

# QUEENSLAND PERINATAL DATA COLLECTION FORM

<b>MOTHER'S DETAILS</b>	PLACE OF BIRTH <input style="width: 100%;" type="text"/>	DATE OF ADMISSION (for birth) <input style="width: 100%;" type="text"/>	FAMILY NAME <input style="width: 100%;" type="text"/>	UR NO. <input style="width: 100%;" type="text"/>
	MOTHER'S COUNTRY OF BIRTH <input style="width: 100%;" type="text"/>	<b>SEROLOGY RESULTS</b>		1ST GIVEN NAME <input style="width: 100%;" type="text"/>
	INDIGENOUS STATUS <input style="width: 100%;" type="text"/>	Syphilis Screen <input style="width: 100%;" type="text"/>	2ND GIVEN NAME <input style="width: 100%;" type="text"/>	DOB <input style="width: 100%;" type="text"/>
	MARITAL STATUS <input style="width: 100%;" type="text"/>	Rubella <input style="width: 100%;" type="text"/>	USUAL RESIDENCE <input style="width: 100%;" type="text"/>	ESTIMATED DATE OF BIRTH <input style="width: 100%;" type="text"/>
ACCOMODATION STATUS OF MOTHER <input style="width: 100%;" type="text"/>	Blood group <input style="width: 100%;" type="text"/>	STATE <input style="width: 100%;" type="text"/>	POSTCODE <input style="width: 100%;" type="text"/>	
	Rh <input style="width: 100%;" type="text"/>	ANTENATAL TRANSFER No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 (include transfers from planned home birth to hospital, from birthing centre to acute care areas etc)		
	Antibodies No <input type="checkbox"/> Yes <input type="checkbox"/>	Reason for Transfer <input style="width: 100%;" type="text"/>	TIME OF TRANSFER prior to onset of labour <input type="checkbox"/> 1	
	Other <input style="width: 100%;" type="text"/>	Transferred from <input style="width: 100%;" type="text"/>	during labour <input type="checkbox"/> 2	

<b>PREVIOUS PREGNANCIES</b>	PREVIOUS PREGNANCIES None <input type="checkbox"/> 1 (go to next section)	METHOD OF BIRTH OF LAST BIRTH	ANTENATAL SCREENING Was antenatal screening for family violence performed? <input style="width: 100%;" type="text"/>	SMOKING During the first 20 weeks of pregnancy did the mother smoke? <input style="width: 100%;" type="text"/>	ALCOHOL During the first 20 weeks of pregnancy did the mother consume alcohol? <input style="width: 100%;" type="text"/>
	Number of previous pregnancies resulting in:	Vaginal non-instrumental <input type="checkbox"/> 10	Was antenatal screening for illicit drug use performed? <input style="width: 100%;" type="text"/>	If yes, how many cigarettes per day? <input style="width: 100%;" type="text"/>	If yes, how many standard drinks has the mother had on a typical day when drinking? <input style="width: 100%;" type="text"/>
	Only livebirths <input style="width: 100%;" type="text"/>	Forceps <input type="checkbox"/> 02	Was antenatal screening for EPDS performed? <input style="width: 100%;" type="text"/>	Was smoking cessation advice offered by a health care provider? <input style="width: 100%;" type="text"/>	Frequency of alcohol consumption <input style="width: 100%;" type="text"/>
	Only stillbirths <input style="width: 100%;" type="text"/>	Vacuum extractor <input type="checkbox"/> 03	What was the EPDS Score? <input style="width: 100%;" type="text"/>	After 20 weeks of pregnancy did the mother smoke? <input style="width: 100%;" type="text"/>	After 20 weeks of pregnancy did the mother consume alcohol? <input style="width: 100%;" type="text"/>
Only abortions/miscarriages/ectopic/hydatiform mole <input style="width: 100%;" type="text"/>	LSCS <input type="checkbox"/> 04			If yes, how many standard drinks has the mother had on a typical day when drinking? <input style="width: 100%;" type="text"/>	
Livebirth & stillbirth <input style="width: 100%;" type="text"/>	Classical CS <input type="checkbox"/> 05			Frequency of alcohol consumption <input style="width: 100%;" type="text"/>	
Livebirth & abortion/miscarriage/ectopic/hydatiform mole <input style="width: 100%;" type="text"/>					
Stillbirth & abortion/miscarriage/ectopic/hydatiform mole <input style="width: 100%;" type="text"/>					
Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole <input style="width: 100%;" type="text"/>					
TOTAL NUMBER OF PREVIOUS PREGNANCIES <input style="width: 100%;" type="text"/>	Number of previous caesareans <input style="width: 100%;" type="text"/>				

<b>PRESENT PREGNANCY</b>	ANTENATAL CARE <i>You may tick more than one box</i>	CURRENT MEDICAL CONDITIONS <i>You may tick more than one box</i>	IMMUNISATION Was immunisation for influenza received during this pregnancy? <input style="width: 100%;" type="text"/>	PROCEDURES & OPERATIONS (during pregnancy, labour and birth) <i>You may tick more than one box</i>	ASSISTED CONCEPTION Was this pregnancy the result of assisted conception? <input style="width: 100%;" type="text"/>
	No antenatal care <input type="checkbox"/>	None <input type="checkbox"/>	Gestation Weeks <input style="width: 100%;" type="text"/>	None <input type="checkbox"/>	If yes, indicated method/s used
	Public hospital/clinic midwifery practitioner <input type="checkbox"/> 06	Pre-existing hypertension <input type="checkbox"/> 010		Chorionic villus sampling <input type="checkbox"/> 1660300	AIH / AID / IUI <input type="checkbox"/> 02
	Public hospital/clinic medical practitioner <input type="checkbox"/> 07	Diabetes mellitus <input type="checkbox"/>		Amniocentesis (diagnostic) <input type="checkbox"/> 1660000	Ovulation induction <input type="checkbox"/> 03
General practitioner <input type="checkbox"/> 08	• Type 1 <input type="checkbox"/> 0240		Cordocentesis <input type="checkbox"/> 1660600	IVF <input type="checkbox"/> 04	
Private medical practitioner <input type="checkbox"/> 03	• Type 2 insulin treated <input type="checkbox"/> 02412		Cervical suture (for cervical incompetence) <input type="checkbox"/> 1651100	GIFT <input type="checkbox"/> 05	
Private midwife practitioner <input type="checkbox"/> 04	• Type 2 oral hypoglycaemic therapy <input type="checkbox"/> 02413		Other (specify) <input style="width: 100%;" type="text"/>	ICSI (intracytoplasmic sperm injection) <input type="checkbox"/> 07	
TOTAL NUMBER OF VISITS <input style="width: 100%;" type="text"/>	• Type 2 diet/exercise <input type="checkbox"/> 02414		ULTRASOUNDS Number of Scans <input style="width: 100%;" type="text"/>	Donor egg <input type="checkbox"/> 08	
GESTATION AT FIRST ANTENATAL VISIT <input style="width: 100%;" type="text"/> weeks	Other (specify) <input style="width: 100%;" type="text"/>		WERE ANY OF THE FOLLOWING PERFORMED?	Frozen embryo transfer/embryo transfer <input type="checkbox"/> 09	
LMP <input style="width: 100%;" type="text"/>	Asthma (treated during this pregnancy) <input type="checkbox"/> J459		Nuchal translucency ultrasound <input type="checkbox"/>	Other (specify) <input style="width: 100%;" type="text"/>	
EDC <input style="width: 100%;" type="text"/>	Epilepsy <input type="checkbox"/> G4090		Morphology ultrasound scan <input type="checkbox"/>	Primary Maternity Model of Care <input style="width: 100%;" type="text"/>	
by US scan/dates/clinical assessment <input style="width: 100%;" type="text"/>	Genital herpes (active during this pregnancy) <input type="checkbox"/>		Assessment for chorionicity scan <input type="checkbox"/>	Maternity Model of Care at onset of labour <input style="width: 100%;" type="text"/>	
HEIGHT <input style="width: 100%;" type="text"/> cm	Anaemia <input type="checkbox"/> D649				
WEIGHT <input style="width: 100%;" type="text"/> kg (self reported at conception)	Renal condition (specify) <input style="width: 100%;" type="text"/>				
	Cardiac condition (specify) <input style="width: 100%;" type="text"/>				
	Hepatitis B Active <input type="checkbox"/> B169				
	Hepatitis B Carrier <input type="checkbox"/> B181				
	Hepatitis C Active <input type="checkbox"/> B171				
	Hepatitis C Carrier <input type="checkbox"/> B182				
	Other (specify) <input style="width: 100%;" type="text"/>				

<b>LABOUR AND BIRTH</b>	INTENDED PLACE OF BIRTH AT ONSET OF LABOUR <input style="width: 100%;" type="text"/>	METHODS USED TO INDUCE LABOUR OR AUGMENT LABOUR? <i>You may tick more than one box</i>	MEMBRANES RUPTURED <input type="checkbox"/> days <input type="checkbox"/> hours <input type="checkbox"/> mins before birth	REASON FOR FORCEPS/VACUUM <input style="width: 100%;" type="text"/>	NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/BIRTH	PRINCIPAL ACCOUCHEUR <input style="width: 100%;" type="text"/>
	OTHER (SPECIFY) <input style="width: 100%;" type="text"/>	Artificial rupture of Membranes (ARM) <input type="checkbox"/> 1	LENGTH OF LABOUR	MAIN REASON FOR CAESAREAN <input style="width: 100%;" type="text"/>	None <input type="checkbox"/>	Other (specify) <input style="width: 100%;" type="text"/>
	ACTUAL PLACE OF BIRTH OF BABY <input style="width: 100%;" type="text"/>	Oxytocin <input type="checkbox"/> 2	• 1st Stage <input style="width: 100%;" type="text"/> hours <input style="width: 100%;" type="text"/> mins	1 <sup>st</sup> ADDITIONAL REASON FOR CAESAREAN <input style="width: 100%;" type="text"/>	Heat Pack <input type="checkbox"/> 02	DAMAGE TO THE PERINEUM <i>You may tick more than one box</i>
	OTHER (BBA) <input style="width: 100%;" type="text"/>	Prostaglandins <input type="checkbox"/> 3	• 2nd Stage <input style="width: 100%;" type="text"/> hours <input style="width: 100%;" type="text"/> mins	2 <sup>nd</sup> ADDITIONAL REASON FOR CAESAREAN <input style="width: 100%;" type="text"/>	Birth Ball <input type="checkbox"/> 03	None <input type="checkbox"/>
ONSET OF LABOUR <input style="width: 100%;" type="text"/>	Mechanical Cervical Dilatation <input type="checkbox"/> 6	PRESENTATION AT BIRTH <input style="width: 100%;" type="text"/>	Cervical dilation prior to caesarean <input style="width: 100%;" type="text"/>	Massage <input type="checkbox"/> 04	Graze/tear vagina, labia, vulva <input type="checkbox"/> 02	
	Antiprogesterone <input type="checkbox"/> 7	Other (specify) <input style="width: 100%;" type="text"/>		Shower <input type="checkbox"/> 05	Lacerated 1st degree <input type="checkbox"/> 02	
	Other (specify) <input style="width: 100%;" type="text"/>	METHOD OF BIRTH <input style="width: 100%;" type="text"/>		Water Immersion <input type="checkbox"/> 06	2nd degree <input type="checkbox"/> 03	
	IF LABOUR INDUCED			Aromatherapy <input type="checkbox"/> 07	3rd degree <input type="checkbox"/> 04	
	MAIN reason for induction <input style="width: 100%;" type="text"/>			Homeopathy <input type="checkbox"/> 08	4th degree <input type="checkbox"/> 05	
	1 <sup>st</sup> Additional reason for induction <input style="width: 100%;" type="text"/>			Acupuncture <input type="checkbox"/> 09	Episiotomy <input type="checkbox"/> 06	
	2 <sup>nd</sup> Additional reason for induction <input style="width: 100%;" type="text"/>			TENS <input type="checkbox"/> 10	Other genital trauma <input style="width: 100%;" type="text"/>	
				Water Injection <input type="checkbox"/> 11	Surgical repair of vagina or perineum? <input type="checkbox"/>	
				Other (specify) <input style="width: 100%;" type="text"/>		
		WATER BIRTH				
		Was this a water birth? <input type="checkbox"/>				
		If yes, was the water birth <input style="width: 100%;" type="text"/>				

**LABOUR AND BIRTH (continued)**

**PHARMACOLOGICAL ANALGESIA DURING LABOUR/BIRTH**  
 None  02  
 Nitrous oxide  08  
 Systemic opioid (incl. narcotic (IM/IV))  04  
 Epidural  05  
 Spinal  10  
 Combined Spinal-Epidural  07  
 Caudal   
 Other (specify)

**LABOUR AND BIRTH COMPLICATIONS**  
*You may tick more than one box*

None  0681  
 Meconium liquor  0689  
 Fetal distress  0690  
 Cord prolapse  0692  
 Cord entanglement with compression  0629  
 Failure to progress  0631  
 Prolonged second stage (active)  0623  
 Precipitate labour/birth

Retained placenta with manual removal  0720  
 • with haemorrhage  0730  
 • without haemorrhage  0721  
 Primary PPH (500-999ml)  0721  
 Primary PPH (1000-1499ml)  0721  
 Primary PPH (>= 1500ml)   
 Other (specify)

CTG in labour?   
 FSE in labour?   
 Fetal scalp pH?   
 Fetal Scalp pH result   
 Lactate?   
 Lactate Result

**ANAESTHESIA FOR OPERATIVE/ INSTRUMENTAL BIRTH**

None  04  
 Epidural  05  
 Spinal  10  
 Combined Spinal-Epidural General anaesthetic  06  
 Local to perineum  02  
 Pudendal  03  
 Caudal  07  
 Other (specify)

**BABY**

For multiple births complete one form per baby

BABY'S UR NO.

DATE OF BIRTH

**INDIGENOUS STATUS - BABY**

TIME OF BIRTH  hours

BIRTHWEIGHT  grams

GESTATION (clinical assessment at birth)  weeks  days

HEAD CIRCUMFERENCE AT BIRTH  cm

LENGTH AT BIRTH  cm

**PLURALITY**

Other (specify)

**SEX**

**BIRTH STATUS**

-macerated

**APGAR SCORE**

1 min  5min

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  1  
 Suction (oral, pharyngeal etc)  02  
 Suction of meconium (oral, pharyngeal etc)  03  
 Suction of meconium via ETT  04  
 Facial O<sub>2</sub>  05  
 Bag and mask  06  
 IPPV via ETT  07  
 CPAP ventilation  13  
 Intubation  14  
 Narcotic antagonist injection  08  
 External cardiac massage  09  
 Other (specify-include drugs)

Urine   
 Meconium   
 Arterial Cord pH?   
 Arterial Cord pH result   
 BE   
 VITAMIN K (first dose)   
 HEPATITIS B (birth dose vaccination)   
 HEPATITIS B IMMUNOGLOBULIN

**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  1  
 Oxygen for > 4 hours  02  
 Phototherapy  03  
 IV/IM antibiotics  04  
 IV fluid  05  
 Mechanical ventilation  06  
 Blood glucose monitoring  10  
 CPAP  11  
 Oro / naso gastric feeding  12  
 Other Treatment

Was baby admitted to ICN/SCN?

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

Main reason for admission to ICN/SCN

**CONGENITAL ANOMALY**

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

Position

Status

Was CA diagnosed antenatally?

**DISCHARGE DETAILS**

**MOTHER PUERPERIUM COMPLICATIONS**  
*You may tick more than one box*

None  0872  
 Haemorrhoids  0860  
 Wound Infection  09903  
 Anaemia  0864  
 Dehiscence/disruption of wound  0862  
 Febrile  T8852  
 UTI  0722  
 Spinal Headache   
 Secondary PPH   
 Other (specify)

**PUERPERIUM PROCEDURES AND OPERATIONS**  
*You may tick more than one box*

None  1823300  
 Blood Patch  1370601  
 Blood Transfusion  1656400  
 D & C   
 Other (specify)

**MOTHER'S DISCHARGE DETAILS**

Discharged  1  
 Transferred  2  
 Place of Transfer

Died  3  
 Remaining in  4  
 Date

Early Discharge Program

**THROMBOPROPHYLAXIS FOLLOWING CAESAREAN**  
*You may tick more than one box*

None

Pharmacological thromboprophylaxis  2  
 Intermittent Calf Compression  3  
 TED Stocking  4  
 Other thromboprophylaxis

**BABY**

**NEONATAL SCREENING**

Discharge weight  grams

Discharged  1  
 Transferred  2  
 Place of Transfer

Died  3  
 Remaining in  4  
 Date

**TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE**  
*You may tick more than one box*

Breast milk/colostrum  1  
 Infant Formula  2  
 Water, fruit juice or water based products  3  
 Nil By Mouth  4

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

Breast milk/colostrum  1  
 Infant Formula  2  
 Water, fruit juice or water based products  3  
 Nil By Mouth  4

**ALTERNATE FEEDING METHOD**  
*You may tick more than one box*

None  02  
 Bottle  03  
 Cup  04  
 Syringe   
 Other

The Queensland Perinatal Data Collection Form must be used as the approved form for the electronic submission of perinatal data to the chief executive, Queensland Health for births occurring from 1 July 2025 (inclusive).

Section 217, Public Health Act 2005, states that after a delivery the designated person must, within time prescribed under a regulation, notify the chief executive in the 'Approved Form'.