum and post-discharge care?

No ☐ Yes ☐

Definition:

- **Continuity of Midwife Carer**
  Where the woman has a 'primary' or 'named' midwife(s), providing the majority of pregnancy, birth and post birth care

Did the same Midwife(s) who provided antenatal care also provide the woman's intrapartum and post-discharge care?

Answer 'yes' if **all** of the following occurred:

a) The woman received antenatal care on a number of occasions by the named midwife or small group of 2 – 4 midwives to the extent that they could be considered 'known' by the woman;
b) The woman was cared for in labour/birth by the named or one of the small group of midwives; and
c) It is embedded in the maternity service that the named or one of the small group of midwives will provide the postnatal care to the woman after discharge.

If you require further assistance with this data field please phone the Maternity, Primary Community & Extended Care Branch on (07) 3234 0691.

6.7 NUMBER OF VISITS

NUMBER OF VISITS	
Less than 2	☐
2 – 4	☐
5 – 7	☐
8 or more	☐

Tick the box (one box only) that corresponds to the number of antenatal visits for the current pregnancy. This information can be obtained from the case notes (hospital clinic patients) or by asking the mother. The question is designed to measure the amount of supervision in the current pregnancy.

Note that if more than one type of antenatal care has been provided, ‘less than 2 visits’ is not a valid option for number of visits. Where more than one type of antenatal care has been provided please report the total number of visits for the pregnancy, not just those provided at the reporting facility.

6.8 CURRENT MEDICAL CONDITIONS

CURRENT MEDICAL CONDITIONS
You may tick more than one box

- None ☐
- Essential hypertension ☐
- Pre-existing diabetes mellitus
  - insulin treated ☐
  - oral hypoglycaemic therapy ☐
  - other ☐
- Asthma (treated during this pregnancy) ☐
- Epilepsy ☐
- Genital herpes (active during this pregnancy) ☐
- Anaemia ☐
- Renal condition (specify) ______________ ☐
- Cardiac condition (specify) ____________ ☐
- Other (specify) ☐

____

Tick the box(es) that correspond to any medical conditions the mother has which may significantly affect the current pregnancy or its management, or document the condition(s) in the space provided (see Appendix D for examples). If the mother has no current medical conditions, tick 'None'. Where 'Renal condition', 'Cardiac condition' or 'Other' is ticked, please provide as much detail as possible to allow an appropriate morbidity code to be assigned. For example rather than report 'Hepatitis', the type and infection status is required, i.e. Acute or Chronic Hepatitis B/C or Carrier of Hepatitis B/C.

Definition:

- **Current medical conditions**
  Includes pre-existing maternal conditions, hypertension or diabetes, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.

- **Pre-existing diabetes mellitus**
  Diabetes pre-existing prior to pregnancy. Indicate whether insulin treated, oral hypoglycaemic therapy treated or other (includes diet, exercise, lifestyle management).

6.9 GESTATION AT FIRST ANTENATAL VISIT

GESTATION AT FIST ANTENATAL VISIT	☐ ☐ Weeks

Record the number of completed weeks of the current pregnancy when the mother had her first contact for antenatal care. The first contact for antenatal care is the first contact with a doctor or nurse where actual pre-birth maternity care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non pregnancy related issues.

6.10 PREGNANCY COMPLICATIONS

PREGNANCY COMPLICATIONS
You may tick more than one box

None		☐
APH (<20 weeks)		☐
APH (20 weeks or later) due to		
	• abruption	☐
	• placenta praevia	☐
	• other	☐
Gestational diabetes		
	• insulin treated	☐
	• oral hypoglycaemic therapy	☐
	• other	☐
PIH/PE	• mild	☐
	• moderate	☐
	• severe	☐
Other (specify)		☐

Tick the box(es) that correspond to any complications of the current pregnancy. If there are complications other than those listed, tick ‘Other’ and specify the complication(s) in the space provided (see Appendix D for examples). If there are no pregnancy complications, tick ‘None’.

Definitions are listed on the next page.

Definitions:

- **Pregnancy complications**
  Complications of pregnancy arising up to the period immediately preceding labour and delivery that are directly attributable to the pregnancy and may significantly affect care during the current pregnancy and/or the outcome.

- **APH (Antepartum haemorrhage)**
  - **Abruption**
    Abruptio placenta. An antepartum haemorrhage resulting from the placenta becoming totally or partially detached from the uterine wall whilst the foetus is still in utero.
  - **Placenta praevia**
    An antepartum haemorrhage resulting from the placenta being located over or very near to the internal os.
  - **Other**
    Any other antepartum haemorrhage, or cause unknown.

- **Gestational diabetes**
  Diabetes specifically occurring during pregnancy. Indicate whether insulin treated, oral hypoglycaemic therapy treated or other (includes diet, exercise, lifestyle management).

- **PIH /PE**
  Pregnancy Induced Hypertension/Pre-Eclampsia. Indicate whether mild, moderate or severe.

6.11 SMOKING

SMOKING
During the first 20 weeks of pregnancy
Did the mother smoke? No ☐ Yes ☐
If yes, how many cigarettes per day? ☐☐☐
Was smoking cessation advice offered by a health care provider? No ☐ Yes ☐
After 20 weeks of pregnancy
Did the mother smoke? No ☐ Yes ☐
If yes, how many cigarettes per day? ☐☐☐
Was smoking cessation advice offered by a health care provider? No ☐ Yes ☐

Smoking during the first 20 weeks of pregnancy

Tick the box that corresponds to the mother’s smoking status during the first 20 weeks of pregnancy.

If the mother smoked at all during the first 20 weeks of pregnancy, record the number of cigarettes smoked per day.

Next, tick the box that indicates whether the mother was offered smoking cessation advice by a health care provider at any time during the first 20 weeks of pregnancy.

Smoking cessation advice can include anything from a stop smoking pamphlet included in an antenatal package/visit, through to a full stop smoking program.

Smoking after 20 weeks of pregnancy

Tick the box that corresponds to the mother's smoking status after 20 weeks of pregnancy.

If the mother smoked at all after 20 weeks of pregnancy, record the number of cigarettes smoked per day.

Next, tick the box that indicates whether the mother was offered smoking cessation advice by a health care provider after the first 20 weeks of pregnancy. Smoking cessation advice can include anything from a stop smoking pamphlet included in an antenatal package/visit, through to a full stop smoking program.

Cigarette smoking is the most important modifiable risk factor for preterm birth, which is the strongest predictor of perinatal death and disability.

6.12 PROCEDURES AND OPERATIONS

PROCEDURES AND OPERATIONS
(during pregnancy, labour and delivery)
You may tick more than one box

None	☐
Chorionic Villus Sampling	☐
Amniocentesis (diagnostic)	☐
Cordocentesis	☐
Cervical suture (for cervical incompetence)	☐
Other (specify)	☐

____

Tick the box(es) that correspond to any medical or surgical procedures and/or operations that were performed on the mother or foetus during the current pregnancy. Please also include those performed during labour and delivery. If a procedure and/or operation was performed other than those listed, tick 'Other' and specify in the space provided (see Appendix D for examples). If no procedures or operations were performed during this pregnancy, tick 'None'. Where procedures are reported that may be performed via different approaches please provide as many details as possible.

For example: cholecystectomy, which may be open or via laparoscope please report as either 'open cholecystectomy' or 'laparoscopic cholecystectomy'.

6.13 NUMBER OF ULTRASOUND SCANS

ULTRASOUNDS		
Number of scans	☐☐	
Nuchal translucency ultrasound	No	Yes
Morphology ultrasound scan	No	Yes
Assessment for chorionicity scan	No	Yes

Enter the number of ultrasound scans performed during the current pregnancy. Enter zero if no ultrasound scans were performed.

This number indicates the total number of obstetric ultrasound scans performed during the current pregnancy. This will therefore include those performed by a radiographer in a recognised medical imaging unit and/or those performed by a health care professional(s) (eg Doctor or Midwife) in a variety of health care settings including hospital wards, community clinics or the premises of private practitioners.

Note that it does not include other non-obstetric ultrasounds (eg maternal renal, or gallbladder scan) and may necessitate asking the mother for confirmation of the number, as not all ultrasounds performed will have a written report.

6.14 TYPES OF ULTRASOUND SCANS

ULTRASOUNDS		
Number of scans		
Were any of the following performed?		
Nuchal translucency ultrasound	No ☐	Yes ☐
Morphology ultrasound scan	No ☐	Yes ☐
Assessment for chorionicity scan	No ☐	Yes ☐

Indicate if a nuchal translucency scan was performed.
Indicate if a morphology ultrasound scan was performed.
Indicate if an assessment for chorionicity scan was performed.

Definitions:

Nuchal translucency:
An ultrasound to assess for major chromosomal abnormalities.

Morphology:
An ultrasound to allow the early diagnosis of morphologic abnormalities.

Chorionicity:
An ultrasound to distinguish between twins who share a membrane. This will identify those multiples who share a chorion and are at risk of twin to twin transfusion syndrome.

6.15 ASSISTED CONCEPTION

ASSISTED CONCEPTION
Was this pregnancy the result of assisted conception?

No ☐ Yes ☐

If yes, indicate method/s used

- AIH/AID ☐
- Ovulation induction ☐
- IVF ☐
- GIFT ☐
- ICSI (intracytoplasmic sperm injection) ☐
- Other (specify) ☐

____

Tick 'Yes' or 'No' to indicate whether this pregnancy was achieved via assisted conception. If 'Yes', tick the box(es) that correspond to the method(s) used to successfully assist conception for this pregnancy.

Definitions:

- **AIH/AID**
  Artificial insemination using either the husband or male partner's sperm or donor sperm.

- **Ovulation induction**
  Ovulation is induced by pharmacological therapy such as Clomid.

- **IVF**
  In Vitro Fertilisation: Co-incubation of sperm and oocyte outside the body of the woman.

- **GIFT**
  Gamete Intra Fallopian Transfer: A medical procedure of transferring an egg(s) and sperm to the body of the woman.

- **ICSI**
  Intracytoplasmic Sperm Injection: Involves the injection of a single sperm directly into the ovum, combined with IVF.

- **Other**
  Indicate the type of method used, eg Assisted hatching, Blastocyst culture.

7 LABOUR AND DELIVERY

7.1 INTENDED PLACE OF BIRTH AT ONSET OF LABOUR

INTENDED PLACE OF BIRTH AT ONSET OF LABOUR
Hospital ☐
Birthing Centre ☐
Home ☐
Other ☐
____

Tick the box (one box only) that corresponds to the intended place of birth at onset of labour. If intended place of birth was other than those listed, tick 'Other' and specify in the space provided.

Definitions:

- **Hospital**
  A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

- **Birthing centre**
  A facility where women are able to birth in an environment which:
  (a) is free-standing or physically separate from a labour ward but has access to emergency medical facilities for both mother and child if required; and
  (b) has home-like atmosphere; and
  (c) focuses on a model of care (eg Midwifery model) which ensures continuity of care/caregiver; a family-centred approach; and informed client participation in choices related to the management of care.

- **Home**
  Home may be the mother's own home or where the baby is born in a home environment where "home" may actually be that of a midwifery practitioner or any other person and attended by a midwifery practitioner.

Mothers who plan to give birth in birthing centres or at home usually have different risk factors compared to those who plan to give birth in hospital.

7.2 ACTUAL PLACE OF BIRTH OF BABY

ACTUAL PLACE OF BIRTH OF BABY
Hospital ☐
Birthing Centre ☐
Home ☐
Other (BBA) ☐
____

Tick the box (one box only) that corresponds to the actual place where the birth of the baby occurred (see Section 7.1 for definitions). If the actual place of birth of the baby was other than those listed, tick 'Other' and specify in the space provided, eg hospital car park, on the way to hospital in an ambulance, etc.

Note that if the mother at the onset of labour intended to have her baby in a hospital but actually delivered at home, this should be reported as 'Other (BBA)' in this field.

This field is used in conjunction with the 'Intended Place of Birth at Onset of Labour' field. It identifies mothers who intend to deliver at hospital but deliver at home, compared to those mothers who intend to deliver at home and do so.

This information is used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of birth was planned.

7.3 ONSET OF LABOUR

ONSET OF LABOUR
Tick one box only
Spontaneous ☐
Induced ☐
No labour (caesarean section) ☐

Tick the box (one box only) that corresponds to how labour commenced. 'No labour' can only be associated with a caesarean section.

Definitions:

- **Spontaneous**
  Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or spontaneous pre-labour rupture of membranes.

- **Induced**
  Medical and/or surgical procedure performed for the purpose of stimulating and establishing labour in a woman who has not commenced labour spontaneously.

- **No labour (caesarean section)**
  Indicates the absence of labour, as in a caesarean section performed before the onset of labour or a failed induction.

Note that when a failed induction of labour results in a caesarean, 'No labour (caesarean section)' should be ticked, and the reason for caesarean should be reported as failed induction of labour.

The onset of labour is closely associated with type of delivery and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are indicators of obstetric intervention.

7.4 METHODS USED TO INDUCE LABOUR OR AUGMENT LABOUR?

Methods used to **induce labour** or **augment labour**? (You may tick more than one box)	
Artificial rupture of membranes (ARM)	☐
Oxytocin	☐
Prostaglandins	☐
Other (specify)	☐
______________________________	

If the labour was induced or spontaneous in onset but subsequently augmented, tick the box(es) that correspond to the method used. If a method was used other than those listed, tick 'Other' and specify in the space provided, eg Foley's catheter.

7.5 REASON FOR INDUCTION

If labour induced
Reason for induction

____

If labour was induced, specify the reason for induction in the space provided, eg rupture of membranes > 24 hours before delivery, post-term, etc. If the reason for induction was a social reason, specify the actual reason(s) rather than writing 'social reasons'.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid reason for induction as augmentation is any medical or surgical intervention that assists with the continuation of a labour that has had a spontaneous or induced onset, eg ARM, administration of oxytocin.

Where a failed induction of labour has occurred, ensure that 'No labour (caesarean section)' has been ticked. The reason the induction was attempted should be reported in the appropriate field (eg medical conditions or pregnancy complications).

7.6 MEMBRANES RUPTURED

MEMBRANES RUPTURED
_____days ____hours ____mins
before delivery

Enter the number of days, hours and minutes before delivery the membranes were ruptured. If membranes ruptured at delivery, then record 'at delivery' or enter 0. If a 'no labour' caesarean section occurs, it cannot be assumed that the membranes ruptured at delivery so record the actual time or write 'at delivery' or enter '0' as above.

7.7 LENGTH OF 1ST AND 2ND STAGE OF LABOUR

LENGTH OF LABOUR

	hours	minutes
1st stage		
2nd stage		

Enter in the length of each of 1st stage and 2nd stage of labour in hours and minutes.

Definitions:
- **Stage 1**
  Begins with the onset of regular uterine contractions and is complete when the cervix is fully dilated (10cm).
- **Stage 2**
  Begins when the cervix is fully dilated (10cm) and is complete with the birth of the baby.

Where the labour is interrupted (eg by caesarean section) and therefore either stage one or two are interrupted, complete as follows:

- If stage one is complete, and stage two interrupted, then report total length of stage one in hours and minutes, and enter 'not completed' for stage two.
- If neither stage is complete, then indicate by writing 'not completed' in both sections of the field.

Please note that if quantitative measurement has not been performed, then clinical judgement based on subjective observation is appropriate (i.e. vaginal examination to confirm dilation is not mandatory). Use of other clinical observations used to manage labour are appropriate indicators of stages of labour.

Where length of stages is unknown please write 'unknown'.

7.8 PRESENTATION AT BIRTH

PRESENTATION AT BIRTH
Tick one box only

- Vertex ☐
- Breech ☐
- Face ☐
- Brow ☐
- Transverse/shoulder ☐
- Other (specify) ☐

____

Tick the box (one box only) that corresponds to the presentation of the fetus at birth. If the presentation at birth is other than those listed, tick 'Other' and specify the presentation in the space provided.

If the presentation is unknown, for example, due to extreme prematurity or macerated fetus, document this in the space provided.

Definitions:

- **Vertex**
  Presentation is where the occiput is the point of reference.

- **Breech**
  Presentation includes breech with extended legs, breech with flexed legs, footling and knee presentations.

- **Face**
  Presentation where the fetal head is hyperextended and the area of the head below the root of the nose and the orbital ridges is at the uterine cervix.

- **Brow**
  Presentation where the fetal head is partly extended and the area of the head between the anterior fontanelle and the root of the nose is at the uterine cervix.

- **Transverse/shoulder**
  Transverse presentation - the long axis of the baby's body is across the long axis of the mother's body.
  Shoulder presentation - the fetal head is in the iliac fossa and the shoulder is at the uterine cervix.

- **Other**
  Examples include compound presentations.

Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

7.9 METHOD OF BIRTH

METHOD OF BIRTH
Tick one box only

Vaginal non-instrumental	☐
Forceps	☐
Vacuum extractor	☐
LSCS	☐
Classical CS	☐
Other (specify)	☐

____

Tick the box (one box only) that corresponds to the method of birth of the baby, i.e. the method of complete expulsion or extraction from its mother of a product of conception. If the method of birth was other than those listed, tick 'Other' and specify the method in the space provided.

Note that a vaginal breech with forceps applied to the after coming head should be recorded as 'Forceps'. Forceps used to assist delivery at caesarean should be reported as a caesarean.

Definitions:

- **Vaginal non-instrumental**
  A birth which is achieved solely by the mother's expulsive efforts requiring no mechanical or surgical assistance.

- **Forceps**
  Where forceps are applied to assist the delivery process, including rotation forceps, liftout, etc.

- **Vacuum Extractor**
  An assisted birth using a suction cap applied to the baby's head, including rotation vacuum, also known as Ventousse Extractor.

- **LSCS**
  Lower segment caesarean section.

- **Classical CS**
  Classical caesarean section.

- **Other**
  Includes birth methods not classified above, eg Hysterotomy or extraction at post mortem.

7.10 WATER BIRTH

WATER BIRTH
Was this a Water birth?
No ☐ Yes ☐
If yes, was the water birth:
Unplanned ☐
Planned ☐

Tick the box to indicate if this birth was a water birth.

If the birth was a water birth, tick the box to indicate if it was an unplanned or a planned water birth.

For a birth to be considered a water birth, the baby's head must remain submerged under water until after the body is born.

7.11 REASON FOR FORCEPS/VACUUM

REASON FOR FORCEPS/VACUUM

____

If forceps or vacuum were used as the method of birth, specify the reason in the space provided, eg 'prolonged active 2nd stage', 'Direct OP'.

7.12 REASON FOR CAESAREAN

REASON FOR CAESAREAN
____

If caesarean section was performed as the method of birth, specify the reason in the space provided, eg 'repeat caesar', 'fetal distress', 'prolonged labour', etc.

Where a caesarean occurs as a result of a failed forceps/vacuum, then reason for caesarean should be reported as 'failed forceps/vacuum' and the original indication for the trial of forceps/vacuum (eg prolonged active 2nd stage) should be reported as a labour and delivery complication.

7.13 CERVICAL DILATATION PRIOR TO CAESAREAN

Cervical dilatation prior to caesarean	
3cm or less	☐
More than 3cm	☐
Not measured	☐

If a caesarean was performed, tick the box (one box only) that corresponds to the level of dilatation of the cervix prior to the caesarean. If the cervical dilatation was not measured, tick 'Not measured'.

Note this field is mandatory when the method of birth is a caesarean, including no labour caesarean. It is not necessary to complete for any other method of birth.

7.14 ANTIBIOTICS AT TIME OF CAESAREAN

ANTIBIOTICS RECEIVED AT TIME OF CAESAREAN Tick one box only	
None	☐
Prophylactic antibiotics received	☐
Antibiotics already received	☐

When the method of birth is either a lower segment caesarean section or a classical caesarean section, tick the box (one box only) that corresponds to the administration of antibiotics to the mother in relation to the caesarean.

If antibiotics were not received at the time of LSCS or classical caesarean section, tick the 'None' box.

If antibiotics have been received for prophylaxis of infection specifically associated with the caesarean, tick the 'Prophylactic antibiotics received' box.

If antibiotics have been received for a known condition (eg. chorioamnionitis, pneumonia, etc) at the time of LSCS or classical caesarean, tick the 'Antibiotics already received' box. This does not include antibiotic prophylaxis.

This information is used to assist the identification of adverse outcomes in relation to maternal health and wellbeing.

7.15 PLACENTA/CORD*

PLACENTA / CORD

____

Indicate whether the placenta was complete or other and/or whether the cord had 3 vessels or other at delivery in the space provided. Report any malformations noted, eg circumvallate placenta, velamentous cord insertion, true knot in cord.

7.16 PRINCIPAL ACCOUCHEUR

PRINCIPAL ACCOUCHEUR
Tick one box only

Obstetrician	☐
Other medical officer	☐
Midwife	☐
Midwifery Student	☐
Medical student	☐
Other (specify)	☐

____

Tick the box (one box only) that corresponds to the principal person who assisted the mother in the birth of the baby. If the principal accoucheur is other than those listed, tick 'Other" and specify the accoucheur in the space provided.

Definitions:

- **Obstetrician**
  A medical doctor who is qualified in the field of obstetrics.
- **Other medical officer**
  Includes registrar, junior house officer, resident, general practitioner, etc.
- **Midwife**
  A registered nurse who is qualified in the field of midwifery.
- **Midwifery Student**
  A registered nurse training to obtain qualifications in the field of midwifery.
- **Medical student**
  A student training to obtain qualifications to become a medical doctor.
- **Other**
  Includes a registered nurse without midwifery qualifications, doulas, ambulance officer, self, husband, other patient, etc.

7.17 PERINEUM

PERINEUM Please tick the most severe		
Intact		☐
Grazes		☐
Lacerated	- 1st degree	☐
	- 2nd degree	☐
	- 3rd degree	☐
	- 4th degree	☐
Episiotomy?	No ☐	Yes ☐

Tick the box that corresponds to the condition of perineum following delivery. Tick 'Yes' or 'No' to indicate whether or not an episiotomy was performed.

Note that if an episiotomy has been performed, the perineum can not be intact and this box should be left blank along with the laceration boxes.

If both a 2nd degree tear and an episiotomy occurred, please note which occurred first.

If an episiotomy is extended to a 3rd or 4th degree tear, tick both corresponding boxes (i.e. episiotomy as well as either 3rd or 4th degree tear.

Definitions:

- **Intact**
  The perineum is intact following delivery.

- **Graze**
  A slight abrasion of the skin following delivery.

- **Lacerated**
  If the perineum is lacerated following delivery, indicate the degree of laceration.
  - **1st Degree**
    Tear or laceration involving one of the fourchette, hymen, labia, skin, vagina or vulva.
  - **2nd Degree**
    Tear or laceration involving the pelvic floor or perineal muscles or vaginal muscles.
  - **3rd Degree**
    Tear or laceration involving the anal sphincter or recto vaginal septum.
  - **4th Degree**
    Third degree tear or laceration also involving the anal mucosa or rectal mucosa.

- **Episiotomy**
  Surgical incision into the perineum and vagina to assist delivery.

Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent intervention rates.

7.18 OTHER GENITAL TRAUMA

Other genital trauma

____

Specify any other genital trauma experienced by the mother in the space provided, including high vaginal tears where the perineum is intact, cervical tears, urethral tears, etc.

7.19 SURGICAL REPAIROF THE VAGINA OR PERINEUM

Surgical repair of vagina or perineum? No ☐ Yes ☐

Tick 'Yes' or 'No' to indicate whether the vagina or perineum was surgically repaired. Note that if an episiotomy has been performed, then corresponding surgical repair would be expected.

7.20 NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY

NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY

- None ☐
- Heat pack ☐
- Birth ball ☐
- Massage ☐
- Shower ☐
- Water immersion ☐
- Aromatherapy ☐
- Homeopathy ☐
- Acupuncture ☐
- TENS ☐
- Other (specify) ☐

____

Tick the box(es) under the Non-Pharmacological Analgesia during Labour/Delivery heading that correspond to the non-pharmacological analgesia administered to the mother during labour and delivery. If non-pharmacological analgesia used was other than those listed, tick 'Other' and specify the non-pharmacological analgesia in the space provided. If no non-pharmacological analgesia was administered, tick 'None'.

Definitions:

- **Heat Pack**: Includes the use of electronic heat pads, heat wheat packs and gel packs.
- **Water Immersion:** The labouring woman places her body into water or other liquid so that it is completely covered by the liquid.
- **TENS:** an electronic device that delivers small electrical impulses to the body via electrodes placed on the skin.
- **Other:** Includes the use of medication, visualisation and hypnotherapy.

7.21 PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY

PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY

None	☐
Nitrous oxide	☐
Systemic opioid (incl. narcotic (IV/IM))	☐
Epidural	☐
Spinal	☐
Combined Spinal-Epidural	☐
Caudal	☐
Other (specify)	☐

Tick the box(es) under the Pharmacological Analgesia heading that correspond to the pharmacological analgesia administered to the mother during labour and delivery. If a pharmacological analgesia other than those listed was used, tick ‘Other’ and specify the pharmacological analgesia in the space provided. If no pharmacological analgesia was administered, tick ‘None’.

Definitions are listed on the next page.

Definitions:

- **Analgesia**
  Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

- **Nitrous Oxide**
  Gas providing light anaesthesia delivered in various concentrations with oxygen.

- **Systemic Opioid (incl. narcotic (IM/IV))**
  Opioid analgesics that acts on the patient's central nervous system.
  This includes drugs which have an agonist action at the opioid receptor on the cell.

- **Epidural**
  Injection of a local anaesthetic into the epidural space of the spinal column.

- **Spinal**
  Injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord, also called the Subarachnoid Block Anaesthesia.

- **Combined Spinal-Epidural**
  Needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column.

- **Caudal**
  Injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.

7.22 LABOUR AND DELIVERY COMPLICATIONS

LABOUR AND DELIVERY COMPLICATIONS You may tick more than one box	
None	☐
Meconium liquor	☐
Fetal distress	☐
Cord prolapse	☐
Cord entanglement with compression	☐
Failure to progress	☐
Prolonged second stage (active)	☐
Precipitate labour/delivery	☐
Retained placenta with manual removal	☐
with haemorrhage	☐
without haemorrhage	☐
Primary PPH (500-999ml)	☐
Primary PPH (=>1000ml)	☐
Other (specify) ______	☐

Tick the box(es) that correspond to any complications that arose during labour and delivery. If complications arose other than those listed, tick 'Other' and specify the complication(s) in the space provided (see Appendix D for examples). If no complications were experienced, tick 'None'.

Definition:

- **Labour and delivery complications**
  Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

7.23 ANAESTHESIA FOR DELIVERY

ANAESTHESIA FOR DELIVERY	
None	☐
Epidural	☐
Spinal	☐
Combined Spinal-Epidural	☐
General anaesthetic	☐
Local to perineum	☐
Pudendal	☐
Caudal	☐
Other (specify) ________	☐

Tick the box(es) under the Anaesthesia heading that correspond to the anaesthesia administered to the mother for delivery. If the anaesthesia used was other than those listed, tick 'Other' and specify the anaesthesia used in the space provided. If no anaesthesia was administered, tick 'None'.

Please note that a response is required in non-pharmacological analgesia, pharmacological analgesia and anaesthesia fields, eg if delivery is by elective caesarean section, and no non-pharmacological or pharmacological analgesia are used, then 'None' should be ticked in both fields.

Note also that local to the perineum for the sole purpose of repair of tear or episiotomy is not considered anaesthetic for delivery, and therefore should not be included.

Definitions are listed on the next page.

Definitions:

- **Anaesthesia**
  Agents administered to the mother for the operative/instrumental delivery of the baby (caesarean section, forceps or vacuum delivery).

- **Epidural**
  Injection of a local anaesthetic into the epidural space of the spinal column.

- **Spinal**
  Injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord. Also called the Subarachnoid Block Anaesthesia.

- **Combined Spinal-Epidural**
  Needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column.

- **General Anaesthetic**
  Various anaesthetic agents given primarily by inhalation or intravenous injection.

- **Local to Perineum**
  Infiltrating the perineum with local anaesthetic.

- **Pudendal**
  Injection of local anaesthetic to the pudendal nerves.

- **Caudal**
  Injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.

7.24 CTG IN LABOUR

CTG in labour?	No ☐	Yes ☐

Tick 'Yes' or 'No' to indicate whether Cardiotocography (CTG) monitoring was performed during labour. Any external trace (including 'routine baseline' traces) recorded during labour, regardless of the duration of recording (i.e. continuous or intermittent) should be reported. A baseline trace recorded prior to labour commencing should not be included.

7.25 FSE IN LABOUR

FSE in labour?	No ☐	Yes ☐

Tick 'Yes' or 'No' to indicate whether Fetal Scalp Electrode (FSE) monitoring was performed during labour.

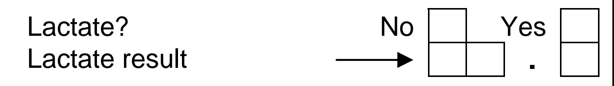
7.26 FETAL SCALP pH AND RESULT

Fetal Scalp pH? No ☐ Yes ☐
Fetal Scalp pH result → ☐ . ☐☐

Indicate whether fetal scalp pH was measured or not.

If the fetal scalp pH was taken then record the fetal scalp pH result.

7.27 LACTATE AND RESULT


Lactate? No ☐ Yes ☐
Lactate result → ☐☐ . ☐

Tick ‘Yes’ or ‘No’ to indicate whether fetal scalp lactate was measured.

If the fetal scalp lactate was taken, record the fetal scalp lactate result.

8 BABY

Identification labels may be attached to the back of the original and duplicate copy of the MR63D form. If an identification label is used only on the hospital copies DO NOT FORGET to complete BABY'S UR NUMBER and DATE OF BIRTH on the Data Collections Unit copy. If a label is used on the duplicate copies, then identifying information that is not required by Data Collections Unit can be crossed through using a felt tipped pen (as ball point will affect the clarity of information on the form due to the carbonisation of the paper)

Note: In the case of multiple births, a separate MR63D must be completed for each baby. If the forms are pinned together prior to dispatch, the common information need not be repeated. Details in the LABOUR AND DELIVERY, BABY, POSTNATAL and BABY DISCHARGE DETAILS must be completed for each baby.

8.1 BABY'S UR NUMBER

Enter the Unit Record (UR) number assigned to the baby (if applicable), eg:

BABY'S UR No.	1	2	3	4	5	6	7	8

For home births where the baby is not admitted to a hospital, this field is not required, however if the private midwifery practitioner assigns a record number for administrative purposes it can be included.

8.2 INDIGENOUS STATUS – BABY

INDIGENOUS STATUS – BABY	
Aboriginal	☐
Torres Strait Islander	☐
Aborig. & Torres Str. Is.	☐
Neither Aboriginal nor Torres Str. Is.	☐

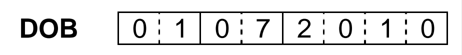
Tick the box (one box only) that corresponds to the Indigenous Status of the baby.

For definitions see section 4.4 Indigenous Status page 402 of this manual.

Note that a baby's indigenous status cannot be determined simply by observation and therefore this question must be asked of all mothers. For further information regarding determining Indigenous status, please refer to the 'Are you of Aboriginal or Torres Strait Islander origin?' pamphlet. If you require copies of this publication, please contact the National Centre for Aboriginal and Torres Strait Islander Statistics (Australian Bureau of Statistics) on the free call number 1800 633 216.

8.3 DATE OF BIRTH

Enter the day, month and year of the baby's date of birth using all boxes, eg
1 July 2010 should be entered as:



8.4 TIME OF BIRTH

Enter the time of birth of the baby using the 24 hour clock, eg 2.30pm should be entered as 14:30 hours. If the time of birth of the baby is midnight, this should be recorded as 00:00 hours to indicate the start of the day.

TIME OF BIRTH ☐☐☐☐ hours

8.5 BIRTHWEIGHT

Enter the first weight of the fetus or baby obtained after birth in grams, eg 3500 grams.

BIRTHWEIGHT ☐☐☐☐ grams

8.6 GESTATION

GESTATION ☐☐ weeks ☐ days
(clinical assessment at birth)

Enter the estimated gestational age of the baby in completed weeks and days, as determined by clinical assessment after birth. Do not use ‘T’ for term, or ‘K’.

Gestational age is a key outcome of pregnancy and an important risk factor for neonatal outcomes.

8.7 HEAD CIRCUMFERENCE AT BIRTH

HEAD CIRCUMFERENCE AT BIRTH ☐☐ . ☐ cm

Enter the head circumference of the baby at birth in centimetres, to the nearest one decimal place.

8.8 LENGTH AT BIRTH

LENGTH AT BIRTH ☐☐ . ☐ cm

Enter the length of the baby at birth in centimetres, to the nearest one decimal place.

8.9 PLURALITY

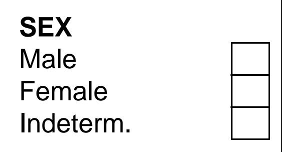
PLURALITY
Single ☐
Twin I ☐
Twin II ☐
Other (Specify) ☐

Tick one box only to indicate whether this pregnancy has resulted in a ‘Single’ birth, or for a multiple birth, tick the box for which baby the form is being completed. For example, if the form relates to the second twin, tick ‘Twin II’.

For the first baby of triplets or higher, tick ‘Other’ and write, for example, ‘Triplet I’ in the space provided.

Note: The plurality refers to the total number of births resulting from this pregnancy. If the pregnancy commences as a twin pregnancy but one foetus is miscarried/aborted before 20 weeks and/or 400 grams, the plurality would be single.

8.10 SEX



Tick the box (one box only) that corresponds to the sex of the baby. If the sex of the baby cannot be determined, tick ‘Indeterm’.

8.11 BIRTH STATUS

BIRTH STATUS
Born alive ☐
Stillborn ☐
- macerated
No ☐ Yes ☐

Tick the box that corresponds to the result of the birth. If the baby was born alive, tick ‘Born alive’. If the baby was not born alive, tick ‘Stillborn’.

If the baby was stillborn, indicate whether the baby was macerated by ticking ‘Yes’ or ‘No’.

Note that maceration status should **only** be completed in the case of stillbirths, and should not be used to indicate ‘peeling skin’ associated with a post term infant.

Definitions are listed on next page.

Definitions:

- **Live birth**
  The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

- **Stillbirth**
  A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

- **Macerated**
  Softening and breaking down of skin caused by prolonged exposure to amniotic fluid in a deceased foetus.

8.12 APGAR SCORE

APGAR SCORE

	1 min	5 min
Heart rate		
Respiratory effort		
Muscle tone		
Reflex irritability		
Colour		
TOTAL		

Enter the 1 minute and 5 minute Apgar scores in the boxes for each of the conditions listed (refer to table below).

Sign	Scores 0	Scores 1	Scores 2
Heart rate	Absent	<100 beats/min	>100 beats/min
Respiratory rate	Absent	Slow, irregular	Good lusty cry
Muscle Tone	Flaccid, limp	Flexion of extremities	Active flexion
Reflex Irritability	No response	Grimace, some motion	Cry, cough
Colour	Cyanotic, pale	Pink body, acrocyanosis	Pink body/extremities

Source: *Manual of Neonatal Care (Fifth Edition), John Cloherty, Eric Eichenwald, Ann Stark. 2004*

Enter the total Apgar scores in the boxes provided.

The Apgar score is a numerical score to evaluate the baby's condition at 1 minute and 5 minutes after birth. It is an indicator of the health of the baby, particularly after complications of pregnancy and/or labour and birth. It is useful in deciding the need for and adequacy of resuscitation.

8.13 REGULAR RESPIRATION

REGULAR RESPIRATIONS
☐☐ minutes

OR At birth ☐
OR Intubated/Ventilated ☐
OR Respirations not established ☐

Enter, to the nearest minute, the time the baby took to establish **regular, spontaneous breathing**. If respirations were established 30 to 59 seconds after birth, record as 1 minute.

If the baby established respirations spontaneously tick the 'at birth box'; if the baby was ventilated, tick the 'intubated/ventilated' box; if respirations were never established, tick the 'respirations not established' box.

8.14 RESUSCITATION

RESUSCITATION
You may tick more than one box

None ☐
Suction (oral, pharyngeal etc) ☐
Suction of meconium via ETT ☐
Facial O2 ☐
Bag and mask ☐
IPPV via ETT ☐
Narcotic antagonist infection ☐
External cardiac massage ☐
Other (specify – include drugs) ☐

____

Tick the box(es) that correspond to the method of resuscitation used. If resuscitation methods were used other than those listed, tick 'Other' and specify the method(s) used in the space provided, eg tactile stimulation. Include other drugs used for resuscitation, eg adrenalin, etc. If no methods were used, tick 'None'.

Definitions are listed on the next page.

Definitions:

- **Suction (oral, pharyngeal, etc)**
  Routine aspiration of the airways only.

- **Suction of meconium (oral, pharyngeal, etc)**
  Meconium is cleared from the airway with a suction tube.

- **Suction of meconium via ETT**
  Meconium is cleared from the airway via insertion of an endotracheal tube.

- **Facial O_2**
  Oxygen is administered via a mask, funnel, nasal prongs, head box, bag and mask without ventilation

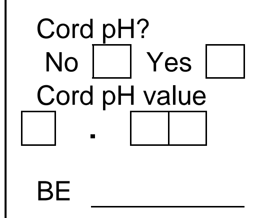
- **Bag and mask**
  Intermittent positive pressure ventilation via a bag and mask, with or without laryngeal mask.

- **IPPV (via ETT)**
  Intermittent positive pressure ventilation via an endotracheal tube.

- **Narcotic antagonist injection**
  Administration of the drug Narcan (naloxene).

This information is required to analyse the need for resuscitation after complications of labour and delivery and to evaluate level of services required for different birth settings.

8.15 CORD Ph AND VALUE


Cord pH?
No ☐ Yes ☐
Cord pH value
☐ . ☐☐
BE ___________

Tick ‘Yes’ or ‘No’ to indicate whether pH of the umbilical cord was measured.

If the Cord pH was measured provide the cord pH value.

Record the Base Excess (BE) level if measured.

Note: this is not a mandatory field on the form and subsequently no information is stored by the PDC from this field.

8.16 VITAMIN K (FIRST DOSE)

VITAMIN K
(first dose)
Oral ☐
IM ☐
None ☐

Tick the box (one box only) that corresponds to the method of administration for first dose of Vitamin K was administered. If no Vitamin K was administered, tick 'None'.

8.17 HEPATITIS B VACCINATION (BIRTH DOSE)

HEPATITIS B
(birth dose vaccination)
No ☐ Yes ☐

Tick the box (one box only) that corresponds to whether or not the birth dose Hepatitis B vaccination was given. Note that this is not exclusive to doses given immediately after birth or whilst still within the delivery room, and therefore includes doses given prior to discharge. This field does not refer to administration of Hepatitis B immunoglobulin, which should be reported in neonatal treatment.

9 POSTNATAL DETAILS

9.1 NEONATAL MORBIDITY

BABY				
NEONATAL MORBIDITY				
None	☐			
Jaundice	☐	→	Diagnosis	________
Respiratory distress	☐	→	Diagnosis	________
Hypo/Hyperglycaemia or Normal	☐	→	Results	________ ←
Neonatal abstinence syndrome	☐	→	Drug name	________
Infection	☐	→	Diagnosis	________
Other (specify)	☐	→	________	

Tick the box(es) that correspond to the conditions/diseases/illnesses/birth traumas experienced by the baby up to the time of discharge or when the baby reaches 28 days of age. Document the diagnosis in the space provided. If a condition is present other than those listed, tick 'Other' and specify the condition(s) in the space provided. If there is no neonatal morbidity, tick 'None' (See Appendix D for examples of neonatal morbidity).

Examples of diagnoses include:

- **Jaundice**
  Physiological, ABO incompatibility, etc.
  (Indicate whether phototherapy was used to treat the jaundice.)

- **Respiratory distress**
  Transient tachypnoea of the newborn, respiratory distress syndrome, etc.

- **Hypo/Hyperglycaemia or Normal**
  When blood glucose monitoring has been reported, please supply the outcome of the observation (hypoglycaemia, hyperglycaemia or normal).

- **Neonatal Abstinence Syndrome**
  Please specify the name of the drug used by mother.

- **Infection**
  Cytomegalovirus, septicaemia, eye infection, etc and also specify the name of the bacteria where applicable.

9.2 NEONATAL TREATMENT

NEONATAL TREATMENT
- None ☐
- Oxygen for >4 hours ☐
- Phototherapy ☐
- IV/IM antibiotics ☐
- IV fluid ☐
- Mechanical ventilation ☐
- Blood glucose monitoring ☐
- CPAP ☐
- Oro / naso gastric feeding ☐
- Other treatment ☐

____

Tick the box(es) that correspond to any neonatal treatments given up to the time of discharge or when the baby reached 28 days of age. If a treatment is used other than those listed, tick 'Other' and specify the treatment(s) in the space provided. If no treatments were used, tick 'None'.

Note that if a treatment has been specified, ensure that a corresponding morbidity has also been specified (eg If phototherapy is ticked, jaundice should also be ticked in morbidities). If blood glucose monitoring is indicated, then the reason for the monitoring and the outcome of the monitoring should be specified (see 9.1).

9.3 ADMITTED TO ICN/SCN

Hospital nurseries are approved for neo-natal facilities for the treatment of newly born children, under the *Health Insurance Act 1973*. Hospitals with facilities which meet the criteria (outlined in the Act) may apply for approval under Section 3(2) of the Act to:

The Director,
Insurance and Hospitals Services Section (MDP86),
Australian Department of Health and Aged Care,
GPO Box 9848,
Canberra, ACT 2601.

Approvals will be renewed every 3 years. (See appendix E for list of facilities with approved Level 2 and 3 nurseries at the time of publication).

Was baby admitted to ICN/SCN?
No ☐ Yes ☐
If yes, how many days was baby admitted to:
- ICN (days) ______________
- SCN (days) ______________

Tick 'Yes' or 'No' to indicate it the baby was admitted to Intensive Care Nursery (ICN) or Special Care Nursery (SCN).

Specify the type of nursery the baby was admitted to by entering the number of days the baby was admitted to ICN and/or SCN, including 0 if the baby was not admitted. Reporting in this field is only required for those facilities where approval is current. Note

that admissions to a neonatal service level 1 (mature infant nursery) **should not be reported**.

Definitions:

- **Neonatal Service Level 1 - Mature Infant Nursery (MIN)**
  Neonatal service level 1 primarily cares for healthy infants of 37 weeks gestation or later, and their mothers, postnatally. Requires a secure area for nursing/supervising infants (See Appendix E for specific criteria).

- **Neonatal Service Level 2 - Special Care Nursery (SCN)**
  Neonatal service level 2 provides services at a higher level than a level 1 neonatal service (neonates of 32 weeks gestation or later) and may be used in a 'step down' capacity by level 3 neonatal services. This practice usually aims to stabilise the baby on ventilation, in consultation with the Neonatologist from a level 3 neonatal service, before transfer to a higher level service (preferably within 6 hours), (See appendix E for specific criteria).

- **Neonatal Services Level 3 - Intensive Care Nursery (NICU)**
  Neonatal service level 3 provides the highest level of life support including medium to long term ventilation of neonates. Services provided from these units include infant follow-up programs with paediatrician(s) experienced in the follow-up of very premature neonates and access to allied health professionals including a paediatric dietician and social worker (See appendix E for specific criteria).

SOURCE: *Queensland Health Clinical Services Capability Framework V2.0 (2005)*

9.4 MAIN REASON FOR ADMISSION TO ICN/SCN

Main reason for admission to ICN/SCN

____

____

If the baby was admitted to either an ICN or SCN, enter one main reason for admission in the space provided. The reason should be a condition, not a treatment, eg 'prematurity' rather than 'tube feeding', or 'respiratory distress' rather than 'oxygen therapy or observation'. The treatment should be included in the Neonatal Treatments field (see 9.2).

9.5 CONGENITAL ANOMALY

CONGENTIAL ANOMALY
No ☐ Yes ☐ Suspected ☐
If yes or suspected enter details below
or in the Congenital Anomaly section

____
____
____

Tick ‘Yes’, ‘No’ or ‘Suspected’ to indicate whether a congenital anomaly is present or suspected. Congenital anomalies are abnormalities (including deformities) that were present at birth and detected prior to separation from care (See Appendix D for examples of congenital anomalies).

In the case of a diagnosed or suspected anomaly, enter a brief description in the space provided then ensure that the Additional Congenital Anomaly Data section of the form is completed. The medical practitioner responsible for the baby should complete the Congenital Anomaly section, which can be updated up to 28 days after the birth.

Perinatal Data Collection will be reporting against each congenital anomaly whether or not the congenital anomaly was diagnosed prior to birth.

Hospitals supplying Perinatal data by MR63D

When entering the description of each congenital anomaly, enter ‘No’ or ‘Yes’ alongside each congenital anomaly to indicate whether the congenital anomaly was diagnosed prior to birth of not.

Hospitals supplying Perinatal data electronically

Supply ‘1’ (no) or ‘2’ (yes) to indicate whether the congenital anomaly was diagnosed prior to birth or not as per the file format.

Validations will be generated if this data item has not been supplied.

10 DISCHARGE DETAILS

10.1 DISCHARGE DETAILS OF THE MOTHER

10.1.1 PUERPERIUM COMPLICATIONS

MOTHER
PERUPERIUM COMPLICATIONS
You may tick more than one box

None	☐
Haemorrhoids	☐
Wound Infection	☐
Anaemia	☐
Dehiscence/disruption of wound	☐
Febrile	☐
UTI	☐
Spinal headache	☐
Secondary PPH	☐
Other (specify)	☐

____

Tick the box(es) that correspond to the puerperium complications experienced by the mother. If a complication is experienced other than those listed, tick 'Other' and specify the complication(s) in the space provided (see Appendix D for examples). If no complications are experienced, tick 'None'.

This field should reflect conditions, not treatments or procedures. For example, a spinal headache would be reported in this field, but if it required intervention such as a blood patch, the treatment would be reported in the puerperium procedures and operations field.

Definition:

- **Puerperium complications**
  Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

10.1.2 THROMBOPROPHYLAXIS FOLLOWING CAESAREAN

THROMBOPROPHYLAXIS FOLLOWING CAESARIAN
You may tick more than one box

None	☐
Pharmacological Thromboprophylaxis	☐
Intermittent Calf Compression	☐
Other (specify)	☐

____

When the method of birth is either a lower segment caesarean section or a classical caesarean section, tick the box(es) that correspond to any puerperium thromboprophylaxis administered following caesarean section.

If Thromboprophylaxis following LSCS or classical caesarean section was not administered, tick the 'None' box.

If Thromboprophylaxis following LSCS or classical caesarean was via pharmacological thromboprophylaxis methods, tick the 'Pharmacological Thromboprophylaxis' box.

If Thromboprophylaxis following LSCS or classical caesarean was via intermittent calf compression, tick the 'Intermittent Calf Compression' box.

If Thromboprophylaxis following LSCS or classical caesarean was via other thromboprophylaxis methods, tick the 'Other (specify)' box and record the method(s) used in the space provided.

This information is used to assist the identification of adverse outcomes in relation to maternal health and wellbeing.

10.1.3 PUERPERIUM PROCEDURES AND OPERATIONS

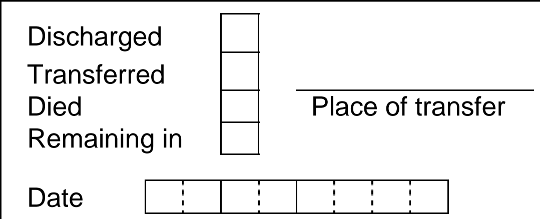
PUERPERIUM PROCEDURES AND OPERATIONS
You may tick more than one box

None	☐
Blood Transfusion	☐
Blood Patch	☐
D & C	☐
Other (specify)	☐

____

Tick the box(es) that correspond to any medical or surgical procedures and/or operations that were performed on the mother during the puerperium. If a procedure and/or operation were performed other than those listed, tick 'Other' and specify in the space provided (see Appendix D for examples). If no procedures or operations were performed during the puerperium, tick 'None'. Where procedures are reported that may be performed via different approaches please provide as many details as possible. For example: ligation of fallopian tubes, which may be via laparotomy or laparoscopy, please report as either 'open abdominal ligation' or 'laparoscopic ligation'.

10.1.4 DISCHARGE DETAILS


Discharged
Transferred
Died
Remaining in
Place of transfer
Date

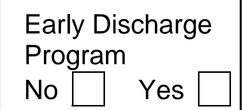
Tick the box (one box only) that corresponds to whether the mother was discharged, transferred to another facility, remaining in hospital or died during the current admission. If the mother was transferred to another facility, enter full name of the other facility in the space provided. In cases such as Mater Mother's Hospital indicate whether the transfer was to the public or private facility. For PDC purposes, a patient transferred from unit to unit within the same facility (eg maternity to intensive care) is not considered a transfer or discharge.

Enter the day, month and year the mother was discharged, transferred or died using all boxes. If the mother is remaining in after 28 days tick the remaining in box and provide the discharge date when available.

Note that if the baby had an extended stay in hospital and the mother was registered as a boarder so that she could be near her baby, enter the date she was formally discharged as an admitted patient, i.e. the day she changed from an admitted patient to a boarder.

Do not complete the discharge details field when a planned homebirth occurred unless the baby was transferred to a facility following delivery.

10.1.5 EARLY DISCHARGE PROGRAM

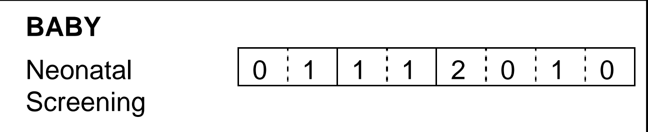

Early Discharge Program
No Yes

Tick the 'Yes' box if the mother was released from hospital to an Early Discharge or other similar program. Note there is currently no standard definition available that constitutes an early discharge program. Please report whatever individual facilities regard as an early discharge program.

10.2 DISCHARGE DETAILS OF THE BABY

10.2.1 NEONATAL SCREENING

Enter the day, month and year when the neonatal screening was performed using all boxes, eg if the neonatal screening was performed on 1 November 2010, enter:


BABY
Neonatal Screening 0 1 1 1 2 0 1 0

Note that this is not a mandatory field on the form, and subsequently no information is stored by PDC from this field.

For enquires regarding neonatal screening tests please contact the Neonatal Screening Unit on 3636 7171 or 3636 7051.

10.2.2 DISCHARGE WEIGHT

Enter the weight* of the baby on discharge in grams.

Discharge weight ______________ grams

Note that this is not a mandatory field on the form, and subsequently no information is stored by PDC from this field.

10.2.3 DISCHARGE DETAILS

Discharged	☐	
Transferred	☐	________________
Died	☐	Place of transfer
Remaining in	☐	
Date	☐☐ ☐☐ ☐☐☐☐	

Tick the box (one box only) that corresponds to whether the baby was discharged, transferred to another facility, remaining in hospital or died during the admission. If the baby was transferred to another facility, enter the full name of the other facility in the space provided. In cases such as Mater Mother's Hospital indicate whether the transfer was to the public or private facility. For PDC purposes, a baby transferred from unit to unit within the same facility (eg Level 3 Nursery to Level 2 Nursery) is not considered a transfer or discharge.

Enter the day, month and year the baby was discharged, transferred or died using all boxes. If the baby is remaining in after 28 days tick the 'Remaining in' box and provide the discharge date when available.

Do not complete the discharge details field when a planned homebirth occurred unless the baby was transferred to a facility following delivery.

10.2.4 FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE

TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE: You may tick more than one box	
Breast milk/colostrum	☐
Infant formula	☐
Water, fruit juice or water-based products	☐
Nil by mouth	☐

Tick the box that applies to the type of fluid the baby received at any time from birth to discharge. More than one box may be ticked. This field may be used as an indicator for the Baby Friendly Health Initiative.

10.2.5 FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE

TYPES OF FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE:
You may tick more than one box

Breast milk/colostrum	☐
Infant formula	☐
Water, fruit juice or water-based products	☐
Nil by mouth	☐

Tick the box that applies to the type of fluid (s) the baby received in the 24 hours prior to discharge (or part thereof). More than one box may be ticked. This field may be used as an indicator for the Baby Friendly Health Initiative.

NOTE: If the baby has received a type of fluid in the 24 hours prior to discharge, the type of fluid must also be selected in the types of fluid the baby received at any time from birth to discharge. See section 10.2.5.

Definitions:

- **Breast milk/colostrum:**
  Includes breast milk/colostrum received directly from the breast as well as expressed breast milk/colostrum received by but not limited to syringe, cup or enteral tube.

- **Infant formula:**
  Refers to commercially prepared formulas that adequately meet the nutritional needs of the newborn.

- **Water, fruit juice or water-based products:**
  Other types of fluid include but is not limited to water, fruit juice, herbal tea or flavoured water.

10.2.6 ALTERNATE FEEDING METHOD

ALTERNATE FEEDING METHOD
You may tick more than one box

Has the baby been fed by?

Bottle	☐
Cup	☐
Syringe	☐
Other (specify)	☐

____

Tick the box(es) that apply to the type of alternate methods used to feed the baby from birth to discharge (or part thereof). More than one box may be ticked.

This includes babies who are fed expressed breast milk/colostrum via an alternate feeding method. This will enable a broader understanding of bottle usage by reducing association with infant formula and consideration of other liquids such as expressed breast milk. This may be an indicator for the Baby Friendly Health Initiative.

11 ADDITIONAL CONGENITAL ANOMALY DATA

11.1 INDICATE BY SHADING OR MARKING THE APPROPRIATE DIAGRAM(S)

See Appendix B for the diagrams included in Section B of the MR63D form.

In the case of congenital anomaly (ies) with apparent physical defects, indicate by shading or marking the anatomical site(s) affected on the appropriate diagram(s).

11.2 ADDITIONAL CONGENITAL ANOMALY DESCRIPTION OR DETAILS

Additional Congenital Anomaly description or details

Extra space is provided for a more detailed description of any congenital anomaly which does not fit in the space provided in the postnatal details section of the form.

11.3 MEDICAL PRACTITIONER'S SIGNATURE

Medical Practitioner's Signature	

This form should be signed by the medical practitioner in charge of the neonatal care of the baby.

11.4 SURNAME

Surname (BLOCK LETTERS)	

Enter the surname of the medical practitioner as it may be necessary to elicit further details at a later date.

11.5 DESIGNATION

Designation	

Enter the position/designation of the medical practitioner.

11.6 DATE

Date	/	/

Enter the date the medical practitioner signed the form.

24 hours prior to discharge, 1005

Aboriginal, 402
Accommodation, 403
Actual place of birth, 702
Address, 406
Aims of the PDC, 201
Amendments, 101
Anaesthesia, 714, 715
Antenatal care, 602, 605
Antenatal transfer, 407
Antibiotics, 707
Antibiotics at time of caesarean, 707
APGAR Score, 804
Appendices, vi
Assessment for chorionicity scan, 608
Assisted conception, 609
Augmented, 703

Base excess, 806
Birth status, 803
Blood glucose monitoring, 902
Born alive, 803

Cervical dilatation, 708
Confidentiality, 201
Congenital anomaly, 904, 1101
Cord pH, 806
Cord pH value, 806
Country of birth, 401, 402
CTG, vii, 715

Date of admission, 401
Date of birth, 801
Designation, 1101
Discharge, 807, 901, 902, 1001, 1003, 1004
Discharge details - baby, 1004
Discharge details - mother, 1001, 1003
Discharged, 201, 202, 1003, 1004
Dispatch of Forms, 202

Early Discharge Program, 1003
EDC, 601, 602
Electronic extract, 101
Electronic transfer of data, 202
Episiotomy, 710, 711, 714
Estimated date of confinement, 601

Feeding, 1004, 1005
Feeding method, 1005
Fetal scalp lactate, 716
Fetal scalp lactate result, 716
Fetal scalp pH, 716
Fetal scalp pH result, 716
First stage of labour, 704

Fluid, 1004, 1005
FSE, 715

Gender, 803
Genital trauma, 711
Gestation at first antenatal visit, 605
Gestational age, 802

Head circumference, 802
Health Act 1937–1988, 201
Height, 602
Hepatitis B, 404, 604, 807

ICN, vii, 902, 903
Indigenous status, 402, 801
Induced, 703
Intended place of birth, 701, 702

Labour and delivery complications, 714
Last menstrual period, 601
Length at Birth, 802
Length of 1st and 2nd Stage of Labour, 704
Livebirth & abortion/miscarriage/ectopic/hydatiform mole, 501
Livebirth & stillbirth, 501
Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole, 501
LMP, 601

Marital status, 403
Medical conditions, 604
Medical practitioners, 101, 102, 201
Mehtod of delivery of last birth, 503
Membranes ruptured, 703
Method of delivery, 503, 705, 706, 707
Morbidity, 901
Morphology ultrasound scan, 608

Neonatal morbidity, 201, 702, 705, 901
Neonatal screening, 1003
Neonatal treatment, 902
NICU, 902, 903
Non-pharmacological analgesia, 711
Not born alive, 803
Nuchal translucency scan, 608
Number of visits, 603

Only abortions/miscarriage/ectopic/hydatiform mole, 501
Only livebirths, 501
Only stillbirths, 501
Onset, 407, 701, 702, 703
Operations, 607, 1001, 1002

Paper forms, 101
Parity, 501
Perinatal Statistics, 201
Perineal laceration, 710
Perineal tear, 710
Perineum, 710, 711, 714

Pharmacological analgesia, 712
Place of delivery, 401
Placenta/Cord, 709
Plurality, 803
Postnatal transfer, 1003
Pregnancy complications, 605
Presentation, 704
Previous caesarean, 503
Previous pregnancies, 501, 503
Principal accoucheur, 709
Private hospitals, 101, 201
Private midwifery, 101, 201
Procedures, 607, 1001, 1002
Procedures and operations, 607
Prophylactic antibiotics, 707
Public Health Act 2005, 201
Public hospitals, 101, 201
Puerperium complications, 1001
Puerperium Procedures and operations, 1002
Puerperium thromboprophylaxis following caesarean, 1002

Reason for caesarean, 707
Reason for forceps/vacuum, 707
Reason for induction, 703
Reason for transfer, 407
Respiration, 805
resuscitation, 806
Resuscitation, 804, 805

SCN, vii, 902, 903
Scope, 201
Second stage of labour, 704
Serology, 404
Sex, 803
Signature, 1101
Smoking, 606
Smoking advice, 606, 607
Smoking status, 607
Smoking Status, 606
Statistical Local Area, vii, 406
Sticky labels, 801
Stillbirth & abortion/miscarriage/ectopic/hydatiform mole, 501
Stillborn, 803
Suburb/town, 406
Surgical Repair, 711
Surname, 1101
Suspected anomaly, 904

Thromboprophylaxis following caesarean, 1002
Time of birth, 802
Time of transfer, 407
Torres Strait Islander, 402
Total number of previous pregnancies, 501
Transferred, 1004
Transferred from, 407
Treatment, 902

Ultrasound scans, 608
Ultrasound Scans, 608
Unit Record (UR) number, 405, 801
Usual residence, 406
Usual Residence, 406

Vaccination, 807
Vitamin K, 807

Water birth, 706
Weight, 602, 1004

DISPATCH DETAILS

DISPATCH INSTRUCTION – PERINATAL DATA COLLECTION

Part 3 of the Public Health Regulation 2005, provide for the compulsory completion of a return in the approved format, of information relating to all births, hospital and non-hospital, in Queensland. This enables the compilation of a comprehensive base of perinatal statistical data for Queensland. All completed information (either paper based form or electronic extract) is required to be forwarded to the Data Collections within 35 days of the birth of a baby. Hospitals should dispatch the returns on a fortnightly or monthly basis unless there are no births for the month.

1. DISPATCH: The forms and the dispatch cover notes are to be forwarded to Data Collections Unit using the confidential envelopes provided. Otherwise the address as below should be used:

   CONFIDENTIAL

   Perinatal Data Collection
   Data Collections Unit
   Health Statistics Centre
   Queensland Health
   GPO Box 48
   Brisbane QLD 4001

2. YOUR CO-OPERATION: It is appreciated that the prompt dispatch of forms for all births is no easy task. However, to achieve the objectives of the Collection, accurate and timely information must be supplied.

3. CONFIDENTIALITY: All information collected is used for statistical purposes only and will not be published in any form which might enable the identification of an individual.

4. QUERIES: If you have any queries concerning the dispatch of these forms, please contact the Perinatal Data Collection Officer on (07) 3235 4359.

DISPATCH COVERNOTE
PERINATAL DATA COLLECTION

Name of Hospital: ____________________________

PERINATAL DATA COLLECTION FORM (MR63d)

A Perinatal Data Collection Form (MR63d) is to be returned for each birth occurring at your hospital or admitted to your hospital directly after birth (do NOT include TRANSFERS from other hospitals **if the originating hospital** has forwarded a form). For a multiple birth, one MR63d is required per baby.

1. Enclosed are copies of the above mentioned forms for babies delivered and discharged/transferred or died, or for any babies who have reached 28 days of age before discharge for the period / / to / / .

2. The total count of MR63D forms is: _____________________ .

3. Please examine the hospital birth register and indicate whether this dispatch completes the return of forms for babies born to all maternity patients delivered and discharged, or any babies who have reached 28 days of age before discharge within the period specified above.

   THE REGISTER HAS BEEN EXAMINED AND THE FORMS PROVIDED HEREIN ARE:

	Complete	☐		
				(tick whichever applicable)
	Incomplete	☐		

   If INCOMPLETE please explain why this dispatch does not complete the return of forms for babies born to all maternity patients delivered and discharged, or any babies who have reached 28 days of age before discharge.

   Reasons for outstanding forms and their expected dispatch date.

   ____

   ____

4. The person to contact at this hospital if queries arise covering this dispatch is:

(Name)		(Position)		(Telephone)

07/08/2009

PERINATAL DATA COLLECTION FORM

QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS

PLACE OF DELIVERY ____ DATE OF ADMISSION (to delivery) ____

MOTHER'S COUNTRY OF BIRTH ____

INDIGENOUS STATUS
- Aboriginal ☐
- Torres Strait Islander ☐
- Aborig. & Torres Str. Is. ☐
- Neither Aboriginal nor Torres Str. Is. ☐

MARITAL STATUS
- Never Married ☐
- Married/defacto ☐
- Widowed ☐
- Divorced ☐
- Separated ☐

ACCOMMODATION STATUS OF MOTHER
- Public ☐
- Private ☐

SEROLOGY
- RPR .... IgG ....
- Rubella ....
- Hepatitis B ....
- Blood Group ....
- Rh ....
- Antibodies No ☐ Yes ☐
- Other ____

FAMILY NAME ____ UR No. ____

1ST GIVEN NAME ____ DOB ____

2ND GIVEN NAME ____ Estimated Date of Birth ☐

USUAL RESIDENCE ____

POSTCODE ____ STATE ☐ SLA ____

ANTENATAL TRANSFER No ☐ Yes ☐
(include transfers from planned home birth to hospital, from birthing centre to acute care areas etc.)

Reason for transfer ____

Transferred from ____

Time of transfer
- prior to onset of labour ☐
- during labour ☐

PREVIOUS PREGNANCIES

PREVIOUS PREGNANCIES

None ☐ (go to next section)

Number of previous pregnancies resulting in:
- Only livebirths ☐☐
- Only stillbirths ☐☐
- Only abortions/miscarriages/ectopic/hydatiform mole ☐☐
- Livebirth & stillbirth ☐
- Livebirth & abortion/miscarriages/ectopic/hydatiform mole ☐
- Stillbirth & abortion/miscarriages/ectopic/hydatiform mole ☐
- Livebirth, stillbirth & abortion/miscarriages/ectopic/hydatiform mole ☐

TOTAL NUMBER of previous pregnancies ☐☐

METHOD OF DELIVERY OF LAST BIRTH
- Vaginal non-instrumental ☐
- Forceps ☐
- Vacuum extractor ☐
- LSCS ☐
- Classical CS ☐
- Other (specify) ☐ ____

Number of previous caesareans ☐☐

SMOKING

During the first 20 weeks of pregnancy
- Did the mother smoke? No ☐ Yes ☐
- If yes, how many cigarettes per day? ☐☐☐
- Was smoking cessation advice offered by a health care provider? No ☐ Yes ☐

After 20 weeks of pregnancy
- Did the mother smoke? No ☐ Yes ☐
- If yes, how many cigarettes per day? ☐☐☐
- Was smoking cessation advice offered by a health care provider? No ☐ Yes ☐

PRESENT PREGNANCY

LMP ____

EDC ____
by US scan/dates/clinical assessment

HEIGHT ☐☐☐ cm

WEIGHT ☐☐☐ kg
(self-reported at conception)

ANTENATAL CARE
You may tick more than one box
- No antenatal care ☐
- Public hospital/clinic midwifery practitioner ☐
- Public hospital/clinic medical practitioner ☐
- General practitioner ☐
- Private medical practitioner ☐
- Private midwife practitioner ☐

NUMBER OF VISITS
- Less than 2 ☐
- 2 - 4 ☐
- 5 - 7 ☐
- 8 or more ☐

CURRENT MEDICAL CONDITIONS
You may tick more than one box
- None ☐
- Essential hypertension ☐
- Pre-existing diabetes mellitus
  - insulin treated ☐
  - oral hypoglycaemic therapy ☐
  - other ☐
- Asthma (treated during this pregnancy) ☐
- Epilepsy ☐
- Genital herpes (active during this pregnancy) ☐
- Anaemia ☐
- Renal condition (specify) ____ ☐
- Cardiac condition (specify) ____ ☐
- Other (specify) ☐ ____

GESTATION AT FIRST ANTENATAL VISIT ☐☐ Weeks

PREGNANCY COMPLICATIONS
You may tick more than one box
- None ☐
- APH (<20 weeks) ☐
- APH (20 weeks or later) due to
  - abruption ☐
  - placenta praevia ☐
  - other ☐
- Gestational diabetes
  - insulin treated ☐
  - oral hypoglycaemic therapy ☐
  - other ☐
- PIH/PE
  - mild ☐
  - moderate ☐
  - severe ☐
- Other (specify) ☐ ____

PROCEDURES AND OPERATIONS
(during pregnancy, labour and delivery)
You may tick more than one box
- None ☐
- Chorionic villus sampling ☐
- Amniocentesis (diagnostic) ☐
- Cordocentesis ☐
- Cervical suture (for cervical incompetence) ☐
- Other (specify) ☐ ____

ULTRASOUNDS
Number of scans ☐☐

Were any of the following performed?
- Nuchal translucency ultrasound No ☐ Yes ☐
- Morphology ultrasound scan No ☐ Yes ☐
- Assessment for chorionicity scan No ☐ Yes ☐

ASSISTED CONCEPTION
Was this pregnancy the result of assisted conception? No ☐ Yes ☐

If yes, indicate method/s used
- AIH / AID ☐
- Ovulation induction ☐
- IVF ☐
- GIFT ☐
- ICSI (intracytoplasmic sperm injection) ☐
- Other (specify) ☐ ____

LABOUR AND DELIVERY

INTENDED PLACE OF BIRTH AT ONSET OF LABOUR
- Hospital ☐
- Birthing centre ☐
- Home ☐
- Other ☐ ____

ACTUAL PLACE OF BIRTH OF BABY
- Hospital ☐
- Birthing centre ☐
- Home ☐
- Other (BBA) ☐ ____

ONSET OF LABOUR
Tick one box only
- Spontaneous ☐
- Induced ☐
- No labour (caesarean section) ☐

Methods used to induce labour or augment labour?
You may tick more than one box
- Artificial rupture of Membranes (ARM) ☐
- Oxytocin ☐
- Prostaglandins ☐
- Other (specify) ☐ ____

If labour induced
Reason for induction ____

MEMBRANES RUPTURED
____ days ____ hours ____ mins before delivery

LENGTH OF LABOUR (hours / minutes)
- 1st stage ____
- 2nd stage ____

PRESENTATION AT BIRTH
Tick one box only
- Vertex ☐
- Breech ☐
- Face ☐
- Brow ☐
- Transverse/shoulder ☐
- Other (specify) ☐ ____

METHOD OF BIRTH
Tick one box only
- Vaginal non-instrumental ☐
- Forceps ☐
- Vacuum extractor ☐
- LSCS ☐
- Classical CS ☐
- Other (specify) ☐ ____

WATER BIRTH
Was this a water birth? No ☐ Yes ☐

If yes, was the water birth
- Unplanned ☐
- Planned ☐

REASON FOR FORCEPS/VACUUM ____

REASON FOR CAESAREAN ____

Cervical dilation prior to caesarean
- 3cm or less ☐
- More than 3cm ☐
- Not measured ☐

ANTIBIOTICS AT TIME OF CAESAREAN
Tick one box only
- None ☐
- Prophylactic antibiotics ☐
- Antibiotics before caesarean ☐

PLACENTA / CORD ____

NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY
- None ☐
- Heat pack ☐
- Birth ball ☐
- Massage ☐
- Shower ☐
- Water Immersion ☐
- Aromatherapy ☐
- Homeopathy ☐
- Acupuncture ☐
- TENS ☐
- Other (specify) ☐ ____

PRINCIPAL ACCOUCHEUR
Tick one box only
- Obstetrician ☐
- Other medical officer ☐
- Midwife ☐
- Student midwife ☐
- Medical student ☐
- Other (specify) ☐ ____

PERINEUM
Please tick the most severe
- Intact ☐
- Grazes ☐
- Lacerated
  - 1st degree ☐
  - 2nd degree ☐
  - 3rd degree ☐
  - 4th degree ☐

Episiotomy? No ☐ Yes ☐

Other genital trauma ____

Surgical repair of vagina or perineum? No ☐ Yes ☐

PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY
- None ☐
- Nitrous oxide ☐
- Systemic opioid (incl. narcotic (IM/IV)) ☐
- Epidural ☐
- Spinal ☐
- Combined Spinal Epidural ☐
- Caudal ☐
- Other (specify) ☐ ____

LABOUR AND DELIVERY COMPLICATIONS
You may tick more than one box
- None ☐
- Meconium liquor ☐
- Fetal distress ☐
- Cord prolapse ☐
- Cord entanglement with compression ☐
- Failure to progress ☐
- Prolonged second stage (active) ☐
- Precipitate labour/delivery ☐
- Retained placenta with manual removal
  - with haemorrhage ☐
  - without haemorrhage ☐
- Primary PPH (500-999ml) ☐
- Primary PPH (=>1000ml) ☐
- Other (specify) ____ ☐

- CTG in labour? No ☐ Yes ☐
- FSE in labour? No ☐ Yes ☐
- Fetal scalp pH? No ☐ Yes ☐
- Fetal scalp pH result → ☐.☐
- Lactate? No ☐ Yes ☐
- Lactate result → ☐☐.☐

ANAESTHESIA FOR DELIVERY
- None ☐
- Epidural ☐
- Spinal ☐
- Combined Spinal Epidural ☐
- General Anaesthetic ☐
- Local to perineum ☐
- Pudendal ☐
- Caudal ☐
- Other (specify) ____ ☐

MR63D HSIC-DATA COLLECTIONS UNIT JULY 2010

BABY

For multiple births complete one form per baby

BABY'S UR No.

DATE OF BIRTH

INDIGENOUS STATUS - BABY
- Aboriginal
- Torres Strait Islander
- Aborig. & Torres Str. Is.
- Neither Aboriginal nor Torres Str. Isl

TIME OF BIRTH ____ hours

BIRTHWEIGHT ____ grams

GESTATION ____ weeks ____ days
(clinical assessment at birth)

HEAD CIRCUMFERENCE AT BIRTH ____ . ____ cm

LENGTH AT BIRTH ____ . ____ cm

PLURALITY
- Single
- Twin I
- Twin II
- Other (Specify)

SEX
- Male
- Female
- Indeterm.

BIRTH STATUS
- Born alive
- Stillborn
- – macerated No Yes

APGAR SCORE

	1 min	5 mins
Heart rate		
Respiratory effort		
Muscle tone		
Reflex irritability		
Colour		
TOTAL		

REGULAR RESPIRATIONS ____ minutes
- OR At birth
- OR Intubated/Ventilated
- OR Respirations not established

RESUSCITATION
You may tick more than one box
- None
- Suction (oral, pharyngeal etc)
- Suction of meconium (oral, pharyngeal etc)
- Suction of meconium via ETT
- Facial O_2
- Bag and mask
- IPPV via ETT
- Narcotic antagonist injection
- External cardiac massage
- Other (specify include drugs)

Urine

Meconium

Cord pH? No Yes

Cord pH value ____ . ____

BE ____

VITAMIN K
(first dose)
- Oral
- IM
- None

HEPATITIS B
(birth dose vaccination)
No Yes

POSTNATAL DETAILS

BABY
NEONATAL MORBIDITY
- None
- Jaundice → Diagnosis
- Respiratory distress → Diagnosis
- Hypo/Hyperglycaemia or Normal → Results
- Neonatal abstinence syndrome → Drug name
- Infection → Diagnosis
- Other (specify) →

NEONATAL TREATMENT
- None
- Oxygen for > 4 hours
- Phototherapy
- IV/IM antibiotics
- IV fluid
- Mechanical ventilation
- Blood glucose monitoring
- CPAP
- Oro / naso gastric feeding
- Other treatment

Was baby admitted to ICN/SCN? No Yes

If yes, how many days was baby admitted to:
- ICN (days)
- SCN (days)

Main reason for admission to ICN/SCN

CONGENITAL ANOMALY
No Yes Suspected

If yes or suspected enter details below or in the Congenital Anomaly section.

DISCHARGE DETAILS

MOTHER
PUERPERIUM COMPLICATIONS
You may tick more than one box
- None
- Haemorrhoids
- Wound infection
- Anaemia
- Dehiscence/disruption of wound
- Febrile
- UTI
- Spinal headache
- Secondary PPH
- Other (specify)

THROMBOPROPHYLAXIS FOLLOWING CAESAREAN
You may tick more than one box
- None
- Pharmacological Thromboprophylaxis
- Intermittent Calf Compression
- Other (specify)

PUERPERIUM PROCEDURES AND OPERATIONS
You may tick more than one box
- None
- Blood Patch
- Blood Transfusion
- D & C
- Other (specify)

- Discharged
- Transferred
- Died
- Remaining in

Place of Transfer

Date

Early Discharge Program No Yes

BABY
Neonatal Screening

Discharge weight ____ grams

- Discharged
- Transferred
- Died
- Remaining in

Place of transfer

Date

TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE
You may tick more than one box
- Breast milk/colostrum
- Infant formula
- Water, fruit juice or water-based products
- Nil by mouth

TYPES OF FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE.
You may tick more than one box
- Breast milk/colostrum
- Infant formula
- Water, fruit juice or water-based products
- Nil by mouth

ALTERNATE FEEDING METHOD
You may tick more than one box
- None
- Bottle
- Cup
- Syringe
- Other (specify)

CONGENITAL ANOMALY/MORBIDITY DATA

B. Indicate by shading or marking the appropriate diagram(s) the anatomical site(s) affected by congenital anomaly(ies).

Medical Practitioner's Signature ....

Surname (BLOCK LETTERS) ....

Designation ....

Date / /

Additional Congenital Anomaly description or details.

OFFICE USE ONLY

ELECTRONIC FILE FORMAT

PERINATAL DATA COLLECTION FILE FORMAT

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

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. 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|20110701|20110731|20110901|201107|
M|N|00102374|20110701|.........
C|N|00102374|20110701|C|02~~~|
C|N|00102374|20110701|C|19~~~|
C|N|00102374|20110701|M|B373~~~|
C|N|00102374|20110701|M|E669~~~|
C|N|00102374|20110701|P|O440~~~|
C|N|00102374|20110701|P|O16~~~~|
C|N|00102374|20110701|L|03|
C|N|00102374|20110701|A|06|
C|N|00102374|20110701|E|ATDOCTOR UNAVAILABLE|
B|N|00102374|20110701|1|..........
D|N|00102374|20110701|1|I|1~~~~|
D|N|00102374|20110701|1|A|05~~~|
D|N|00102374|20110701|1|F|1|
D|N|00102374|20110701|1|D|1|
D|N|00102374|20110701|1|B|02|
D|N|00102374|20110701|1|G|1|
M|N|00102381|20110701|.........
C|N|00102381|20110701|M|0212~~~|
C|N|00102381|20110701|O|1370601|
B|N|00102381|20110701|1|..........
D|N|00102381|20110701|1|M|D649~|
D|N|00102381|20110701|1|P|O721~|
D|N|00102381|20110701|1|F|1|
D|N|00102381|20110701|1|D|1|
B|N|00102381|20110701|2|..........
D|N|00102381|20110701|2|C|Q3511322|
D|N|00102381|20110701|2|M|P288~|
D|N|00102381|20110701|2|N|04|
D|N|00102381|20110701|2|F|1|
D|N|00102381|20110701|2|D|1|
D|N|00102381|20110701|2|D|2|
D|N|00102381|20110701|2|E|CALADD'S BANDS|
D|N|00102381|20110701|2|B|01|
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, THE 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 2011 is being prepared. The extract period is selected as occurring from 01/07/2011 to 31/07/2011, and the nominal monthly period for the File Header should be input as 201107 (July 2011). 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 (eg 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 9302=New Zealand 9399=overseas 9799=at sea 9989=no fixed address 0989=not stated/unknown	Validated against National Localities Index postcodes and supplementary codes Must not be blank

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
Statistical local area	4 num Right adjusted and zero filled from left	Statistical Local Area of usual residential address of the mother (corresponding to the NLI). Supplementary codes: 9301=Papua New Guinea 9302=New Zealand 9399=Overseas – other (not PNG or NZ) 9799=At sea 9899=Australian External Territories 9989=no fixed address 0989=not stated/unknown May be blank	May be blank Validated against National Localities Index SLA codes and supplementary codes Validated against postcode and locality of usual residence

Transferred antenatally flag	1 num	Patient transferred antenatally including transfers from planned home births to hospital, birthing centre to acute care etc. 1=not transferred antenatally 2=transferred antenatally 9=not stated or unknown	Must be 1, 2 or 9 Must not be blank
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: 00991=Gold Coast 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 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
Number of antenatal visits	1 num	Number of antenatal visits this pregnancy. 1=less than 2 3=2-4 4=5-7 5=8 or more 9=not stated/unknown	Validated against list of number of antenatal visit codes Must not be blank If antenatal care type=03 then antenatal visits>=3 If antenatal care flag= 1 then antenatal visits=1

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 9=not stated/unknown	Validated against list of separation types Must not be blank

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: 00991=Gold Coast 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 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 (ie 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 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 moles	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 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

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 1=no morphology ultrasound performed 2=morphology ultrasound performed 9=no morphology ultrasound stated/unknown	Validated against list of morphology ultrasound codes 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

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 space filled from right.
		If Code Type = T,M,P then
		an ICD-10-AM diagnosis code up to 5 characters (do not use punctuation).
			If Code Type = T,M,P then
			Must be a valid ICD-10-AM diagnosis 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 an ICD-10-AM procedure code of 7 characters (do not use punctuation).	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
		19=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

		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 (eg hysterotomy)
		99=not stated/unknown
		
		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
			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
			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

		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	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
Reason for induction	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters indicating reason for induction. May be blank.	Must be a valid ICD-10-AM diagnosis code Must be blank if onset of labour=1 or 3 Must not be blank if onset of labour=2
Presentation at birth	1 num	Presentation of baby at birth. 1=vertex 2=breech 3=other cephalic 4=face 5=brow 7=transverse/shoulder 8=other (eg oblique/hand etc) 9=not stated/unknown	Validated against list of presentation codes Must not be blank
Filler (Previously analgesia flag)	1	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
Reason for Caesarean	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate 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
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

Perineum	1 num	Condition of perineum following delivery. 1=intact 2=1st degree laceration 3=2nd degree laceration 4=3rd degree laceration 5=4th degree laceration 6=episiotomy only 7=perineal grazes 9=not stated/unknown	Validated against list of perineum codes Must not be blank Must be 1 if onset of labour=3 and method of birth =04 or 05
Episiotomy	1 num	Indicates if episiotomy performed. 1=no episiotomy performed 2=episiotomy performed 9=not stated/unknown	Validated against list of episiotomy codes Must be 1 if perineum=1 Must be 2 if perineum=6 (Can be 1/2/9 if perineum = 2/3/4/5/9) Must not 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 2=twins 3=triplets etc Valid range 1-8 9=not stated/unknown	Must not be blank Must be less than 10 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. 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
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: 00991=Gold Coast 00994=RBWH 00995=Mackay 00989=Townsville 00990=Toowoomba 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 2=more than 3cm 3=not measured May be blank	Validated against list of cervical dilatation codes 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 May be blank	If Water birth flag = 2 then must not be blank If Water birth flag = 1 then must be blank May be blank

Volume	1 num	The volume of PPH loss 1=500 – 999mls 2=>1000mls 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

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	Must be I, A, S, R, T, L, C, M, P, N, F, D, E ,

		A=Pharmacological Analgesia S=Anaesthesia R=Resuscitation 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	B or G

Baby's birth code	5 char
	Left adjusted and space filled from right.
	
	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 = L,P,M then
		an ICD-10-AM diagnosis code up to 5 characters
		
		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
			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 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

		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 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 = 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 a 2 digit code for pharmacological Analgesia: 02=nitrous oxide	If Code Type = A then Validated against list of pharmacological analgesia codes Record must not exist if pharmacological analgesia flag=1 or 9

		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
		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
		
		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
			Record must exist if pharmacological analgesia flag=2
			
			If Code Type = S then
			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
			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

		99=not stated/unknown
		
		If Code Type = T then
		A 2 digit code for Neonatal Treatment:
		02=oxygen for >4 hours
		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
		98=other
		99=not stated/unknown
			If Code Type = T then
			Validated against list of Neonatal treatment codes
			Record must not exist if neonatal treatment flag=1 or 9
			Record must exist if neonatal treatment flag=2
			
			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 A 1 digit code for the type of fluid the baby received during the 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	If Code Type = F then Validated against a list of type of fluid the baby received during 24 hours prior to 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
		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
		If Code Type = E then A 2 character extra text identifier	If Code Type = E then First 2 letters validated against list of Extra Text identifiers

		followed by up to 120 characters of text
		Extra text identifiers:
		RI=Reason induction
		FV=Reason forceps/vacuum
		RC=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
		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
		8=Other thromboprophylaxis
		9=Not stated/Unknown
			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
			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

EXAMPLES OF CONDITIONS TO REPORT

MEDICAL CONDITIONS

The following is a list of examples of medical conditions, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

Abnormal Papanicolaou smear
AIDS
Alcoholism
Anaemia (pre-existing)
Anomalies of the reproductive system – please specify
Appendicitis
Asthma
Cardiac conditions - please specify
Cervical dysplasia, eg CIN I, II etc
Coagulation disorders – please specify
Cystic Fibrosis
Diabetes mellitus (pre-existing) - Specify if insulin, oral hypoglycaemic agent or other treated
Domestic violence (physical, emotional, threatened, etc)
Drug abuse – dependent, non-dependent (specify which drug/s)
Epilepsy
Essential hypertension
Fracture of coccyx/sacrum or pelvis
Gastrointestinal disorders – please specify, eg Crohn's Disease, Cholecystitis
Hepatitis – Specify type and infection status (eg A, B, C, carrier, infectious).
Hyperthyroidism
Hypothyroidism
Infection, Streptococcus, Group B
Liver disorders– please specify
Musculoskeletal disorders – please specify, eg Carpal Tunnel Syndrome, Back pain, Scoliosis
Obesity
Paraplegia, quadriplegia
Past history rheumatic fever
Previous infertility, eg IVF, GIFT, Clomid-induced pregnancy
Psychiatric disorders – please specify
Renal disease– please specify
Respiratory disorders– please specify
Sexually transmitted diseases – if active and affect the management of the current pregnancy (eg syphilis, gonorrhoea, chlamydia, donovaniasis, genital herpes, genital warts, etc.)
Systemic lupus erythematosus (SLE)
Thalassaemia
TORCH conditions – please specify
Urinary incontinence
Uterine disorders– please specify
Viral infections – please specify

PREGNANCY COMPLICATIONS

The following is a list of examples of pregnancy complications, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

Abdominal pain
Abnormal glucose tolerance test
Admission for social reason/assessment of pregnancy
Amnionitis, Chorioamnionitis
Anaemia (of pregnancy)
APH - 20 weeks or more
Cervical incompetence
Cephalopelvic/fetopelvic disproportion – please specify
Deep vein thrombosis
Eclampsia
False (spurious) labour
Gestational diabetes – specify if insulin, oral hypoglycaemic agent or other treated
Grand multiparity
High head at term
Hyperemesis gravidarum
Infection of genito-urinary tract
Intrauterine fetal death
Intrauterine growth retardation
Iso-immunisation - Rh, ABO
Malpresentation – please specify
Motor vehicle accident – please specify any injuries sustained in the accident
Placenta praevia – specify with or without haemorrhage, include grade or degree
Placental abruption
Pregnancy - induced hypertension/pre-eclampsia
- mild
- moderate
- severe

Polyhydramnios/Oligohydramnios
Premature labour
Premature rupture of membranes (spontaneous rupture of membranes before the onset of contractions)
Premature, prolonged rupture of membranes (pprom)
Previous caesarean section
Prolonged rupture of membranes (>24 hours)
Prolonged pregnancy
Threatened miscarriage/abortion
Threatened premature labour
Unstable lie
Vomiting in late pregnancy

PROCEDURES AND OPERATIONS

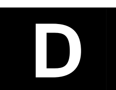
The following is a list of examples of procedures and operations, which should be recorded on the Perinatal Data Collection form. This is not a past history and only includes procedures and operations performed during the present pregnancy, labour and delivery. Note that this is not an exhaustive list.

Appendicectomy
Amniocentesis
Amnioscopy
Blood transfusion
C.A.T. scan
CTG in labour
Cervical suture
Cholecystectomy – specify open or laparoscopic
Chorionic villi sampling
Doppler studies
Drainage of abscess – specify site
External cephalic version, specify combined internal/external version
Fetal blood sampling ∓ Biopsy
FSE in labour
Intrauterine transfusion
Mechanical ventilation
Ultrasound pelvimetry

LABOUR AND DELIVERY COMPLICATIONS

The following is a list of examples of labour and delivery complications, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

Amniotic fluid embolism
Cephalo-pelvic disproportion
Cervical tear
Compound presentation
Cord entanglement
Cord presentation
Cord prolapse
Deep transverse arrest
Failed instrumental delivery – specify type
Failure to progress
Fetal distress
High head at term
Incoordinate uterine action
Intra-partum haemorrhage
Maternal pyrexia
Malpresentation – please specify
Meconium liquor
Obstructed labour
Perineal Tears (1st, 2nd, 3rd, 4th degree)
Placental abruption, specify degree
Placenta accreta
Precipitate labour/delivery
Primary post partum haemorrhage – within first 24 hours
Prolonged labour
Prolonged second stage
Prolapsed uterus
Pulmonary embolus
Retained placenta/membranes – indicate whether manual removal performed
Rupture of uterus
Septicaemia
Shoulder dystocia
Uterine scar – previous caesarean section
Vaginal haematoma
Vaginal tear



NEONATAL MORBIDITY

The following is a list of examples of neonatal morbidity conditions, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

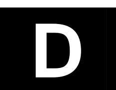
ABO incompatibility
Anaemia
Apnoea
Birth asphyxia
Birth injury/trauma eg # clavicle, cephalhaematoma
Broncho-pulmonary dysplasia
Cerebral haemorrhage
Eye infection
Feeding problem
Hydrocephalus
Hyaline membrane disease
Hyperglycaemia
Hypoglycaemia
Hypothermia
Infant of diabetic mother
Infection - specify site/organism eg septicaemia, cytomegalovirus, eye infection
Intra Uterine Growth Retardation (IUGR)
Jaundice - physiological
- ABO incompatibility
- Rhesus incompatibility
- biliary atresia etc.

Large for gestational age
Meconium aspiration
Necrotising enterocolitis
Neonatal abstinence syndrome
Physiological jaundice (only if phototherapy required)
Pneumonia
Pneumothorax
Pneumomediastinum
Polycythaemia
Pulmonary haemorrhage
Pulmonary hypertension
Respiratory distress - specify condition eg Transient tachypnoea of the newborn, Respiratory distress syndrome
Retained fetal lung fluid
Rhesus incompatibility
Seizures
Septicaemia
Small for gestation age

CONGENITAL ANOMALIES

The following is a list of examples of congenital anomalies, which should be recorded on the Perinatal Data Collection Form if they are present or suspected. Note that this is not an exhaustive list.

Chromosomal -	Trisomy 18 (Edward's syndrome) Trisomy 21 (Down's syndrome) Turner's syndrome	
Central nervous system -	Anencephaly Meningocele Spina bifida	
Alimentary -	Cleft lip and/or cleft palate Tracheo-oesophageal fistula Oesophageal atresia and/or Stenosis Hernia - umbilical, diaphragmatic	Biliary Atresia Hirschsprung's Disease Imperforate anus Gastroschisis Duodenal atresia
Genito-urinary tract -	Renal agenesis Atresia and stenosis of urethra or bladder neck Polycystic kidney(s) Exstrophy of bladder Hypospadias Indeterminate sex Undescended testes at term	
Cardio-vascular system -	Transposition of the great vessels Fallot's Tetralogy Ventricular septal defect Patent ductus arteriosus at term Coarctation of the aorta	
Skeletal -	Talipes equinovarus (club foot) Congenital dislocation of hip Phocomelia	Polydactyly Achondroplasia Syndactyly
Metabolic -	Phenylketonuria Galactosaemia Hypothyroidism Fibrocystic disease	
Muscular -	Exomphalos	



PUERPERIUM COMPLICATIONS

The following is a list of examples of puerperium complications, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

Anaemia
Baby for adoption
Breast – any disorders of the breast and lactation (specify whether with or without attachment difficulties)
eg breast engorgement
cracked nipples
suppressed lactation
Deep vein thrombosis
Eclampsia
Febrile
Haemorrhoids
Infection of genito-urinary tract
Mastitis - breast infection
Post natal depression
Post partum haemorrhage - secondary - after first 24 hours
Post-partum thyroiditis
Pregnancy induced hypertension
Puerperal psychosis
Pulmonary embolism
Pyrexia
Reaction to epidural/spinal eg headache requiring blood patch
Retained products of conception, with or without haemorrhage
Secondary post partum haemorrhage
Septicaemia
Spinal headache
Thrombophlebitis
Urinary retention
Urinary tract infections
Vaginal/vulval haematoma
Wound disruption - breakdown
- infection

PUERPERIUM PROCEDURES AND OPERATIONS

The following is a list of examples of procedures and operations that were performed during the puerperium, which should be recorded on the Perinatal Data Collection form. Note that this is not an exhaustive list.

Appendicectomy
Blood patch, spinal or epidural
Blood transfusion
C.A.T. scan
Cholecystectomy – specify open or laparoscopic
Curette (D and C) post partum
Doppler studies
Drainage of abscess – specify site
Evacuation of haematoma – specify site eg Vulva
Hysterectomy
Haemorrhoidectomy
Laparoscopy
Magnetic Resonance Imaging (MRI) of pelvis etc
Manual exploration of uterus
Manual removal of placenta
Mechanical ventilation
Resuture of perineum (following breakdown of perineal repair)
Tubal Ligation

REGISTERED NEONATAL INTENSIVE CARE UNITS AND SPECIAL CARE NURSERIES

NEONATAL INTENSIVE CARE UNITS
Gold Coast Hospital
Mater Misericordiae Women's & Children's Private Health Service
Mater Misericordiae Mother's Public Hospital
Royal Brisbane & Women's Hospital
The Townsville Hospital

SPECIAL CARE NURSERIES - Public Hospitals
Bundaberg Base Hospital
Caboolture Hospital
Cairns Base Hospital
Gold Coast Hospital
Hervey Bay Hospital
Ipswich Hospital
Logan Hospital
Mackay Base Hospital
Mater Misericordiae Mother's Public Hospital
Mount Isa Base Hospital
Nambour General Hospital
Redcliffe Hospital
Redland Hospital
Rockhampton Hospital
Royal Brisbane & Women's Hospital
The Townsville Hospital
Toowoomba Hospital

SPECIAL CARE NURSERIES - Private Hospitals
Cairns Private Hospital
John Flynn – Gold Coast Private Hospital
Mater Misericordiae Hospital (Mackay)
Mater Misericordiae Hospital (Rockhampton)
Mater Women's and Children's Hospital (Hyde Park)
Mater Misericordiae Women's & Children's Private Health Service
Nambour Selangor Private Hospital
North West Brisbane Private Hospital
Pindara Private Hospital
St Andrew's Ipswich Private Hospital
St Vincent's Hospital
Sunnybank Private Hospital
Sunshine Coast Private Hospital
The Wesley Hospital

The Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3 (CSCF v3.0) has been developed as a result of a comprehensive review of version 2.0 (released in 2005). A 12 month transition period is planned as part of the roll out of CSCF v3.0. The responsibility for implementing, monitoring, complying with and notifying changes in service levels in public health facilities will rest with District Chief Executive Officers.

Please direct any queries regarding the CSCF v3.0 and licensing within the private health sector to Private_Health@health.qld.gov.au or contact Private Health Regulatory Unit, Queensland Health on: 07 3328 9048.

Please direct any other queries regarding the CSCF v3.0 to CSCF@health.qld.gov.au or Access Improvement Services, Centre for Healthcare Improvement, Queensland Health on: 07 3237 1469.

The full document can be found at the following web address:http://www.health.qld.gov.au/cscf/