Queensland Perinatal Data Collection (QPDC) Manual

2025-2026

Version 1.0

Queensland Government

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For more information contact: Statistical Collections and Integration Unit, Statistical Services Branch, Department of Health, GPO Box 48, Brisbane QLD 4001, email PERIMAIL@health.qld.gov.au.

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

Contents

1. Introduction

This manual provides an overview for the completion of the Queensland Perinatal Data Collection (QPDC) and the data items that are collected. 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 Hospital and Health Services and Department of Health personnel who are involved in the collection and use of perinatal data.

For users completing, submitting and approving QPDC online forms, this manual should be read in conjunction with the Perinatal Online User Manual.

1.1 Requirements

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 Department of Health for every baby born in Queensland. The Queensland Perinatal Data Collection commenced in November 1986. All unit record information collected by Statistical Collections and Integration Unit is treated as strictly confidential. All information collected is used for statistical purposes only.

1.2 Australian Government Reporting Requirements

Australian Institute of Health and Welfare (AIHW)

The National Perinatal Data Collection (NPDC) is a national population-based cross-sectional data collection of pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other staff, using information obtained from mothers and from hospital or other records, complete notification forms for each birth. Information is included in the NPDC on both live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. The NPDC is compiled annually by the Australian Institute of Health and Welfare.

The Perinatal National Minimum Data Set (NMDS) is a specification for perinatal data elements for mandatory collection and reporting at the national level and depends on a national agreement to collect the data in a uniform way. This core set of data elements is agreed to and progressed by the National Perinatal Data Development Committee (NPDDC) and endorsed by the National Health Information Standards and Statistics Committee (NHISSC). The Perinatal NMDS was first specified in 1997. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth, and data items relating to the baby, including birth status, sex and birthweight. More data elements are included in the NPDC than are specified in the Perinatal NMDS. Definitions of all data elements in the Perinatal NMDS are included in the AIHW's online metadata registry, 'METeOR' .

2. The Queensland Perinatal Data Collection (QPDC)

The aims of the QPDC 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 Department of Health services. It is also intended to be a 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.

The Statistical Services Branch (SSB) releases an annual report presenting summary statistics based on the data collected via the QPDC. This report is available on QHEPS:

http://qheps.health.qld.gov.au/hsu/publications.htm

or via the following website: http://www.health.qld.gov.au/hsu/

Through 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 are also available via request, on a one off or regular basis, from the Statistical Reporting and Coordination Unit (SRCU) within SSB. 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. (Note that in some instances charges may apply – contact SRCU for further details).

2.1 Scope of the QPDC

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. These forms or extract should be forwarded to the Statistical Collections and Integration Unit within 35 days of the birth of a baby.

The quality of information produced from the QPDC 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.

2.2 MR63D PDF Forms

MR63D PDF forms are completed by a small number of hospitals and private midwifery practitioners and submitted to the QPDC in this format. The PDF 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 may create copies to be used as a summary for the patient's chart and this includes some items which are not essential for the QPDC but may be useful in hospitals.

2.3 Perinatal Online

Perinatal Online (PNO) is a web-based application, developed by SSB, which enables facilities to enter perinatal data for both the mother and the baby(s) and perform an electronic extract to SCIU to report QPDC data.

Refer to the PNO Online User Manual for information on this application.

2.4 QPDC Changes for 2025-2026

For additional information on the QPDC File Format refer to:
https://www.health.qld.gov.au/hsu/collections/pdc

Change Description	Reference Page/s in File Format
1. Update of ICD-10-AM 12th edition to ICD-10-AM 13th edition: ICD-10-AM/ACHI/ACS Thirteenth Edition will be used by all Australian States and Territories for births occurring on or from 1 July 2025. Note: This will require change to reference files in electronic systems.	**4 of 87**
2. Pregnancy – assisted conception methods – description update The reference code description for code 02 (Artificial insemination) will be updated to the following to align with Queensland Health Data Dictionary (QHDD) terminology standards and provide further reporting clarity: 02 Artificial/Intrauterine Insemination Note: This may require a change to the reference file in electronic systems.	**49 of 87**

2.4.1. QPDC Electronic File Format Changes for 2025-2026

The QPDC electronic file format has changes associated with the QPDC changes for 2025-2026, as shown in the section above.

The link to the latest Electronic File Format can be found at the following link - https://www.health.qld.gov.au/hsu/collections/pdc

2.5 QPDC Reporting Requirements

2.5.1. QPDC Reporting Timeframes

All MR63D forms or electronic extract of births must be submitted to QPDC by 35 days following the birth of the baby or reference month (e.g. for the reference month of September, QPDC forms or extracts must be submitted by 4 November).

Refer to the table below for the reporting schedule:

Reporting Period	Finalised Data Due Date All Hospitals
July	5 September
August	5 October
September	4 November
October	5 December
November	4 January
December	6 February
January	7 March (6 in a leap year)
February	4 April
March	5 May
April	6 June
May	5 July
June	4 August

2.5.2. Data Quality

The QPDC adheres to the Queensland Health Data Quality Framework[1] and the Data Quality Dimensions used to support data quality assessments as well as ongoing measurement of data quality levels. Hospitals should ensure that the following principals guide the collection and reporting of data to the Queensland Department of Health (DoH) via the Statistical Services Branch (SSB):

- Accurate
- Valid
- Reliable
- Timely
- Relevant
- Complete
- Unique

The Data Quality Dimensions assists Hospitals in defining and identifying drivers to achieve data quality. Hospitals should ensure that the data provided is complete,

[1] Queensland Health Data Quality Framework (2023). Available from <Data Quality Framework (health.qld.gov.au)> [29 April 2025]

consistent and undergoes regular validations and is of a high quality to ensure the DoH can fulfill its regulatory functions. SSB cannot accept data containing a high number of validation errors. If this is identified, SSB will contact the EVA Plus Primary User for your facility via phone and/or email. The validation errors identified must be addressed on your relevant Patient Administration System to ensure that erroneous data is not reported to SSB. Once addressed SSB will be able to accept a re-submission of data.

For private facilities, under the *Private Health Facilities Act 1999* (the Act) private facilities must comply with the requirements of the Act. In particular, the submission of reports to enable the State to give information to the Commonwealth under an agreement with the Commonwealth and prescribed under section 7(4)(c) of the *Private Health Facilities Regulation 2000* (the Regulations).

2.6 Data Definitions

The Queensland Health Data Dictionary (QHDD) is available on the Queensland Health web page. The dictionary contains data definitions from a number of sources e.g., Qld Health, the National Health Data Dictionary, and some from the HL7 standard. It catalogues many definitions in 'current' use as well as listing those endorsed as standards by Qld Health.

For more detail on any of the following data items please view the Queensland Health Data Dictionary to obtain more information about the inventory of data elements or contact the Principal Data Standards Officer, Statistical Services Branch on email DQSTD@health.qld.gov.au.

3. Mothers Details

3.1 Facility – Facility code

A valid facility code from the Corporate Reference Data System (CRDS) Facility data set maintained by Statistical Standards and Strategies Unit (SSSU), SSB.

A valid facility code from the Corporate Reference Data System (CRDS) Facility data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB).

The place of birth for electronically submitted data is provided as a facility number and is a numerical code that uniquely identifies each Queensland Health care facility. For a full list of facility numbers refer to the Queensland Hospital Admitted Patient Data Collection Manual Appendix A. https://www.health.qld.gov.au/hsu/collections/qhapdc

For hospitals using the PDF MR63D form, enter the name of the hospital where the birth occurred. For births notified by a hospital but not delivered in the hospital (e.g. 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, record the name of the private midwife practitioner in this field.

This field allows the Statistical Collections and Integration 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.

3.2 Admitted patient hospital stay - admission date

Date on which an admitted patient commences a hospital stay. For the QPDC submission record, this is the admission date for the birthing episode.

For this Collection, record the date of admission for the birth to the facility where the birth takes place or in the case of a BBA the date the mother presents to the hospital post birth. For planned home births where the baby is not admitted to a hospital, this field is not required.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY

3.3 Person - Country of Birth (SACC 2016)

The country in which a person was born.

A valid code from the Corporate Reference Data System (CRDS) Country (SACC) domain edition 2.2.1-2016, maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB).

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.

For a full list of Country of birth codes refer to the Queensland Hospital Admitted Patient Data Collection Manual Appendix E. https://www.health.qld.gov.au/hsu/collections/qhapdc

3.4 Person - Indigenous status

Whether a person identifies as being of Aboriginal or Torres Strait Islander origin. In this case, the mother.

Code	Description
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin

Code	Description
9	Not stated/unknown

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 contact the Aboriginal and Torres Strait Islander Health Division at FNHO_CORRO@health.qld.gov.au.

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 that person lives.

Given the 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.

3.5 Person - Marital status (reporting)

A person's current relationship status in terms of a couple relationship, or for those not in a couple relationship, the existence of a current or previous registered marriage.

Code	Description
1	Never married
2	Married (registered or defacto)
3	Widowed
4	Divorced
5	Separated

Code	Description
9	Not stated/unknown

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.

3.6 Admitted patient hospital stay – chargeable status of mother

Accommodation chargeable status elected by the mother on admission. This item does not indicate the insurance status of the mother.

Code	Description
1	Public
4	Private

Code	Description
9	Not stated/unknown

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

A patient who is ineligible for Medicare does not have access to hospital treatment 'free of charge'. Queensland Public Hospitals are to provide Medicare ineligible patients with a choice to be treated as a public or private patient. Different fees apply depending on the option chosen. Refer to the Queensland Health *Fees and Charges Register*.

A patient who is compensable (e.g. entitled to receive compensation for their hospital treatment) does not have access to treatment 'free of charge'. However, they do have the right to be treated either by a hospital nominated doctor ('public') or by a doctor of their choice ('private').

3.7 Serology

This field is collected via the MR63D form and/or PNO and is not mandatory, however if results reported in this field affect the management of the pregnancy, please report the associated condition in Medical Conditions or Pregnancy Complications.

Instructions	
Syphilis	Enter +/- in both fields to show Syphilis and IgG status.
Rubella	Enter immune/not immune
Blood Group	Enter blood group e.g. O/A/B/AB
Rh	Enter the Rhesus factor +/-
Antibodies	Enter the appropriate box for Yes/No.
Other	Enter a text response for any other serology results not included in the above options.

3.8 Person (name) - family name (QHAPDC, QPDC)

The part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given name.

Representational Attributes	
Datatype	Character
Representation Class	Text
Format	X[X(23)]
Minimum Character Length	1
Maximum Character Length	24

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.

3.9 Person (name) - first given name (QHAPDC, QPDC)

The person's first or most common identifying name within the family group or by which the person is uniquely socially identified.

Representational Attributes	
Datatype	Character
Representation Class	Text
Format	X[X(14)]
Minimum Character Length	1
Maximum Character Length	15

A mother may have more than one given name. If so, the mother's first given name should be recorded here. If first 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.

Some mothers may not have a family name and a given name and they have only one name by which they are known. If the patient has only one name, record it as the family name.

For HBCIS hospitals, record the one name in the family name field and record a full stop "." In the given name field. For recording of non-alphanumeric characters refer to the Health Informatics Service's Recording of non-alphanumeric characters in person and provider identification data fact sheet. Please note there are known issues with the use of forward slash (/) for name fields from which the hyphen (-) may be used instead.

3.10 Person (name) - second given name (QHAPDC, QPDC)

The person's second or least used identifying name within the family group or by which the person is uniquely socially identified.

Representational Attributes	
Datatype	Character
Representation Class	Text
Format	X[X(14)]
Minimum Character Length	1
Maximum Character Length	15

A mother may have more than one given name. If so, the mother's second given name should be recorded here. If the mother does not have a second given name, then leave this field blank.

3.11 Patient identifier (Mother UR Number)

A unique number used to identify a patient within a facility. In this case, the mother.

Representational Attributes	
Datatype	Character
Representation Class	Identification Number
Format	X(8)
Minimum Character Length	8
Maximum Character Length	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 unique number for administrative purposes it can be included.

3.12 Person - date of birth (Mother)

The date of birth of an individual. In this case, the mother.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8

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 (e.g. for unconscious mothers, use the year 1970)

Example: If a mother is admitted in 2025 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: 15061995

Although provision is made for recording an unknown date of birth (using 15/06/1970), 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.

3.13 Date – estimated mother's date of birth indicator

Indicates whether any part of the mother's date of birth (day, month, year) was intentionally estimated by a clinician.

Code	Description
E	Estimated
N	Not estimated

3.14 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 usual residential address should be recorded. Do not use a post office box address for any part of the usual residence details.

3.14.1. Person (address) – address of usual residence (QHAPDC, QPDC)

The street number and name of usual residential address of person, or equivalent in rural areas.

Representational Attributes	
Datatype	Character
Representation Class	Text
Format	X[X(39)]
Minimum Character Length	1
Maximum Character Length	40

For interstate mothers, use the street number and name of the mother's usual residence, not the address of a vacation premises or similar.

Please use a solidus ("/"), separate a flat, unit, apartment or townhouse number from the street number for example: "Unit 1/246 Main Street"

If unknown, leave this field blank.

3.14.2. Person (address) – suburb/town/locality of usual residence (QHAPDC, QPDC)

The name of the suburb/town/locality of usual residential address of person.

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 suburb/town/locality of usual residence.

Representational Attributes	
Datatype	Character
Representation Class	Text
Format	X[X(39)]
Minimum Character Length	1
Maximum Character Length	40
Permissible Values	A valid locality from the Corporate Reference Data System (CRDS) Locality data set maintained by the Statistical Services Branch. Supplementary localities: At sea New Zealand No fixed address Not stated Overseas-other Papua New Guinea Unknown

For interstate mothers, use the suburb of the mother's usual residence, not the address of a vacation premises or similar.

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

Unknown suburb/town/locality

If a suburb/town/locality is unknown (e.g. an unconscious patient is unable to provide the information), record **Unknown**. Do not leave the field blank.

Although provision is made for recording unknown, every effort should be made during the course of the admission to determine (and record) a patient's suburb/town/locality.

3.14.3. Person (address) – Australian postcode of usual residence

The postcode aligned with the suburb/town/locality of usual residence of a person.

For interstate mothers, use the postcode of the mother's usual residence, not the address of a vacation premises or similar.

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.

Representational Attributes	
Datatype	Numeric character
Representation Class	Code
Format	N(4)
Minimum Character Length	4
Maximum Character Length	4
Permissible Values	Valid postcodes from the Corporate Reference Data System (CRDS) Locality data set maintained by Statistical Services Branch.
Supplementary Values	

Code	Description
0989	Not stated/unknown
9301	Papua New Guinea
9302	New Zealand
9399	Overseas-other
9799	At sea
9989	No fixed address

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. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, Jervis Bay and Norfolk Island.

Unknown postcode

If a postcode is unknown (e.g. an unconscious patient is unable to provide the information), record code **0989 Not stated or unknown**. Do not leave the field blank.

Although provision is made for recording 0989 Not stated or unknown, every effort should be made during the course of the admission to determine (and record) a patient's postcode.

3.15 Female (pregnant) - antenatal transfer indicator

An indicator of whether the mother was transferred antenatally.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

This includes transfers from planned home births to hospital, from birthing centre to acute care area or where the mother has been transferred from a different location.

This does not include a mother who has had her antenatal care received at a health care centre where there was no intention of birthing at that health care centre.

3.16 Reason for antenatal transfer code

A code which describes the reason for the mother being transferred prior to the birth.

Record the reason for the transfer of the mother from the initial location, e.g. ‘unavailability of medical services’, ‘premature rupture of membranes’.

A valid ICD-10-AM code is permissible for reporting.

Note: When care begins in a facility with a Birth Centre and a transfer is required to the facility's Birth Suite an antenatal transfer exists. For all cases the details for the antenatal transfer are to be completed. Refer to 3.16 Reason for antenatal transfer, 3.17 Episode of care - facility referred/transferred from, code and 3.18 Time of antenatal transfer.

3.17 Episode of care – facility referred/transferred from, code (antenatal transferred from)

The identifier for the facility from which the person is transferred.

A valid facility code from the Corporate Reference Data System (CRDS) Facility data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB).

A valid facility code from the Corporate Reference Data System (CRDS) Facility data set maintained by Statistical Standards and Strategies Unit (SSSU), SSB.

The place of birth for electronically submitted data is provided as a facility number and is a numerical code that uniquely identifies each Queensland Health care facility. For a full list of facility numbers refer to the Queensland Hospital Admitted Patient Data Collection Manual Appendix A. https://www.health.qld.gov.au/hsu/collections/qhapdc

The initial place of treatment that the mother has been transferred from. For PDF MR63D forms, record the full name of the facility, including whether public or private where applicable, or where transferred from a home birth, record 'home birth'.

Note: When care begins in a facility with a Birth Centre and a transfer is required to the facility's Birth Suite an antenatal transfer exists. For all cases the details for the antenatal transfer are to be completed. Refer to 3.16 Reason for antenatal transfer, 3.17 Episode of care - facility referred/transferred from, code and 3.18 Time of antenatal transfer.

3.18 Time of antenatal transfer

Whether the mother was transferred prior to onset of labour or during labour.

Code	Description
1	Prior to onset of labour
2	During labour
9	Not stated/unknown

Note: When care begins in a facility with a Birth Centre and a transfer is required to the facility's Birth Suite an antenatal transfer exists. For all cases the details for the antenatal transfer are to be completed. Refer to 3.16 Reason for antenatal transfer, 3.17 Episode of care - facility referred/transferred from, code and 3.18 Time of antenatal transfer.

4. Previous Pregnancies

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

4.1 Female – previously pregnant indicator

Indicator of whether the female was previously pregnant.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

If the mother has had no previous pregnancies, record 'No' 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.

4.2 Female – number of previous pregnancies (all livebirth)

The total number of previous pregnancies where all outcomes were livebirths.

A value in the range 0-98.

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in only livebirths.

4.3 Female – number of previous pregnancies (all stillbirth)

The total number of previous pregnancies where all outcomes were stillbirths.

A value in the range 0-98.

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in only stillbirths.

4.4 Female – number of previous pregnancies (all abortions/miscarriages/ectopics/hydatidiform moles)

The total number of previous pregnancies where all outcomes were only abortions/miscarriages/ectopics/hydatidiform moles.

A value in the range 0-98.

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in only abortions/miscarriage/ectopic /hydatidiform moles.

4.5 Female – number of previous pregnancies (livebirth and stillbirth combination)

The total number of previous pregnancies where all outcomes resulted in a combination of only livebirth and stillbirth.

Valid range 00-20

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only livebirth and stillbirth.

4.6 Female – number of previous pregnancies (livebirth and abortion/miscarriage/ectopic /hydatidiform mole combination)

The total number of previous pregnancies where all outcomes resulted in a combination of only livebirth and abortion/miscarriage/ectopic /hydatidiform mole.

Valid range 00-20

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only livebirth and abortion/miscarriage/ectopic /hydatidiform mole.

4.7 Female – number of previous pregnancies (stillbirth and abortion/miscarriage/ectopic /hydatidiform mole combination)

The total number of previous pregnancies where all outcomes resulted in a combination of only stillbirth and abortion/miscarriage/ectopic /hydatidiform mole.

Valid range 00-20

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only stillbirth and abortion/miscarriage/ectopic/hydatidiform mole.

4.8 Female – number of previous pregnancies (livebirth, stillbirth and abortion/miscarriage/ectopic /hydatidiform mole combination)

The total number of previous pregnancies where all outcomes resulted in a combination of livebirth and stillbirth and abortion/miscarriage/ectopic /hydatidiform mole.

Valid range 00-20

Code	Description
99	Not stated/unknown

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of livebirth and stillbirth and abortion/miscarriage/ectopic/hydatidiform mole.

4.9 Female - total number of previous pregnancies

The actual number of pregnancies must be recorded, even if that number is zero.

Valid range 00-20

Code	Description
99	Not stated/unknown

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.

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

4.10 Female – method of birth of last birth indicator

Indicates whether there are birth methods for the last birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

4.11 Female – method of birth of last birth indicator

The method of complete expulsion or extraction from its mother of a product of conception for the last birth.

Code	Description
02	Forceps
03	Vacuum extractor
04	Lower Segment Caesarean Section (LSCS)
05	Classical Caesarean Section (CCS)
10	Vaginal - non instrumental

Code	Description
99	Not stated/unknown

Record the method of birth of the last birth. If a previous multiple pregnancy resulted in two or more different outcomes (e.g. Vaginal non-instrumental and LSCS), report both. This should be further clarified by noting in this section that a multiple pregnancy occurred.

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 report 'LSCS'.

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

4.12 Female - number of previous caesarean sections

The number of previous caesarean sections performed on the woman.

Valid range 00-15

Code	Description
99	Not stated/unknown

In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born. Exclude the current birth if by caesarean section.

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

5. Present Pregnancy

For antenatal screening additional information refer to The Department of Health - Maternity Services.

https://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-pdb-maternity

Note: If the mother has had no antenatal care provided during the pregnancy, then the response to the Antenatal Screening questions must be 'No'. If the mother is screened at her first presentation to hospital for birth of the baby this is not included as an antenatal care visit.

5.1 Pregnancy – antenatal screening performed for family violence indicator

An indicator of whether a female has received family violence screening during the antenatal stage of the pregnancy.

Code	Description
1	Not Offered
3	Yes
2	Declined
9	Not stated/inadequately described

Record the response that corresponds to the mother's antenatal screening status for family violence.

Family violence has become a significant policy priority across Australia. The term 'Family Violence' has replaced 'Domestic Violence' in keeping with clinical practice guidelines. Family violence is the preferred term used to identify experiences of violence as it encompasses the broad range of extended family and kinship relationships in which violence may occur.

Violence poses serious health risks to pregnant women (including breast and genital injury, miscarriage, antepartum haemorrhage and infection, blunt or penetrating abdominal trauma and death) and babies (including fetal fractures, low birth weight, injury, suppressed immune system). Women exposed to violence are more likely to have a miscarriage, stillbirth, premature birth or termination of pregnancy than other women. Women exposed to violence during pregnancy are more likely to develop depression in the postnatal period.

5.2 Pregnancy – antenatal screening performed for illicit drug use indicator

An indicator of whether screening for illicit drug use was performed during the antenatal stage of the pregnancy.

Code	Description
1	Not Offered
3	Yes
2	Declined
9	Not stated/inadequately described

Record the response that corresponds to the mother's antenatal screening status for illicit drug use.

Use of amphetamines, opiates and marijuana is associated with preterm birth. Illicit drugs include illegal drugs (such as cannabis, opiates, and certain types of stimulants), pharmaceutical drugs (such as pain-killers and tranquilisers) when used for non-medical purposes, and other substances used inappropriately (such as inhalants).

5.3 Pregnancy – antenatal screening Edinburgh Postnatal Depression Scale (EPDS) indicator

Indicates if Edinburgh Postnatal Depression Scale (EPDS) was assessed as part of antenatal screening during the pregnancy.

Code	Description
1	Not Offered
3	Yes
2	Declined
9	Not stated/inadequately described

Detecting symptoms of depression and anxiety during pregnancy relies on clinical judgement and experience. Use of the EPDS complements this process. The aim is not to form a diagnosis, but to identify women who may benefit from further follow up.

5.4 Pregnancy – antenatal screening Edinburgh Postnatal Depression Scale (EPDS) Score

The score for the Edinburgh Postnatal Depression Scale (EPDS) assessed as part of antenatal screening during the pregnancy.

A valid value in the range: 00-30, 98 and 99	
Code	**Description**
98	Unknown
99	Not Stated

The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a pregnant woman has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. (Beyond Blue: http://www.beyondblue.org.au/resources/for-me/pregnancy-and-early-parenthood/edinburgh-postnatal-depression-scale).

5.5 Female - influenza vaccine administered during pregnancy indicator

An indicator of whether an influenza vaccine was administered to the pregnant woman during the pregnancy. An influenza vaccine may be administered at any stage of the pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

Pregnant women who contract influenza are up to three times more likely to be hospitalised or die compared with their non-pregnant female peers. Influenza vaccine for pregnant women is fully funded and provided free of charge as part of the National Immunisation Program – a program joint funded by the Commonwealth and State and Territory Governments.

5.6 Female – gestational age when influenza vaccine administered, completed weeks

The number of weeks of pregnancy when the influenza vaccine was administered to the pregnant woman, in completed weeks.

Vald range 01-45

Code	Description
99	Not stated/unknown

5.7 Female - pertussis vaccine administered during pregnancy indicator

An indicator of whether a pertussis vaccine was administered to the pregnant woman during the pregnancy. A pertussis vaccine may be administered at any stage of the pregnancy. Pertussis is also known as whooping cough.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

Infants who contract pertussis in the first few weeks of life have a much higher risk of severe disease and death. The Immunisation Schedule Queensland 2025 Adolescents and Adults includes a funded program for maternal pertussis vaccination.

5.8 Female – gestational age when pertussis vaccine administered, completed weeks

The number of weeks of pregnancy when the pertussis vaccine was administered to the pregnant woman, in completed weeks.

Vald range 01-45

Code	Description
99	Not stated/unknown

5.9 Female – tobacco smoking in the first 20 weeks of pregnancy indicator

An indicator of whether a female smoked tobacco during the first 20 weeks of pregnancy.

Code	Description
1	No
2	Yes
3	Declined to answer

Code	Description
9	Not stated/inadequately described

Tobacco cigarette smoking refers to tobacco delivered to the user in the form of a cigarette and does not include pipes or cigars.

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

5.10 Female (pregnant) – number of tobacco cigarettes smoked per day during the first 20 weeks of pregnancy

The total number of cigarettes usually smoked daily by a female during the first 20 weeks of pregnancy until the birth.

Code	Description
001-997	Valid range

Code	Description
998	Occasional tobacco cigarette smoking (less than one)
999	Not stated/Inadequately described

5.11 Female (pregnant) – advice given (tobacco cigarette smoking cessation) during the first 20 weeks of pregnancy indicator

An indicator of whether a pregnant woman was given tobacco cigarette smoking cessation advice from a health care provider during the first 20 weeks of pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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

5.12 Female – tobacco smoking after 20 weeks of pregnancy indicator

An indicator of whether a female smoked tobacco after 20 weeks of pregnancy until the birth.

Code	Description
1	No
2	Yes
3	Declined to answer

Code	Description
9	Not stated/inadequately described

Tobacco cigarette smoking refers to tobacco delivered to the user in the form of a cigarette and does not include pipes or cigars.

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

5.13 Female - number of tobacco cigarettes smoked per day after 20 weeks of pregnancy

The total number of cigarettes usually smoked daily by a female after 20 weeks of pregnancy until the birth.

Code	Description
001-997	Valid range

Code	Description
998	Occasional tobacco cigarette smoking (less than one)
999	Not stated/Inadequately described

5.14 Female (pregnant) – advice given tobacco cigarette smoking cessation) after 20 weeks of pregnancy indicator

An indicator of whether a pregnant woman was given tobacco cigarette smoking cessation advice from a health care provider after 20 weeks of pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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

5.15 Alcohol

High-level and/or frequent intake of alcohol in pregnancy increases the risk of miscarriage, stillbirth and premature birth. Alcohol crosses the placenta and nearly equal concentrations in the mother and fetus can be attained. Exposure of the fetus to alcohol may result in a spectrum of adverse effects, referred to collectively as fetal alcohol spectrum disorders (FASD).

5.16 Female - alcohol consumption in the first 20 weeks of pregnancy indicator

An indicator of whether a female consumed alcohol in the first 20 weeks of pregnancy.

Code	Description
1	No
2	Yes
3	Declined to answer

Code	Description
9	Not stated/inadequately described

This data item is self-reported and to ensure consistency of results, this data element should be collected after the first 20 weeks of pregnancy.

5.17 Female - number of standard drinks consumed on a typical day when drinking alcohol in the first 20 weeks of pregnancy

The total number of standard drinks consumed on a typical day when drinking alcohol by a female in the first 20 weeks of pregnancy.

A valid value between 001-997

Code	Description
998	Occasional drinking (less than one)
999	Not stated/inadequately described

Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the national Health and Medical Research Council (NHMRC) 2009 guidelines.

This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council (NHMRC) 2009 guidelines, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

5.18 Female - alcohol consumption frequency in the first 20 weeks of pregnancy

The frequency of alcohol consumption by a female in the first 20 weeks of pregnancy.

Code	Description
1	Monthly or less
2	2-4 times a month
3	2-3 times a week
4	4 or more times a week

Code	Description
9	Not stated/inadequately described

This data item is self-reported and to ensure consistency of results, this data element should be collected after the first 20 weeks of pregnancy.

5.19 Female - alcohol consumption after 20 weeks of pregnancy indicator

An indicator of whether a female consumed alcohol after 20 weeks of pregnancy until the birth.

Code	Description
1	No
2	Yes
3	Declined to answer

Code	Description
9	Not stated/inadequately described

This data item is self-reported and to ensure consistency of results, this data element should be collected after the birth.

5.20 Female - number of standard drinks consumed on a typical day when drinking alcohol after 20 weeks of pregnancy

The total number of standard drinks consumed on a typical day when drinking alcohol by a female after 20 weeks of pregnancy.

A valid value between 001-997

Code	Description
998	Occasional drinking (less than one)
999	Not stated/inadequately described

Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the National Health and Medical Research Council (NHMRC) guidelines.

This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the NHMRC, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

5.21 Female - alcohol consumption frequency after 20 weeks of pregnancy

The frequency of alcohol consumption by a female after 20 weeks of pregnancy until the birth.

Code	Description
1	Monthly or less
2	2-4 times a month
3	2-3 times a week
4	4 or more times a week

Code	Description
9	Not stated/inadequately described

This data item is self-reported and to ensure consistency of results, this data element should be collected after the birth.

5.22 Pregnancy – last menstrual period estimated indictor

Indicates whether any part of the date (day, month or year) of the mother's last menstrual period (LMP) was intentionally estimated by a clinician.

Code	Description
E	Estimated
N	Not estimated

5.23 Pregnancy – first day of the last menstrual period

Date of the first day of the mother's last menstrual period.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8

If the date of the LMP is unknown leave the field blank/null. 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.

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. A value of E should then be reported in the LMP estimated indicator field.

5.24 Pregnancy – estimated date of confinement estimated indicator

Indicates whether any part of them mother's estimated date of confinement (day, month or year) was intentionally estimated by a clinician

Code	Description
E	Estimated
N	Not estimated

5.25 Female (pregnant) – estimated date of confinement

Estimated date of confinement as indicated by ultrasound scan, date of last menstrual period or clinical assessment.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8

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. A value of E should then be reported in the EDC estimated indicator field.

5.26 Person – height (self-reported), total centimetres

A person's height, measured in centimetres.

Valid height range: 100cm - 250cm

Code	Description
999	Not stated/unknown

Record the mother's height in total centimetres (round down if required).

Height will be used in conjunction with self-reported weight for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

5.27 Person - weight (self-reported), total kilograms

A person's self-reported weight (body mass).

Valid weight range: 35kg - 200kg

Code	Description
999	Not stated/unknown

Record the mother's weight in total kilograms (round down if required). 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.

5.28 Pregnancy - antenatal care indicator

Indicator of whether antenatal care was received for the current pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

5.29 Pregnancy - antenatal care type

The type of service provider delivering the antenatal care during the pregnancy.

Code	Description
03	Medical practitioner - private - specialist
04	Midwifery practitioner - private
06	Midwifery practitioner - public hospital/clinic
07	Medical practitioner - public hospital/clinic
08	Medical practitioner - Private - general practitioner

Code	Description
99	Not stated/unknown

More than one may be reported to indicate the different antenatal care service provider types providing care during the pregnancy. If the mother received no antenatal care, then No should be reported in the antenatal care indicator field.

5.30 Female - number of antenatal care visits

The total number of antenatal care visits attended by a pregnant female.

Must be a value between 001 and 999.

Code	Description
999	Not stated/unknown

If more than one type of antenatal care has been provided, report the total number of visits for the pregnancy, not just those provided at the reporting facility.

The number of antenatal care visits is an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants.

Receiving antenatal care at least four times, as recommended by World Health Organization (WHO), increases the likelihood of receiving effective maternal health interventions during antenatal visits (WHO 2015).

5.31 Pregnancy – estimated duration (at the first visit for antenatal care), completed weeks

The estimated duration of a pregnancy in total completed weeks, on the day of the first visit for antenatal care.

Valid range 00 - 46

Code	Description
99	Not stated/unknown

The date of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided and documentation entered relating to that visit on the antenatal record of patient's pregnancy and/or birth.

It does not include a visit where the sole purpose of contact is to confirm the pregnancy, or those contacts that occurred during the pregnancy that related solely to non-pregnancy related issues. Nor does it include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of blood or tissue for pathology testing. An exception to this rule is made when the health professional performing the procedure or test is a clinician or midwife and the visit directly relates to this pregnancy and the health and wellbeing of the fetus.

It does not include a first contact after the onset of labour.

Antenatal care visits are attributed to the pregnant woman. The duration of the pregnancy on that day is the same as the gestational age of the fetus or baby on that day.

5.32 Female (pregnant) – medical condition indicator

Indicator of pre-existing diseases and conditions, 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.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

5.33 Female (pregnant) – medical condition code (ICD-10-AM 13th edn)

Pre-existing maternal diseases, conditions 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.

Such conditions are those regarded by the clinician to affect the management of the pregnancy. Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease, chronic renal disease and inhaled or ingested substances such as smoking marijuana or cocaine.

Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the fetus and perinatal morbidity.

For information on the coding of COVID-19 refer to the SSB webpage.

https://www.health.qld.gov.au/hsu/collections/pdc

There is no arbitrary limit on the number of conditions specified. A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

5.34 Pregnancy (current) – complication indicator

Indicator of complications arising up to the period immediately preceding birth that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

5.35 Pregnancy (current) – complication code (ICD-10-AM 13th edn)

Complications arising up to the period immediately preceding birth that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induces hypertension and gestational diabetes.

Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

There is no arbitrary limit on the number of complications specified. A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code within chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O99), from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

5.36 Female – procedures/operations during pregnancy, labour, birth or puerperium indicator

An indicator of whether any procedures or operations were performed on a female during the pregnancy, labour, birth or puerperium. In this case, the pregnancy, labour, birth period.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

5.37 Female – procedure/operation during pregnancy, labour, birth or puerperium code (ACHI 13th edn)

A procedure or operation performed on a female during the pregnancy, labour or birth or puerperium. In this case, the pregnancy, labour, birth period.
A valid Australian Classification of Health Interventions, (ACHI) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

Note: procedure or operations performed after the birth of the baby are reported as a puerperium procedure or operation in the postnatal section.

5.38 Total number of ultrasound scans performed

Total number of ultrasound scans performed in the current pregnancy.

Valid values between 00-50

Code	Description
99	Not stated/unknown

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) (e.g. 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 (e.g. 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.

5.39 Female (pregnant) - nuchal translucency ultrasound performed indicator

Indicates whether a nuchal translucency ultrasound was performed on the mother during the pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

A nuchal translucency ultrasound is performed during pregnancy to assess for major chromosomal abnormalities.

5.40 Female (pregnant) - morphology ultrasound performed indicator

Indicates whether an assessment for morphology ultrasound was performed on the mother during the pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

A morphology ultrasound is performed during pregnancy to allow the diagnosis of morphologic abnormalities.

5.41 Female (pregnant) - assessment for chorionicity ultrasound performed indicator

Indicates whether an assessment for chorionicity ultrasound was performed on the mother during the pregnancy.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

An assessment for chorionicity ultrasound is performed during pregnancy 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.

5.42 Pregnancy – assisted conception indicator

An indicator of whether the pregnancy was the result of assisted conception.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

5.43 Pregnancy – assisted conception method

A method used to increase the chance of conception due to an infertile or subfertile woman and/or man.

Code	Description
02	Artificial/Intrauterine Insemination
03	Ovulation induction
04	In-Vitro Fertilisation
05	Gamete Intra-Fallopian Transfer
07	Intracytoplasmic Sperm Injection
08	Donor egg
09	Embryo Transfer
19	Other

Code	Description
99	Not stated/unknown

Definitions	
AI/IUI	Artificial Insemination using either the husband or male partner's sperm or donor sperm. Includes Intrauterine Insemination (IUI), Intravaginal Insemination (IVI) or Intracervical insemination (ICI).

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 Intrafallopian Transfer: A medical procedure of transferring an egg(s) and sperm to the body of the woman. Note: Zygote Intrafallopian Transfer (ZIFT) and Pronuclear Stage Tubal Transfer (PROST) are to be reported against this data item.
ICSI	Intracytoplasmic Sperm Injection: Involves the injection of a single sperm directly into the ovum, combined with IVF.
Donor Egg	The process by which a woman donates eggs for purposes of assisted reproduction. Egg donation typically involves in vitro fertilization technology, with the eggs being fertilized in the laboratory.
Frozen embryo transfer/embryo transfer	Embryo freezing gives more opportunity for a pregnancy for each hormone stimulation cycle and egg collection. Frozen embryo and fresh embryo transfer are used in conjunction with IVF, (IVF Australia) or ICSI or GIFT.
Other	Indicate the type of method used, e.g. Assisted hatching, Blastocyst culture.

Note: When FET is reported, an accompanying method of hormone stimulation & egg collection is required such as IVF, ICSI or GIFT.

5.44 Female – primary maternity model of care identifier

The maternity model of care a female received for the majority of pregnancy care.

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNNN
Maximum character length:	6

Supplementary codes:
988888= Interstate
988899= Overseas
999994= Planned Homebirth
999997= Not applicable
999999= Not stated/ inadequately described

This value is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.

To search for a MaCCS code refer to the following website - https://maccs.aihw.gov.au/

The model of care a female received for the majority of pregnancy care, as determined by the number of antenatal visits within that model of care.

Where the number of antenatal visits is equal for more than one model of care, the referring model of care should be selected. For example, if a female was in a low-risk GP shared care model for 6 antenatal visits and then developed hypertension and pre-eclampsia and was referred to a high-risk model for 6 antenatal visits, the GP shared care should be selected for this data element.

For assistance with the MaCCS contact the AIHW via maccs@aihw.gov.au.

Refer to **Appendix A – Reporting maternity models of care examples** for reporting guidance.

5.45 Female – maternity model of care at the onset of labour or non-labour caesarean section identifier

The maternity model of care a female is under at the onset or at the time of non-labour caesarean section.

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNNN
Maximum character length:	6

Supplementary codes:
999994= Planned Homebirth
999997= Not applicable
999999= Not stated/ inadequately described

This value is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.

To search for a MaCCS code refer to the following website - https://maccs.aihw.gov.au/

For assistance with the MaCCS contact the AIHW via maccs@aihw.gov.au.

Refer to **Appendix A – Reporting maternity models of care examples** for reporting guidance.

6. Labour and Birth

6.1 Birth event - intended place of birth

The intended place of birth at the onset of labour (or immediately prior to no labour caesarean section).

Code	Description
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free-standing
4	Home
7	Freebirth
8	Other

Code	Description
9	Not stated/unknown

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.

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 (Note: all Birth Centres in Queensland are currently attached to a hospital)	A facility where women are able to birth in an environment which: • Is free-standing or physically separate from a labour ward but has access to emergency or medical facilities for both mother and child if required; and • Has home-like atmosphere; and • Focuses on a model of care (e.g. Midwifery model) which ensures continuity of care/caregiver; a family-centred approach; and informed client participation related to the management of care.
Home	Should be reserved for those births that occur at the home intended (planned home births). 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. If the mother is part of a Publicly Funded Homebirth service and intended to have her baby at home, then report 'Home' as the intended place of birth.

Freebirth	Used for births that occur in the community, that are planned outside of a medical setting and without a midwife or other medical professional in attendance, for example, free births. This code is only for use by the QPDC team.
Other	Used when birth occurs at a home other than that intended; a community health centre or for babies 'born before arrival'.

6.2 Birth event - actual place of birth

The actual place where the birth occurred.

Code	Description
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
5	Born before arrival
7	Community, non-medical (freebirth)
8	Other

Code	Description
9	Not stated/unknown

Record the response (only one) that corresponds to the actual place where the birth of the baby occurred (see below for definitions).

If the actual place of birth of the baby was other than those listed, select 'Other' and specify in the space provided.

If the baby was born inside the hospital building (Emergency Department, Outpatient Clinic, hallway, bathroom etc then this should be reported as in the Hospital.

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 'Born Before Arrival' in this field.

If the mother at the onset of labour intended to have her baby at home with a private practice midwife but actually delivered at home prior to the private practice midwife arriving, this should be reported as 'Born Before Arrival' in this field.

If the mother at the onset of labour intended to have her baby at home with a Publicly Funded Homebirth service midwife but delivered at home prior to the Publicly Funded Homebirth service midwife arriving, this should be reported as 'Born Before Arrival' in this field.

If the mother is part of a Publicly Funded Homebirth service, the actual place of birth should reflect where the birth occurred. For example, if the baby is delivered at home, report the

place of birth as 'Home'. The birth will be reported using the routine data supplied by the facility providing the Publicly Funded Homebirth Service.

If maternal or fetal indications necessitate the mother to go to the hospital, and the baby is delivered in the hospital, report the place of birth as 'Hospital'.

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.

Note: where the Intended Place of Birth at onset of Labour is not the same as the Actual Place of Birth for e.g. Intended Place of Birth at onset of Labour is a Birth Centre but the woman requires transfer to the Actual Place of Birth is hospital this is considered an antenatal transfer. Refer to 3.16 Reason for antenatal transfer, 3.17 Episode of care - facility referred/transferred from, code and 3.18 Time of antenatal transfer for more information.

If the hospital where the baby is delivered is the same as the one providing the Publicly Funded Homebirth service, an antenatal transfer does not need to be reported.

If the hospital where the baby is delivered is different from the one providing the Publicly Funded Homebirth service, an antenatal transfer must be reported.

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.

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 (Note: all Birth Centres in Queensland are currently attached to a hospital)	A facility where women are able to birth in an environment which: • Is free-standing or physically separate from a labour ward but has access to emergency or medical facilities for both mother and child if required; and • Has home-like atmosphere; and • Focuses on a model of care (e.g. Midwifery model) which ensures continuity of care/caregiver; a family-centred approach; and informed client participation related to the management of care.

Home	Should be reserved for those births that occur at the home intended (planned home births). 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. If the mother is part of a Publicly Funded Homebirth service and intended to have her baby at home, then report 'Home' as the intended place of birth.
Born Before Arrival	Used for births that occur before arrival at hospital or birth centre for planned hospital or birth centre births, or before the arrival of the homebirth midwife for planned home births.
Community, non-medical (freebirth)	Record for births that occur in the community, that are planned outside of a medical setting and without a midwife or other medical professional in attendance, for example, free births. This may include a home or other location in the community.
Other	Record for births that occur at a home other than that intended or at a community health centre. This excludes planned hospital, birth centre, home births, born before arrival or community, non-medical.

6.3 Birth event – labour onset type

The manner in which labour started in a birth event.

Code	Description
1	Spontaneous
2	Induced
3	No labour (Caesarean section)

Code	Description
9	Not stated/inadequately described

Record the response (only one) that corresponds to how labour commenced. 'No labour' can only be associated with a caesarean section.
Note that when a failed induction of labour (labour is not established) results in a caesarean, 'No labour (caesarean section)' should be selected and the reason for caesarean should be reported as failed induction of labour. A failed induction differs to a caesarean due to Failure to Progress.

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

Definitions

Spontaneous	Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilation 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 caesarean section performed before the onset of labour or a failed induction.

6.4 Birth event – induction/augmentation indicator

Indicates whether induction or augmentation was used during the labour.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.5 Birth event – induction/augmentation methods

The method used to induce labour in a birth event.

Code	Description
1	Artificial rupture of membranes
2	Oxytocin
3	Prostaglandins
6	Mechanical cervical dilatation
7	Antiprogestogen
8	Other

Code	Description
9	Not stated/unkown

If the labour was induced in onset, report the response(s) that correspond to the method used. If a method used was other than those listed, select ‘Other’ and specify in the space provided, e.g. Foley’s catheter.

If the labour was spontaneous in onset and subsequently augmented, select the response(s) that correspond to the method used. If a method used was other than those listed, select ‘Other’ and specify in the space provided, e.g. Foley’s catheter.

6.6 Birth event - main reason for induction of labour code (ICD-10-AM 13th edn)

The main indication for an induction of labour being performed to commence a birth event.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

PDF MR63D - If labour was induced, specify the main reason for induction in the space provided, e.g. rupture of membranes > 24 hours before birth, post-term etc. If the main 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 main reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid main 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, e.g. ARM, administration of oxytocins.

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

6.7 Birth event - first additional reason for induction of labour code (ICD-10-AM 13th edn)

The first additional indication for an induction of labour being performed to commence a birth event.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

If labour was induced and there is more than one reason indicated, specify the first additional reason for induction in the space provided, e.g. rupture of membranes > 24 hours before birth, post-term etc.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid first additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid first additional 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, e.g. ARM, administration of oxytocins.

6.8 Birth event - second additional reason for induction of labour code (ICD-10-AM 13th edn)

The second indication for an induction of labour being performed to commence a birth event.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

If labour was induced and there are more than two reasons indicated, specify the second additional reason for induction in the space provided, e.g. rupture of membranes > 24 hours before birth, post-term etc.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid second additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid second additional 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, e.g. ARM, administration of oxytocins.

6.9 Birth event – rupture of membranes before birth, total hours

The number of hours before birth, the membranes ruptured.

A value in the range 00000-99998

Code	Description
99999	Not stated/unknown

Record the number of days, hours and minutes before birth the membranes were ruptured. If membranes ruptured at birth, then record 'at birth' or Record '0'. If a 'no labour' caesarean section occurs, it cannot be assumed that the membranes ruptured at birth so record 'at birth' or Record '0' as above. Note: recorded as the total number of hours in electronic databases.

6.10 Birth event - length of first stage of labour, total minutes

The duration of the first stage of labour, in minutes.

A value in the range 00001-99997

Code	Description
00000	Interupted
99998	Not measured
99999	Not stated/unknown

Stage 1 begins with the onset of regular uterine contractions and is complete when the cervix is fully dilated (10cms).

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 indications of stages of labour. Note: recorded as the total number of minutes in electronic databases.

6.11 Birth event - length of second stage of labour, total minutes

The duration of the second stage of labour, in minutes.

A value in the range 00001-99997

Code	Description
00000	Interupted
99998	Not measured
99999	Not stated/unknown

Stage 2 begins when the cervix is fully dilated (10cms) and is complete with the birth of the baby.

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 indications of stages of labour. Note: recorded as the total number of minutes in electronic databases.

6.12 Birth event - presentation at birth

The part of the fetus which lies in the lower segment of the uterus, over the cervical os, at birth.

Code	Description
1	Vertex
2	Breech
4	Face
5	Brow
6	Other cephalic
7	Transverse/shoulder
8	Other

Code	Description
9	Not stated/unknown

PDF MR63D - If the presentation is unknown, for example due to extreme prematurity or macerated fetus, document this in the space provided.

Definitions	
Vertex	Presentation at birth is the upper back part of the fetal head. This is, the occiput is the point of reference.
Breech	Presentation at birth is the buttocks or legs. Includes breech with extended legs, breech with flexed legs, footling and knee presentations.
Face	Presentation at birth is the face. That is, the fetal head is hyper-extended and the area of the head below the root of the nose and the orbital ridge is at the cervical os.
Brow	Presentation at birth is the brow. That is, 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 cervical os.
Other cephalic	Presentation at birth is the head, other than vertex, face or brow. This is, the fetus is in longitudinal lie with the head entering the pelvis first. For example, deflexed occipito posterior.
Transverse/shoulder	Presentation at birth is either transverse or shoulder. Transverse: the long axis of the fetal body is across the long axis of the mother's body. Shoulder: the fetal head is in the iliac fossa and the shoulder is at the cervical os.
Other	Presentation at birth is none of the above. For example, compound presentations.
Not stated/unknown	Presentation at birth is not stated or unknown. For example, fetus papyraceus, or macerated fetus.

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

6.13 Birth event - method of birth

The method of complete expulsion or extraction of a product of conception from the female in a birth event.

Code	Description
02	Forceps
03	Vacuum extractor
04	Lower Segment Caesarean Section (LSCS)
05	Classical Caesarean Section (CCS)
10	Vaginal - non instrumental

Code	Description
99	Not stated/unknown

Note that a vaginal breech with forceps to the after coming head should be recorded as 'Forceps'. Forceps used to assist birth 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 assists the birth 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, includes where a hysterotomy is performed to extract the product of conception.
Classical CS	Classical caesarean section.

6.14 Birth event - water birth indicator

An indicator of whether the birth was a water birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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

6.15 Birth event - water birth planned indicator

An indicator of whether the water birth was planned or unplanned

Code	Description
1	Unplanned
2	Planned

Code	Description
9	Not stated/unknown

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

6.16 Reason for forceps/vacuum extraction

If forceps or vacuum were used as the method of birth, specify the reason for this.

Representational Attributes	
Datatype	Alphanumeric
Representation Class	Code
Format	ANN{N[N]}
Minimum Character Length	3
Maximum Character Length	5
Permissible Values	A valid ICD-10-AM code from the Corporate Reference Data System (CRDS) maintained by Statistical Services Branch (SSB).

For example, 'prolonged active 2nd stage', 'Direct OP'.

6.17 Birth event - main reason for caesarean section code (ICD-10-AM 13th edn)

The primary reason for why a caesarean section is performed during a birth event.

For example, 'repeat caesarean', 'fetal distress', 'prolonged labour', etc.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

Note: When ICD-10-AM 13th edition code Z352 (Supervision of pregnancy with other poor reproductive or obstetric history is recorded a 'type of poor reproductive or obstetric history' must be provided as per the file format specification'.

Permissible Values

Code	Description
1	Previous shoulder dystocia
2	Previous perineal trauma/4th degree tear
3	Previous adverse fetal/neonatal outcome
8	Other

6.18 Birth event - first additional reason for caesarean section code (ICD-20-AM 13th edn)

The first additional reason for why a caesarean section is performed during a birth event.

For example, 'repeat caesarean', 'fetal distress', 'prolonged labour', etc.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

Note: When ICD-10-AM 13th edition code Z352 (Supervision of pregnancy with other poor reproductive or obstetric history is recorded a 'type of poor reproductive or obstetric history' must be provided as per the file format specification'.

Permissible Values

Code	Description
1	Previous shoulder dystocia
2	Previous perineal trauma/4th degree tear
3	Previous adverse fetal/neonatal outcome
8	Other

6.19 Birth event - second additional reason for caesarean section code (ICD-10-AM 13th edn)

The second additional reason for why a caesarean section is performed during a birth event.

For example, ‘repeat caesarean’, ‘fetal distress’, ‘prolonged labour’, etc.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

Note: When ICD-10-AM 13th edition code Z352 (Supervision of pregnancy with other poor reproductive or obstetric history is recorded a ‘type of poor reproductive or obstetric history’ must be provided as per the file format specification’.

Permissible Values

Code	Description
1	Previous shoulder dystocia
2	Previous perineal trauma/4th degree tear
3	Previous adverse fetal/neonatal outcome
8	Other

6.20 Cervical Dilation Prior to Caesarean

The level of dilation of the cervix (in cm) prior to the caesarean section.

Code	Description
1	3cm or less
2	More than 3cm
3	Not measured

If a caesarean was performed, select the response (only one) that corresponds to the level of dilation of the cervix prior to the caesarean. If the cervical dilation was not measured, select ‘Not measured’.

Note this field is mandatory when the method of birth is a caesarean, including no labour caesareanand is recommended being captured at the time the decision was made to perform the caesarean.

6.21 Caesarean section event - antibiotics administered

Whether antibiotics were administered at the time of caesarean section.

Code	Description
1	No antibiotics administered
2	Antibiotics administered - prophylactic
3	Antibiotics administered - therapeutic

Code	Description
9	Not stated/unknown

No antibiotics administered: If antibiotics were not received at the time of LSCS or classical caesarean section.

Antibiotics administered – Prophylactic: If antibiotics have been received for prophylaxis of infection specifically associated with the caesarean.

Antibiotics administered – therapeutic: If antibiotics have been received for a known condition (e.g. chorioamnionitis, pneumonia, etc) at the time of LSCS or classical caesarean. This does not include antibiotic prophylaxis.

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

6.22 Principal Accoucheur

The principal person assisting the mother in the birth of the baby.

Code	Description
1	Obstetrician
2	Other medical officer
3	Registered midwife
4	Midwife student
5	Medical student
6	Any other person
7	No attendant/self

Code	Description
9	Not stated/unknown

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.
Registered Midwife	A registered nurse who is qualified in the field of midwifery.

Midwife 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.
Any other person	Includes a registered nurse without midwifery qualifications, doulas, ambulance officer, self, husband/partner, other patient etc.
No attendant/self	No-one else assisted the mother in the birth of the baby.

6.23 Female – state of perineum following birth

The state of the perineum following a birth event.

Code	Description
02	1st degree laceration/vaginal graze
03	2nd degree laceration
04	3rd degree laceration
05	4th degree laceration
06	Episiotomy
98	Other

Code	Description
99	Not stated/unknown

Note that more than one outcome may be reported to indicate if there is multiple damage to the perineum.

If both a 2nd degree tear and an episiotomy occurred, please select both corresponding boxes.

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

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.

Definitions	
Graze/Tear – vagina, labia, vulva	A slight abrasion to the vagina, labia, vulva following birth.

Lacerated	• 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 birth.

6.24 Surgical repair of the perineum or vagina indicator

Indicator of whether there was a surgical repair to the perineum or vagina.

Code	Description
1	No
2	Yes
9	Not stated/unknown

Note that if an episiotomy has been performed, then corresponding surgical repair would be expected.

6.25 Birth event – non-pharmacological analgesia administered/used indicator

An indicator of whether non-pharmacological analgesia was administered to or used by the mother during labour and/or birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.26 Birth event – type of non-pharmacological analgesia administered/used

The type of non-pharmacological analgesia administered to or used by a female to relieve pain during a birth event.

Code	Description
02	Heat pack
03	Birth ball
04	Massage
05	Shower
06	Water immersion
07	Aromatherapy
08	Homoeopathy
09	Acupuncture
10	TENS
11	Water injection
98	Other

Code	Description
99	Not stated/unknown

6.27 Birth event –pharmacological analgesia administered indicator

An indicator of whether pharmacological analgesia was administered to or used by the mother during labour and/or birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.28 Birth event – type of pharmacological analgesia administered

Type of pharmacological agents administered to the mother by injection or inhalation to relieve pain during labour and/or birth.

Code	Description
02	Nitrous oxide
04	Epidural
05	Spinal
07	Caudal
08	Systemic opioid (inc IM/IV narcotic)
10	Combined spinal-epidural
19	Other

Code	Description
99	Not stated/unknown

The use of pharmacological analgesia may influence the duration of labour, may affect the health status of the baby and is an indicator of obstetric intervention.

6.29 Birth event – labour and birth complication indicator

Indicates whether a complication occurred during the labour and birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.30 Birth event – labour and birth complication code (ICD-10-AM 13th edn)

Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed birth of the baby and placenta.

Where Primary PPH is reported, the amount in mls is also required – please refer to File Format https://www.health.qld.gov.au/hsu/collections/pdc

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

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code within chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O99), from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

6.31 Birth event - cardiotocography performed indicator

An indicator of whether Cardiotocography (CTG) monitoring was performed during the labour.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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.

A CTG prior to a 'no labour caesarean' should not be reported.

6.32 Birth event - fetal scalp electrode indicator

Indicates if Fetal Scalp Electrode (FSE) monitoring was performed during labour.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

Internal fetal monitoring involves placing an electrode directly on the fetal scalp through the cervix. This test is performed to evaluate fetal heart rate and variability between beats, especially in relation to the uterine contractions of labour.

6.33 Birth event – fetal scalp pH measured indicator

Indicator of whether the fetal scalp pH was measured.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.34 Birth event - fetal scalp pH result

A numerical score determined from a sample of blood taken from the fetal scalp during labour.

Valid range 6.49 - 7.50

Code	Description
99.9	Not stated/unknown

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

This data element is used to indicate fetal wellbeing during labour.

6.35 Fetal scalp lactate measured indicator

Indicator of whether the fetal scalp lactate was measured.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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

6.36 Fetal scalp lactate measured result

A numerical score allocated during the birth event to assess lactate levels of the newborn.

Code	Description
00.0-30.9	Valid range

Code	Description
99.9	Not stated/unknown

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

The fetal scalp lactate measured result can help to determine if the newborn did not receive enough oxygen during the birth event.

6.37 Birth event - anaesthesia administered indicator

An indicator of whether anaesthesia was administered to the mother for during a birth event.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

6.38 Birth event - type of Anaesthesia administered

The type of anaesthesia administered to a female during an operative/instrumental labour/birth.

Code	Description
02	Local anaesthetic to perineum
03	Pudendal
04	Epidural
05	Spinal
06	General anaesthesia
07	Caudal
10	Combined spinal-epidural
19	Other

Code	Description
99	Not stated/unknown

This item should be recorded for operative or instrumental birth of the baby only. It does not include the removal of placenta.

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

Anaesthetic use may affect the health status of the baby and is an indicator of obstetric intervention.

When more than one type of anaesthesia was used, record all types administered.

7. Baby

7.1 Patient identifier (Baby UR number)

A unique number used to identify a patient within a facility. In this case, the baby.

Representational Attributes	
Datatype	Character
Representation Class	Identification Number
Format	X(8)
Minimum Character Length	8
Maximum Character Length	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 unique number for administrative purposes it can be included.

7.2 Person - date of birth

The date of birth of an individual. In this case, the baby.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8
Permissible Values	Valid date

7.3 Person - Indigenous status (Baby)

Whether a person identifies as being of Aboriginal or Torres Strait Islander origin. In this case, the baby.

Code	Description
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin

Code	Description
9	Not stated/unknown

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

Aboriginal and Torres Strait Islander Cultural Practice Program at FNHO_CPP@health.qld.gov.au

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 that person lives.

Given the 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.

7.4 Time of Birth

The time of the baby's birth.

24 hour clock 0000 (midnight) to 2359.

Code	Description
9999	Not stated/unknown

Record the time of birth of the baby using the 24 hour clock, e.g. 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.

7.5 Product of birth - birth weight, total grams

The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth (e.g. BBA), measured in grams.

Representation Class	Quantitative Value
Format	N(4)
Minimum Character Length	4
Maximum Character Length	4
Permissible Values	-
Supplementary Values	Code: 9999 — Description: Not stated/unknown

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

If the baby was a stillbirth, the birthweight must be >= 400 grams or the gestation at least 20 weeks to be within the scope of the collection. Stillbirths less than 20 weeks gestation and less than 400 grams in weight are outside the scope of the QPDC. All livebirths are within scope, regardless of weight or gestation.

7.6 Gestational age after birth, completed weeks

The gestational age of the baby in completed weeks determined by clinical assessment after birth.

Valid range 00 - 46

Code	Description
99	Not stated/unknown

Must be in completed weeks, for example, 40 weeks and 5 days is rounded down to 40 weeks.

Stillbirths less than 20 weeks gestation and less than 400 grams in weight are outside the scope of the QPDC. All livebirths are within scope, regardless of weight or gestation.

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

7.7 Product of birth - gestational age after birth, completed days

The days component of a baby's gestational age determined by clinical examination after birth.

Valid range 0 - 6

Code	Description
9	Not stated/unknown

Gestational days at birth is used in conjunction with gestational weeks at birth and does not represent the total gestational days. For example, for a baby with a gestational age of 35 weeks and 3 days, record '3' is a key outcome of pregnancy and an important risk factor for neonatal outcomes.

7.8 Product of birth - head circumference, total centimetres

The head circumference of the baby at birth, measured in centimetres.

Valid values in the range 00.0 - 99.7

Code	Description
99.8	Not measured
99.9	Not stated/unknown

This metadata item applies to newborn babies. It enables the calculation of growth centiles which requires the measurement of head circumference and birth weight and/or length. Baby head circumference together with other anthropometric measurements assist with determining whether a baby is small for gestational age or has experienced intrauterine growth restriction. In addition, head circumference measurement enables identification of newborns with microcephaly, either primary or as an association with other pathology, for example, Fetal Alcohol Syndrome.

Head circumference should preferably be measured in the first hour of life at the same time as the birthweight is measured, to maximise comparability of these two measures in percentile calculations. A narrow, flexible, inelastic tape measure with clearly legible intervals and labels should be used.

Ideally the circumference should be plotted on a percentile chart to ensure it is within the 10th-90th percentile curves and consistent with the length and weight percentile.

7.9 Product of birth - length at birth, total centimetres

The length of the baby at birth, in centimetres.

A valid value in the range 00.0-99.7

Code	Description
99.8	Not measured
99.9	Not stated/unknown

This metadata item applies to newborn babies. It enables the calculation of growth centiles which requires the measurement of head circumference and birth weight and/or length.

Length at birth should preferably be measured on the day of birth.

7.10 Pregnancy – birth plurality

The total number of births (live births and stillbirths) resulting from this pregnancy.

Code	Description
1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other

Code	Description
9	Not stated/unknown

Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus was likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included, they should be recognisable as a fetus and have been expelled or extracted with other products of conception where pregnancy ended at 20 or more weeks gestation. Fetuses aborted before 20 completed weeks and less than 400 grams are excluded. If the pregnancy commences as a twin pregnancy but one fetus is miscarried/aborted before 20 weeks and 400 grams, the plurality is single.

7.11 Person – sex (code)

Sex refers to a person's biological characteristics. A person's sex is usually described as being either male or female. A person may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics.

Code	Description
1	Male
2	Female
3	X

Code	Description
9	Not stated/inadequately described

Male - Persons who have male or predominantly masculine biological characteristics, or male sex assigned at birth

Female - Persons who have female or predominantly feminine biological characteristics, or female sex assigned at birth.

X - Persons who have mixed or non-binary biological characteristics (if known), or a non-binary sex assigned at birth or reported their sex as another term.

The label 'X' has replaced ‘Other’ to recognise the problem of othering and the offence it causes. Terms such as ‘indeterminate’, ‘intersex’, ‘non binary’, and ‘unspecified’ are variously used to describe the ‘X’ category.

Sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.

7.12 Product of birth - birth status

The status of the baby at birth.

Code	Description
1	Live birth
2	Stillbirth (fetal death)

Code	Description
9	Not stated/unknown

Live birth - Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the 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; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth (fetal death) - Stillbirth is 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 fetus 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. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

7.13 Product of birth – macerated indicator

Indicator of whether a stillborn baby was macerated.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

Maceration is the softening and breaking down of skin from prolonged exposure to amniotic fluid in a deceased fetus.

Note: 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.

7.14 Product of birth - Apgar score at 1 minute

Numerical score used to indicate the baby's condition at 1 minute after birth.

Numeric codes in range 00 to 10

Code	Description
99	Not stated/unknown

The score is based on the assessment of 5 characteristics of the baby. Heart rate, respiratory condition, muscle tone, reflex irritability and skin colour. Each characteristic is given a score of between 0 and 2 points with a maximum total Apgar score of 10 points.

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.

Definitions	
Appearance	Blue or pale skin tone = 0 Pink body but blue fingers and toes = 1 Completely pink = 2
Pulse	No heart rate detected = 0 Slow heart rate (below 100 beats/minute) = 1 Fast heart rate (more than 100 beats/minute) = 2
Grimace	No response when the sole of the foot is stimulated = 0 Baby grimaces when the foot is stimulated = 1 Baby cries when the foot is stimulated = 2
Activity	Baby is limp = 0 Baby shows some muscle flexing in the feet and hands = 1 Baby is active and can flex the muscles in its feet and hands = 2
Respiration	There are no signs of the baby's breathing = 0 Baby has only a weak cry and can't seem to get enough air into its lungs = 1 Baby is breathing well and can cry strongly = 2

7.15 Product of birth - Apgar score at 5 minutes

Numerical score used to indicate the baby's condition at 5 minutes after birth.

Numeric codes in range 00 to 10

Code	Description
99	Not stated/unknown

The score is based on the assessment of 5 characteristics of the baby. Heart rate, respiratory condition, muscle tone, reflex irritability and skin colour. Each characteristic is given a score of between 0 and 2 points with a maximum total Apgar score of 10 points.

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.

See table at 7.14 APGAR Score at 1 minute for details.

7.16 Time to establish regular respirations

The time (in minutes) to establish regular respirations for a live born baby.

Code	Description
00	At birth
97	Respirations not established
98	Intubated
-	Values in the range 00 - 60.

Code	Description
99	Not stated/unknown

Record to the nearest minute, the time the baby took to establish regular, spontaneous breathing. For example, record 20 seconds as 01, record 1 minute 12 seconds as 02, and so on.

If the baby established respirations spontaneously the time recorded would be 00.
If the baby was intubated or ventilated record as ‘intubated.
If respirations were never established, record as ‘respirations not established’.

7.17 Product of birth - active resuscitation indicator

Indication of whether active measures were taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

This does not include any drug therapy.

7.18 Product of birth - active resuscitation method

Method of active measure taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Code	Description
02	Suction (oral, pharyngeal, etc)
03	Suction of meconium (oral, pharyngeal, etc)
04	Suction of meconium via ETT
05	Facial oxygen
06	Bag and mask
07	IPPV via ETT
08	Narcotic antagonist injection
09	External cardiac massage
11	Adrenaline/sodium bicarbonate
12	Other drugs
13	Continuous positive airway pressure (CPAP) ventilation
14	Intubation
19	Other stimulations

Code	Description
99	Not stated/unknown

Resuscitation also includes routine oral suction and intubation. Required to analyse need for resuscitation after complications of labour and birth, and to evaluate level of services needed for different birth settings. IPPV is also known as intermittent positive pressure respiration. More than one method may be recorded for each baby.

Intubation or laryngeal mask ventilation may be added at any stage of the resuscitation. The timing will often depend on the familiarity and skill of the clinician with the procedure. For a skilled and experienced clinician, intubation will normally occur earlier in the resuscitation.

7.19 Birth – arterial cord pH measured indicator

Indicates whether the arterial umbilical cord pH was measured.

Code	Description
1	Not measured
2	Measured

Only applicable for live births. Stillbirth should be recorded as Not measured.

7.20 Birth – arterial cord pH result

Numerical result determined after birth to assess blood gases of the newborn which can determine if the newborn did not receive enough oxygen during labour.

Valid range between 6.49 and 7.50.

Lower limit of 6.49 and upper limit of 7.50

7.21 Vitamin K administered method

The method of administration for the first dose of vitamin K to the baby.

Code	Description
1	Oral
2	Intramuscular
3	None given

Code	Description
9	Not stated/unknown

7.22 Product of Birth - hepatitis B vaccination administered status

The status of whether the birth dose of Hepatitis B vaccination was administered to the baby.

Code	Description
1	Not given Hepatitis B vaccination
2	Given Hepatitis B vaccination

Code	Description
9	Not stated/unknown

This field does not refer to administration of Hepatitis B Immunoglobulin.

7.23 Birth - hepatitis B immunoglobulin administered status

The Hepatitis B immunoglobulin administered status of the baby at birth.

Code	Description
1	Hepatitis B immunoglobulin not administered
2	Hepatitis B immunoglobulin administered

Code	Description
9	Not stated/unknown

This field does not refer to administration of Hepatitis B Vaccination.

8. Postnatal Details

8.1 Product of birth - neonatal morbidity indicator

Indicator of whether any neonatal morbidity (conditions or diseases of the baby) were present up to the time of the discharge or when the baby reaches 28 days of age.

Code	Description
1	No neonatal morbidity
2	One or more neonatal morbidities

Code	Description
9	Not stated/unknown

Only applicable to live births. Still births are recorded as no neonatal morbidity.

8.2 Neonatal morbidity code (ICD-10-AM 13th edn)

Neonatal morbidity (conditions or diseases of the baby) present prior to discharge, transfer or death.

Only applicable to live births.

A valid ICD-10-AM code from the Corporate Reference Data System (CRDS) maintained by Statistical Services Branch (SSB) is permissible for reporting. A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code within chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O99), from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

8.3 Product of birth - neonatal treatment indicator

Indicator of whether any neonatal treatment was given up to the time of discharge or when the baby reached 28 days of age.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

Only applicable to live births. Still births are recorded as no neonatal treatment.

8.4 Birth - neonatal treatment type

The type of neonatal treatment given during the birth episode.

Code	Description
02	Oxygen for more than 4 hours
03	Phototherapy
04	Intravenous (IV)/Intramuscular (IM) antibiotics
05	Intravenous (IV) fluid
06	Mechanical ventilation
07	Intra-arterial (IA) line
08	Exchange transfusion
10	Blood glucose monitoring
11	Continuous Positive Airway Pressure (CPAP)
12	Oro/nasogastric feeds
19	Other

Code	Description
99	Not stated/unknown

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

Only applicable to live births.

8.5 Number of days in intensive care nursery (ICN)

Number of whole days the baby was present in the intensive care nursery (ICN).

Valid range 000-998

Code	Description
999	Not stated/unknown

If baby in the ICN for less than 24 hours report this as 001.
If baby was not in ICN report this as 000.

Intensive Care Nursery: A Specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

Neonatal Intensive Care Unit: must be capable of providing complex, multi-system life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of similar nature.

For further information in regards to nursery details see the QHAPDC Manual or MAC Manual located at: https://www.health.qld.gov.au/hsu/collections/dchome

For information about ***Neonatal Services*** see the ***Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.2****, available* at: Neonatal services (health.qld.gov.au) or by contacting:

Public health sector
Health Protection Unit
Phone: (07) 3328 9430
Email: cscf@health.qld.gov.au

Private health sector
Private Heath Regulation Unit
Phone: (07) 3708 5325
Email: Private.Health@health.qld.gov.au

For further information in regards to nursery details see the QHAPDC Manual or MAC Manual located at: https://www.health.qld.gov.au/hsu/collections/dchome

8.6 Number of days in special care nursery (SCN)

Number of whole days the baby was present in the special care nursery (SCN).

Valid range 000-998

Code	Description
999	Not stated/unknown

If baby in the SCN for less than 24 hours report this as 001.
If baby was not in SCN report this as 000.

Special Care Nursery: A nursery that monitors and cares for newborns suffering from illness or disability at birth requiring specialist medical care, nursing attention and hospital treatment. Facilities include humidicribs, cardiorespiratory monitoring, IV fluid therapy, tube feeds and phototherapy.

8.7 Reason for admission to ICN/SCN

The reason as to why the baby was admitted to an intensive care nursery or special care nursery.

If the baby was admitted to either an ICN (level 6) or SCN (level 4 and 5), the reason should be a condition, not a treatment, e.g. ‘prematurity’ rather than ‘tube feeding’, or ‘respiratory distress’ rather than ‘oxygen therapy or observation’. The treatment should be included in the Neonatal Treatment field.

A valid ICD-10-AM code from the Corporate Reference Data System (CRDS) maintained by Statistical Services Branch (SSB) is permissible for reporting.

8.8 Product of birth - congenital anomaly indicator

Indicates whether an anatomical defect or chromosomal abnormality was present at birth and detected prior to separation from care.

Code	Description
1	No
2	Yes
3	Suspected

Code	Description
9	Not stated/unknown

8.9 Product of birth - congenital anomaly code

An anatomical defect or chromosomal abnormality that is present at birth and detected prior to separation.

A valid ICD-10-AM code from the Corporate Reference Data System (CRDS) maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

8.1 Product of birth - congenital anomaly position (ICD-10-AM 13th edn)

The laterality of the structural abnormalities (including deformations) present at birth.

Code	Description
1	Right
2	Left
3	Bilateral
4	Unilateral (unspecified)
5	Anterior
6	Posterior
7	Central/midline
8	Not applicable

Code	Description
9	Not stated

Record for each congenital anomaly.

A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code within chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O99), from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

8.2 Product of birth - congenital anomaly status

Indicates whether an anatomical defect or chromosomal abnormality was confirmed or suspected.

Code	Description
1	Suspected
2	Confirmed
3	Suspected and cannot confirm

Code	Description
9	Not stated/unknown

8.3 Product of birth - congenital anomaly diagnosed prior to birth indicator

Indicator of whether congenital anomaly was diagnosed prior to birth.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

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

9. Discharge Details

9.1 Discharge Details of the Mother

9.1.1. Female - puerperium complication indicator

Indicates whether there were medical/obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.2 Female – puerperium complications code (ICD-10-AM 13th edn)

A medical/obstetric complication of the mother occurring during the postnatal period up to the time of separation from care.

Record all puerperium complications.

A valid ICD-10-AM code from the Corporate Reference Data System (CRDS) maintained by Statistical Services Branch (SSB) is permissible for reporting. A valid International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 13th edition code within chapter 15 Pregnancy, Childbirth and the Puerperium (O00-O99), from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

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.

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.

9.2.1. Caesarean section event - puerperium thromboprophylaxis administered indicator

Indicates whether puerperium thromboprophylaxis was administered following caesarean section.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.2.2. Caesarean section event – type of puerperium thromboprophylaxis administered

The type of puerperium thromboprophylaxis administered/used following caesarean section.

Code	Description
2	Pharmacological thromboprophylaxis
3	Intermittent calf compression
4	TED stockings
8	Other thromboprophylaxis

Code	Description
9	Not stated/unknown

When more than one puerperium thromboprophylaxis is administered, record all types administered. Only valid when the method of birth is a LSCS or classical caesarean.

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

9.2.3. Female – procedures and operations during pregnancy, labour, birth or puerperium indicator

An indicator of whether any procedures or operations were performed on a female during the pregnancy, labour, birth or the puerperium. In this case, the puerperium period.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.2.4. Female – procedure/operation during pregnancy, labour, birth or puerperium code (ACHI 13th edn)

A procedure or operation performed on a female during the pregnancy, labour, birth or puerperium, as represented by a code. In this case, the puerperium period.

A valid Australian Classification of Health Interventions, (ACHI) 13th edition code from the Corporate Reference Data System (CRDS) ICD-10-AM data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB) is permissible for reporting.

9.2.5. Discharge status of mother/baby (Mother)

The mode of formal separation of the mother.

Code	Description
1	Discharged
2	Transferred
3	Died
4	Remaining in

Code	Description
9	Not stated/unknown

This item refers to formal separations, that is, discharge, transfer to another facility, or death. It does not refer to statistical separation/episode of care type changes.

If the mother is remaining in after 28 days select remaining in 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, Record the date she was formally discharged as an admitted patient, i.e. the day she changed from an admitted patient to a boarder.

Homebirths only: do not complete the discharge details field unless the mother was transferred to a facility following birth.

9.2.6. Admitted patient hospital stay - facility mother transferred to

The unique code that identifies the facility to which the mother was transferred after birth.

Valid facility code from the Corporate Reference Data System (CRDS) facility data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB).

This data element is applicable when the mother has been transferred to another hospital after birth.

9.2.7. Admitted patient hospital stay – separation date (Mother)

Date on which the mother was discharged, transferred or died.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8

9.2.8. Birth event - early discharge program indicator

Indicates if the mother was released from hospital to an Early Discharge or other similar program.

Code	Description
1	No
2	Yes

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.

9.3 Discharge Details of the Baby

9.3.1. Neonatal Screening

The date when neonatal screening was performed.

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

9.3.2. Discharge Weight

The weight of the baby on discharge in grams.

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

9.3.3. Discharge status of mother/baby (Baby)

The mode of formal separation of the baby.

Code	Description
1	Discharged
2	Transferred
3	Died
4	Remaining in

Code	Description
9	Not stated/unknown

This item refers to formal separations, that is, discharge, transfer to another facility, or death. It does not refer to statistical separation/episode of care type changes.

If the baby is remaining in after 28 days select remaining in provide the discharge date when available.

Homebirths only: do not complete the discharge details field unless the baby was transferred to a facility following birth.

9.3.4. Admitted patient hospital stay - facility baby transferred to

The unique code that identifies the facility to which the baby was transferred after birth.

Valid facility code from the Corporate Reference Data System (CRDS) facility data set maintained by Statistical Standards and Strategies, Statistical Services Branch (SSB).

This data element is applicable when the baby has been transferred to another hospital after birth.

9.3.5. Admitted patient hospital stay – separation date (Baby)

Date on which the baby was discharged, transferred or died.

Representational Attributes	
Datatype	Numeric character
Representation Class	Date
Format	DDMMYYYY
Minimum Character Length	8
Maximum Character Length	8

9.3.6. Product of birth - fluid received any time prior to discharge indicator

Indicates whether the baby received fluids(s) any time prior to discharge, transfer or death.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.3.7. Product of birth - fluid type received any time prior to discharge

The type of fluid ingested by the baby at any time prior to discharge, transfer or death. More than one type may be selected.

Code	Description
1	Breast milk/colostrum
2	Infant formula
3	Water, fruit juice or water-based products
4	Nil fluids by mouth

Code	Description
9	Not stated/unknown

Breast milk/colostrum includes breast milk/colostrum received directly from the breast as well as expressed breast milk/colostrum received by syringe, cup or enteral tube.

Infant formula refers to commercially prepared formulas that adequately meet the nutritional needs of the newborn.

Other types of fluid include, but is not limited to, water, fruit juice, herbal tea or flavoured water.

This field may be used as an indicator for the Baby Friendly Health Initiative to obtain accreditation from World Health Organisation.

9.3.8. Product of birth - fluid received in 24 hours prior to discharge indicator

Indicates whether the baby received fluid(s) in the 24 hours prior to discharge, transfer or death.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.3.9. Product of birth - fluid type received in 24 hours prior to discharge

The type of fluid ingested by the baby in the 24 hours prior to discharge, transfer or death. More than on type may be selected.

Code	Description
1	Breast milk/colostrum
2	Infant formula
3	Water, fruit juice or water-based products
4	Nil fluids by mouth

Code	Description
9	Not stated/unknown

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

9.3.10. Birth - alternate feeding method prior to discharge indicator

An indicator of whether an alternative method other than breast feeding (mouth to nipple feeding only) was used from birth to discharge.

Code	Description
1	No
2	Yes

Code	Description
9	Not stated/unknown

9.3.11. Birth – type of alternate feeding method prior to discharge

The type of alternative feeding method used other than breast feeding (mouth to nipple feeding only) from birth to discharge. More than one method may be selected.

Code	Description
02	Bottle
03	Cup
04	Syringe
98	Other

Code	Description
99	Not stated/unknown

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.

10. Examples of conditions to report

10.1 Medical conditions

The following is a list of examples of medical conditions, which should be reported to the Queensland Perinatal Data Collection. 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, e.g. CIN I, II etc.
Coagulation disorders – please specify
COVID-19
Cystic Fibrosis
Diabetes mellitus (pre-existing) - Specify if insulin, oral hypoglycaemic agent and/or diet and exercise 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, e.g. Crohn's Disease, Cholecystitis
Hepatitis – Specify type and infection status (e.g. A, B, C, carrier, infectious/active)
Hypertension – pre-existing
Hyperthyroidism
Hypothyroidism
Infection, Streptococcus, Group B
Liver disorders– please specify
Musculoskeletal disorders – please specify, e.g. Carpal Tunnel Syndrome, Back pain, Scoliosis
Obesity
Paraplegia, quadriplegia
Past history rheumatic fever
Previous infertility, e.g. 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 (e.g. syphilis, gonorrhoea, chlamydia, donovanosis, genital herpes, genital warts, etc.)
Systemic lupus erythematosus (SLE)
Thalassaemia
TORCH conditions – please specify
Urinary incontinence
Uterine disorders– please specify
Viral infections – please specify

10.2 Pregnancy Complications

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

Abnormal glucose tolerance test
Admission for social reason/assessment of pregnancy
Amnionitis, Chorioamnionitis
Anaemia (of pregnancy)
APH
Cervical incompetence
Cephalopelvic/fetopelvic disproportion – please specify
Deep vein thrombosis
Eclampsia
False (spurious) labour
Gestational diabetes – specify if insulin, oral hypoglycaemic agent or diet and/or exercise treated
Grand multiparity
High head at term
Hyperemesis gravidarum
Hypertension – gestational (mild)
- Pre eclampsia (moderate)
- Pre eclampsia (severe)
- HELLP

Infection of genito-urinary tract
Intrauterine fetal death
Intrauterine growth retardation
Iso-immunisation - Rh, ABO
Malpresentation – please specify
Placenta abruption
Placenta praevia – specify with or without haemorrhage, include grade or degree
Placental abruption
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
Termination of pregnancy
Threatened miscarriage/abortion
Threatened premature labour
Unstable lie
Vomiting in late pregnancy

10.3 Procedures and Operations

The following is a list of examples of procedures and operations, which should be reported to the Queensland Perinatal Data Collection. **This is not a past history and only includes procedures and operations performed during the present pregnancy, labour and birth**. Note that this is not an exhaustive list.

Appendicectomy – specify open or laparoscopic
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
FSE in labour
Intrauterine transfusion
Mechanical ventilation
Ultrasound pelvimetry

10.4 Labour and Birth Complications

The following is a list of examples of labour and birth complications, which should be reported to the Queensland Perinatal Data Collection. 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 birth – 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 – specify type
Perineal Tears (1st, 2nd, 3rd, 4th degree)
Placental abruption
Placenta accreta
Precipitate labour/birth
Primary post-partum haemorrhage – within first 24 hours and indicate the blood volume loss in mls
Prolonged labour
Prolonged second stage
Prolapsed uterus
Pulmonary embolus
Retained placenta/membranes – indicate with or without haemorrhage and whether manual removal performed
Rupture of uterus – before or during labour
Septicaemia
Shoulder dystocia
Uterine scar – previous caesarean section
Vaginal haematoma

10.5 Vaginal tear – indicate the degree (1st, 2nd, 3rd, 4th) Neonatal Morbidity

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

ABO incompatibility
Anaemia
Apnoea
Birth asphyxia

Birth injury/trauma e.g. # clavicle, cephalohaematoma
Broncho-pulmonary dysplasia
Cerebral haemorrhage
Covid-19
Eye infection
Feeding problem
Hydrocephalus
Hyaline membrane disease
Hyperglycaemia
Hypoglycaemia
Hypothermia
Infant of diabetic mother
Infection - specify site/organism e.g. 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
Pneumonia
Pneumothorax
Pneumomediastinum
Polycythaemia
Pulmonary haemorrhage
Pulmonary hypertension
Respiratory distress - specify condition e.g. Transient tachypnoea of the newborn,
Respiratory distress syndrome
Retained fetal lung fluid
Rhesus incompatibility
Seizures
Septicaemia
Small for gestation age

10.6 Congenital Anomalies

The following is a list of examples of congenital anomalies, which should be reported to the Queensland Perinatal Data Collection 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 Biliary Atresia Tracheo-oesophageal fistula Hirschsprung's Disease Oesophageal atresia and/or Stenosis Imperforate anus Gastroschisis Hernia – umbilical, diaphragmatic 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) Polydactyly Congenital dislocation of hip Achondroplasia Phocomelia Syndactyly
Muscular	Exomphalos

10.7 Puerperium Complications

The following is a list of examples of puerperium complications, which should be reported to the Queensland Perinatal Data Collection. 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) e.g. 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 thyroiditis
Pregnancy induced hypertension – specify severity
Puerperal psychosis
Pulmonary embolism
Pyrexia
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 or infection (specify if vaginal or abdominal)

10.8 Puerperium Procedures and Operations

The following is a list of examples of procedures and operations that were performed during the puerperium, which should be reported to the Queensland Perinatal Data Collection. 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 e.g. Vulva
Hysterectomy
Haemorrhoidectomy
Laparoscopy – specify reason
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

11. Neonatal Intensive Care Units and Special Care Nurseries

11.1 Neonatal Intensive Care Units (Level 6)

CODE	FACILITY NAME
00936	GOLD COAST UNIVERSITY HOSPITAL
00003	MATER MOTHERS' HOSPITAL
00318	MATER WOMEN'S & CHILDREN'S PRIVATE HEALTH SERVICES
00201	ROYAL BRISBANE & WOMEN'S HOSPITAL
00200	TOWNSVILLE UNIVERSITY HOSPITAL

11.2 Special Care Nurseries–Public Hospitals (Level 4 & 5)

CODE	FACILITY NAME
00062	BUNDABERG BASE HOSPITAL
00030	CABOOLTURE HOSPITAL
00214	CAIRNS HOSPITAL
00936	GOLD COAST UNIVERSITY HOSPITAL
00069	HERVEY BAY HOSPITAL
00015	IPSWICH HOSPITAL
00029	LOGAN HOSPITAL
00172	MACKAY BASE HOSPITAL
00246	MOUNT ISA BASE HOSPITAL
00016	REDCLIFFE HOSPITAL
00028	REDLAND HOSPITAL
00141	ROCKHAMPTON HOSPITAL
00201	ROYAL BRISBANE & WOMEN'S HOSPITAL
00032	SUNSHINE COAST UNIVERSITY HOSPITAL
00200	TOWNSVILLE UNIVERSITY HOSPITAL
00104	TOOWOOMBA HOSPITAL

11.3 Special Care Nurseries–Private Hospitals (Level 4 & 5)

CODE	FACILITY NAME
00391	GREENSLOPES PRIVATE HOSPITAL
00375	GOLD COAST PRIVATE HOSPITAL
00441	JOHN FLYNN PRIVATE HOSPITAL
00401	MATER PRIVATE HOSPITAL MACKAY
00380	MATER PRIVATE HOSPITAL ROCKHAMPTON
00003	MATER MOTHERS' HOSPITAL
00318	MATER WOMEN'S & CHILDREN'S PRIVATE HEALTH SERVICES
00411	MATER PRIVATE HOSPITAL TOWNSVILLE (HYDE PARK CAMPUS)
00320	NORTH WEST PRIVATE HOSPITAL
00331	PINDARA PRIVATE HOSPITAL
00313	ST ANDREW'S IPSWICH PRIVATE HOSPITAL
00366	ST VINCENT'S HOSPITAL TOOWOOMBA
00334	BUDERIM PRIVATE HOSPITAL
00316	THE WESLEY HOSPITAL

The responsibility for implementing, monitoring, complying with and notifying changes in service levels in public health facilities will rest with HHS Chief Executive Officers.

Please direct any queries regarding the CSCF v3.2 and licensing within the private health sector to Private_Health@health.qld.gov.au or phone 07 3708 5325.

Please direct any other queries regarding the CSCF v3.2 to CSCF@health.qld.gov.au or phone 07 3328 9430.

The service modules can be found at the following web address: Service modules | Queensland Health

12. Abbreviations

CODE	FACILITY NAME
AI	Artificial Insemination
AIHW	Australian Institute of Health and Welfare
BBA	Born Before Arrival
BE	Base Excess
BMI	Body Mass Index
COVID-19	Coronavirus disease of 2019
CPAP	Continuous Positive Airway Pressure
CTG	Cardiotocography
CSCF	Clinical Services Capability Framework
EDC	Estimated Date of Confinement
ETT	Endotracheal Tube
FET/ET	Frozen Embryo Transfer/Embryo Transfer
FSE	Fetal Scalp Electrode
GIFT	Gamete Intra Fallopian Transfer
HELLP	Haemolysis/Elevated Liver enzymes/Low Platelet count
HHS	Hospital and Health Services
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICI	Intracervical Insemination
ICN	Intensive Care Nursery
ICSI	Intracytoplasmic Sperm Injection
IM	Intramuscular
IPPV	Intermittent Positive Pressure Ventilation
IUI	Intrauterine Insemination

IV	Intravenous
IVF	In Vitro Fertilisation
IVI	Intravaginal Insemination
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean Section
MaCCS	Maternity Care Classification System
MR63D	Queensland Perinatal Data Collection Form
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NPDC	National Perinatal Data Collection
NPDDC	National Perinatal Data Development Committee
QPDC	Perinatal Data Collection
PNO	Perinatal Online Form
PPH	Post-Partum Haemorrhage
QHDD	Queensland Health Data Dictionary
SCIU	Statistical Collections and Integration Unit
SCN	Special Care Nursery
SRCU	Statistical Reporting and Coordination Unit
SSB	Statistical Services Branch
UR	Unit Record Number
US	Ultrasound

Appendix A – Reporting maternity models of care examples

The following examples provided are intended to be a guide on how model of care items should be reported to the QPDC.

- Primary Model of Care (**PMOC**).
- Maternity model of care at the onset of labour or non-labour caesarean section (**OMOC**).

EXAMPLE SCENARIOS			HOW TO REPORT THE CORRECT MODEL OF CARE CODE
Model of care CHANGES during pregnancy	**1**	A woman attends **10 antenatal appointments**, the first 4 under one model of care, and the next 6 under another model of care **at the same hospital.**	**The PMOC and the OMOC will be the same code** (the one used for the most visits).
	2	A woman attends **10 antenatal appointments**, the first 6 under one model of care, and the next 4 under a different model of care **at the same hospital.**	**The PMOC and OMOC will be different codes.** The birthing hospital should use different model ID codes for the two items.
	3	A woman attends **8 antenatal appointments**, the first 3 of these under one model of care and the next 5 under a different model of care **at a different hospital**.	**The PMOC and the OMOC will be the same code.** The birthing hospital should use the same model ID code for both items (the one used for the most visits).
	4	A woman attends 5 antenatal appointments under one model of care and is put under another higher-risk model and attends 5 appointments under this model before giving birth.	**The PMOC and the OMOC will be different codes.** The birthing hospital should use the model ID code for the first model of care for PMOC, and the model ID code of the higher-risk model for the OMOC.
	5	A woman lives in a regional area and receives all their antenatal care with their local antenatal/postnatal maternity service and births at the closest birthing hospital as planned.	**The PMOC and the OMOC will be the same code** (the model of care they were under has not changed). The antenatal/postnatal model of care code should have been shared with the birthing hospital. If this code has not been shared with the birth hospital, it

			can be found under the service name at MaCCS DCT - Search (aihw.gov.au).
Antenatal care and birthing at different services	**6**	A woman lives in a regional area and receives most of their antenatal care with their local antenatal/postnatal maternity service. They are referred later in pregnancy to a larger regional hospital for their remaining antenatal care and births at this hospital as planned.	**The PMOC and the OMOC will be different codes.** The antenatal/postnatal model of care code should have been shared with the birthing hospital and be used as the PMOC. The OMOC will the code the women were under late in pregnancy at the birthing hospital.
	7	A woman starts their antenatal care at a local maternity service but moves during their pregnancy and births at a different hospital.	**The PMOC and the OMOC will be the same code** if they have more antenatal visits under the new model of care where they move to. **The PMOC and the OMOC will be different codes** if they have less antenatal visits under the model of care where they move to (the PMOC should then reflect the model from the original location).
	8	The woman did not receive antenatal care at a maternity service but arrives at a public hospital for birthing.	**PMOC and OMOC will be 999997 (not applicable).**
BIRTH plan changes	**9**	A woman has planned a homebirth with a privately practising midwife (PPM). During labour there are complications, and they end up birthing in a nearby hospital.	**The PMOC and the OMOC will be the same code (the birth location changes but not the model of care they were under).** Use the code for the model provided by the PPM if this is available. If this is not available, a generic PPM code can be used (there is one for each jurisdiction).
	10	A woman attends their antenatal appointments at the hospital they intend to birth, goes away for a weekend, begins labour and is taken to a local hospital for birthing.	**The PMOC and the OMOC will be the same code (the birth location changes but not the model of care they were under).** The birthing hospital should use the same model ID code for both items. This will **not** be a model from the birthing hospital, but one from where the woman had their antenatal care. This can be found at MaCCS DCT -

			Search (aihw.gov.au). If this information cannot be obtained then a supplementary code, such as not stated (9999999) should be supplied.
	11	A woman attends their antenatal appointments at the hospital they intend to birth, goes into labour and gives birth on the way to the hospital.	**The PMOC and the OMOC will be the same code (the birth location changes but not the model of care they were under).** The birthing hospital should use the same model ID code for both items. This will be one the woman was under during their pregnancy.