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	Generally, private facility IDs will be supplied as '99999', home deliveries='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 admission grouped in 5-year intervals, capped at 85+. If other grouping required, please provide strong justification.	☐	
	Age on admission (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 (SACC) - detailed country of birth (requires strong justification)	☐	
	Country of birth major groups (e. Oceania and Antarctica, North-west Europe)	☐	
Baby demographics			
Sex of baby	Female, male, intersex or indeterminate, not stated/inadequately described	☐	
Indigenous Status	As nominated by parents - aboriginal and/or Torres Strait Islander, not aboriginal/TSI, 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		☐	
Smoking	At any time during the pregnancy (available from 30 June 2009)	☐	
	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 measured or self-reported height and self-reported weight)	☐	
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 e.g. 'Less than 2','2 - 4' etc.)	☐	

Commonly requested data items. PLEASE NOTE: All data items are released at the discretion of the Data Custodian. Please provide a justification for each data item requested that relates back to your research questions.

	Gestation at first antenatal visit (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 (Please specify conditions of interest and ICD codes)	☐	
Pregnancy complications	Complications of the current 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 (please specify conditions of interest and ICD 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 (Please specify complications of interest and ICD codes)	☐	
Birthweight	First weight of the baby obtained after birth in grams	☐	
Gestation	Estimated gestational age of the baby in completed weeks, as determined by clinical assessment after birth. Days in addition to completed weeks also available from 1 July 2010.	☐	
Head circumference at birth	Head circumference of the baby at birth in centimetres, to the nearest one decimal place	☐	

Length at birth	Length of the baby at birth in centimetres, to the nearest one decimal place	☐	
Plurality	The total number of births (>20 weeks and/or >=400 grams) resulting from this pregnancy	☐	
Birth status	Result of the birth – live birth, 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 (please 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 (please 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 (please specify conditions of interest and ICD codes)	☐	
Congenital anomaly	Congenital anomaly(s) of the baby detected at birth or prior to separation from care (please 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 (please specify conditions of interest and ICD codes)	☐	

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Puerperium procedures and operations	Medical or surgical procedures and/or operations that were performed on the mother during the postnatal period up to the time of separation from care (please specify procedures of interest and ACHI codes)	☐	
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 (usually Qld vs 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.