

Commonly requested data items

Data item	Comments	Required	Justification
Linkage variables (baby and mother details, as applicable)			
Facility ID	For linkage, can be supplied upon request, see below.		
UR number	For linkage only, not to be released to the researcher.		
Full name	For linkage only, not to be released to the researcher.		
Date of birth	For linkage only, not to be released to the researcher.		
Sex	For linkage, can be supplied upon request, see below.		
Address	For linkage only, not to be released to the researcher.		
Episode information			
Facility ID	Private facility IDs will be supplied as 99999/'Private', home deliveries as 'Home'		
Facility type	Public acute, birthing centre, private, home birth etc.		
Episode start date (mother)	Admission date DDMMYYYY (requires strong justification)		
	Admission date MMYYYY		
	Admission year YYYY		
Episode end date (mother)	Separation date DDMMYYYY (requires strong justification)		
	Separation date MMYYYY		
Length of stay (mother)	Length of stay in days (usually capped at 30 days unless strong justification)		
Date of birth (baby)	Date of birth DDMMYYYY (requires strong justification)		
	Month and year of birth MMYYYY		
	Year of birth YYYY		
Episode end date (baby)	Separation date DDMMYYYY (requires strong justification)		
	Separation date MMYYYY		
Length of stay (baby)	Length of stay in days (usually capped at 30 days unless strong justification)		
Discharge status (mother)	Whether the mother was discharged, transferred to another facility, remaining in hospital or died following the birth admission		
Discharge status (baby)	Whether the baby was discharged, transferred to another facility, remaining in hospital or died following the birth admission		

Mother demographics

Age	Age on confinement grouped in 5-year intervals, capped at <15 and 45+. If other grouping required, please provide strong justification.		
	Age on confinement (requires strong justification)		
Marital status	Never married, married/de facto, widowed, divorced/separated, not stated/unknown		
Indigenous status	Whether the mother identifies as Aboriginal and/or Torres Strait Islander, not Aboriginal/Torres Strait Islander, not stated, not known		
Country of birth (ABS Standard Australian Classification of Countries)	Detailed country of birth (requires strong justification)		
	Country of birth major groups (e.g. Oceania and Antarctica, North-West Europe, etc.)		

Baby demographics

Sex	Female, male, intersex or indeterminate, not stated/inadequately described		
Indigenous status	As nominated by parents - Aboriginal and/or Torres Strait Islander, not Aboriginal/Torres Strait Islander, not stated, not known (available from 1 July 2010)		

Clinical information – prior to delivery

Number of previous pregnancies	Includes livebirths, stillbirths, abortions, miscarriages, ectopic, and hydatiform mole. Individual counts for livebirths, stillbirths and other are also available		
	Parity (number of previous pregnancies resulting in either live birth or stillbirth)		
Number of previous caesareans	Excludes current birth. Counts number of operations, not number of babies born by caesarean		
Smoking	At any time during the pregnancy (available from 1 July 2007)		
	During the first 20 weeks of pregnancy (available from 1 July 2009)		
	After 20 weeks of pregnancy (available from 1 July 2009)		
Body Mass Index	Mother's BMI at conception (based on self-reported weight/height, capped at <18 and 40+ kg/m ²)		
Antenatal visits	Total number of antenatal visits (including all types of care) (available from 1 July 2012 – prior to this number of antenatal visits is available for categories 'Less than 2', '2 - 4' etc.)		

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Gestation at first antenatal visit	Gestation at first visit where pre-birth maternity care provided, excluding visits to confirm pregnancy and for non-pregnancy related issues (available from 1 July 2009)		
Assisted conception	Whether the pregnancy was achieved via assisted conception		
	Method(s) used to successfully assist conception for this pregnancy		
Current medical conditions	Medical conditions the mother has (pre-existing or arising during the pregnancy) that are not directly attributable to pregnancy but that may significantly affect the current pregnancy and/or the outcome (specify conditions of interest and ICD codes)		
Pregnancy complications	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy (specify conditions of interest and ICD codes)		
Procedures and operations	Medical or surgical procedures and operations performed during the pregnancy, labour or delivery (specify procedures of interest and ACHI codes)		
Clinical information – during and after delivery			
Onset of labour	How labour commenced – spontaneous, induced, no labour (caesarean section)		
Presentation at birth	Presentation of the fetus at birth – vertex, breech, face, brow, transverse/shoulder, other		
Method of birth	The method resulting in complete expulsion or extraction from the mother – vaginal non-instrumental, forceps, vacuum extractor, lower segment caesarean section, classical caesarean section, other		
Damage to the perineum	Damage to the perineum following delivery – includes degree of laceration, episiotomy etc.		
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 (specify complications of interest and ICD codes)		
Gestation	Estimated gestational age of baby in completed weeks/days		
Birthweight	First weight of the baby obtained after birth in 250 gram intervals, capped at <1000 and 4500+ unless strong justification provided		
Head circumference at birth	Head circumference of the baby at birth in centimetres, to the nearest one decimal place		

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Length at birth	Length of the baby at birth in centimetres, to the nearest one decimal place		
Plurality	The number of births (≥ 20 weeks and/or ≥ 400 grams, and livebirths) resulting from this pregnancy		
Birth status	Result of the birth – livebirth, stillbirth		
APGAR score	Numerical score used to describe the baby's condition after birth including appearance, pulse, grimace, activity and respiration		
	1-minute APGAR score		
	5-minute APGAR score		
Regular respirations	The time taken (to the nearest minute) for the baby to establish regular, spontaneous breathing		
Resuscitation	The method of resuscitation used (where applicable) – includes facial O ₂ , suction of meconium via endotracheal tube, Narcotic antagonist injection, etc.		
Neonatal morbidity	Conditions, diseases, illnesses and birth traumas experienced by the baby up to the time of discharge or when the baby reaches 28 days (specify conditions of interest and ICD codes)		
Neonatal treatment	Neonatal treatments given to the baby up to the time of discharge or when the baby reached 28 days of age (specify treatments of interest and ACHI codes)		
Admitted to Intensive Care Nursery (ICN)	Number of days baby was admitted to ICN		
Admitted to Special Care Nursery (SCN)	Number of days baby was admitted to SCN		
Reason for ICN/SCN admission	Main reason for ICN/SCN admissions (specify conditions of interest and ICD codes)		
Congenital anomaly	Congenital anomalies of the baby detected at birth or prior to separation from care (specify conditions of interest and ICD codes). If required congenital anomaly information can also be provided based on linked perinatal admitted patient and death data up to 5 years of age		
Puerperium complications	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care (specify conditions of interest and ICD codes)		

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Puerperium procedures and operations	Provided under 'Procedures and operations' above.		
Geographical information			
Facility HHS	Hospital and Health Service (HHS) area of hospital		
Patient HHS	HHS of mother's usual residence		
ARIA+	Accessibility and Remoteness Index of Australia (mother's usual residence)		
SEIFA	Socio-Economic Index for Areas based on the Index of Relative Advantage and Disadvantage (mother's usual residence)		
SA2 code	Statistical Area level 2 (SA2) of mother's usual residence – available from 1 July 2007 (back-mapped) (strong justification required)		
State of residence	Australian state of mother's usual residence (Queensland/ Other unless strong justification provided)		

Please note that a strong justification is required for release of data items that carry a higher risk of identifying an individual.

Variables used for data linkage (names and addresses) are only available on the Queensland Perinatal Data Collection from 1 July 2007. For years of data available for this data collection please refer to the [Master Linkage File coverage dates](#).

For more details about these and other data items collected on perinatal events, please refer to the [Perinatal Data Collection Manual](#). Please note that not all data items listed in the QPDC manual are available for all facilities. Please check availability with the data custodian prior to requesting any data items that are not included on the commonly requested data item list.

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