Queensland Perinatal Data Collection File Format

2023-2024 Version 1.0

The QPDC File Format must be used as the approved form for the electronic submission of perinatal data to the Chief Executive, Queensland Health for births occurring from 1 July 2023 (inclusive).

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

Queensland Government

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Published by the State of Queensland (Queensland Health), July 2023

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

Document Information

Version: v1.0

Published by: Statistical Collections and Integration Unit
Statistical Services Branch
Healthcare Purchasing and System Performance

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Effective Date: 1 July 2023

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

Release History:

Effective Date	Release	Pages	Details
July 2019	Version 1.35	Numerous	1. Update of ICD-10-AM/ACHI from 10th edition to ICD-10-AM/ACHI 11th edition 2. Paragraph added to introduction to provide clarity to hospitals that the data must be of a high quality prior to submission to SSB. Note that it is poor practice to default any unanswered items to 'Not stated/ unknown/inadequately described' 3. Amend description to add clarity to the 'Estimation indicator' for Last Menstrual Period, Estimated Date of Confinement and Mothers' Date of Birth. Systems should not default to 'E' in any circumstance. 4. Add response value 'declined to answer' to Cigarette Smoking during the first 20 weeks indicator; Cigarette Smoking after 20 weeks indicator; Antenatal Screening performed for illicit drug use; Antenatal Screening using Edinburgh Postnatal Depression Scale indicator and amend validation to include new value of 3 in Mother Record 5. Remove and add filler Antenatal Screening for Domestic Violence in Mother Record and Add new

			item Antenatal Screening performed for Family Violence indicator to Mother Record 6. Remove and add filler Antenatal Screening for Alcohol Use in Mother Record Add Alcohol consumption in the first 20 weeks of pregnancy indicator in Mother Record Add Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy in Mother Record Add Alcohol consumption frequency in the first 20 weeks of pregnancy in Mother Record Add Alcohol consumption after 20 weeks of pregnancy indicator in Mother Record Add Number of standard drinks consumed when drinking alcohol after 20 weeks of pregnancy in Mother Record Add Alcohol consumption frequency after 20 weeks of pregnancy in Mother Record 7. Add new values to Code Type 'R' Resuscitation Methods in Baby Code Record 8. Terminology updates to conform to METeOR and QHDD
July 2020	Version 1.36		1. Add Female-primary maternity model of care identifier in Mother Record Add Female-maternity model of care at the onset of labour or non-labour caesarean section identifier in Mother Record 2. Terminology updates to conform to METeOR and QHDD
July 2020	Version 1.36a		3. Amended validation to Female-primary maternity model of care identifier in Mother Record Amended validation to Female-maternity model of care at the onset of labour or non-labour caesarean section identifier in Mother Record
July 2021	Version 1.37		New additional 'Actual Place of Birth' codes to include born before arrival and community, non-medical

			(freebirth) in Baby's Birth Detail Record
July 2022	Version 1.0		1. Update of ICD-10-AM/ACHI from 11th edition to ICD-10-AM/ACHI 12th edition 2. Amend wording of Number of standard drinks consumed on a typical day when drinking alcohol before 20 weeks of pregnancy in Mother Record 3. Amend wording of Number of standard drinks consumed on a typical day when drinking alcohol after 20 weeks of pregnancy in Mother Record
July 2023	Version 1.0	Numerous	1. Anaesthesia indicator description update 2. Person-Sex (code) description update 3. Amend wording of Cord pH 4. Amend wording of Cord pH result

1 File Format 2023-2024 Collection Year

1.1 Introduction

This document specifies the file format for the electronic submission of perinatal data by facilities (providing maternity services) to the Statistical Services Branch, Queensland Department of Health for the Queensland Perinatal Data Collection (QPDC) for births occurring from 1 July 2023 (inclusive).

A record must be provided for each birth that meets the scope of the QPDC.

This document describes the electronic file format for perinatal data for use in public and private hospitals.

Hospitals are advised that data reported to the Statistical Services Branch (SSB) must be of high quality. The Department of Health requires data to be of sufficient quality to enable its regulatory purposes such as to meet legislative requirements, deliver accountabilities to state and commonwealth governments and monitor and promote improvements in the safety and quality to be fulfilled.

Poor quality data containing high numbers of validation errors will not be accepted by SSB and the hospital will be advised. Before SSB will accept and process this data the validation errors must be corrected (on the hospital's information system), re-extracted and submitted to SSB.

It was identified in the *Perinatal National Minimum Data Set compliance evaluation 2010-2015* report produced by the Australian Institute of Health and Welfare (AIHW) (https://www.aihw.gov.au/reports/mothers-babies/perinatal-national-minimum-data-set-compliance-eva/contents/table-of-contents) that data were considered out of scope if they were missing, not stated or invalid, or if there were inadequate data. Data are only evaluated as compliant if data are provided for 99.5% of in-scope births. As a result, it is expected that less than 0.5% of 'Not stated/unknown/inadequately described' responses are to be submitted in any individual monthly extract and if there are more than 0.5% unknowns, the file may be rejected on non-compliance grounds.

Note: it is an unacceptable practice to default any unanswered items to 'Not stated/unknown/inadequately described' for any data item even though the file format allows for this value. All 'Not stated/unknown/inadequately described' responses will trigger a validation for response back to the submitting hospital for amended data or a valid reason why the data are unknown.

1.2 Record Types

The data will be contained in a single file containing a number of different record types. The record types are:

File Header **Record Type 'F'**

This contains information related to the file such as the file's extract period. There is one of these records in the file and it should be the first record in the file.

Type Details **Record Type 'T'**

This record contains counts of New, Amend and Delete record types that occur in the file. There will be one of these records for each of the record types Mother's Details, Mother's Code, Baby's Birth Details and Baby's Birth Code. A Data Type field on a Type Details record identifies the record type that the counts relate to. The Data Types are:

Data Type 'M' Mother's Details
Data Type 'C' Mother's Code
Data Type 'B' Baby's Birth Details
Data Type 'D' Baby's Birth Code

These records should occur at the end of the file in the above order.

Mother's Details **Record Type 'M'**

This record contains the data related to the mother in a particular confinement. The data values that uniquely identify a particular confinement are the mother's UR Number and the date of confinement. There is one mother detail record per confinement.

Mother's Code **Record Type 'C'**

Mother's Code records are used to contain the multiple codes that relate to the mother in a confinement such as medical condition codes or conception method codes.

The Mother's UR Number and Date of Confinement fields on the record identify the confinement it is associated with and the Code Type field identifies the particular code involved. The Code Types are:

Code Type 'C' Conception Method
Code Type 'T' Reason for Transfer

Code Type ‘M’ Medical Condition
Code Type ‘P’ Pregnancy Complication
Code Type ‘O’ Procedure/Operation
Code Type ‘L’ Method of Birth of Last Birth
Code Type ‘A’ Antenatal Care Type
Code Type ‘E’ Extra Text

For each particular confinement and Code Type, there can be multiple code values and thus multiple records. However, a particular code value can only occur once for a particular confinement and Code Type. An example of this for a particular confinement is as follows:

Code Type ‘C’, Code Value 02
Code Type ‘C’, Code Value 19
Code Type ‘M’, Code Value B373
Code Type ‘M’, Code Value E669
Code Type ‘P’, Code Value O440
Code Type ‘P’, Code Value O16

Note that for example, another instance of Code Type ‘C’, Code value 02 for the same confinement is not valid.

Baby’s Birth Details Record Type ‘B’

These records contain the details relating to each birth of a baby for a confinement. A baby’s birth is uniquely identified by the Mother’s UR Number, the Date of Confinement and the Baby Number which is the birth order of the baby e.g. 1=twin 1, 2=twin 2, 1=singleton.

There is one of these records per birth per confinement **and therefore there can be more than one Baby’s Birth Detail record for each Mother Detail Record**.

Baby’s Birth Code Record Type ‘D’

Baby’s Birth Code records are used to contain the multiple codes that relate to a baby’s birth in a confinement such as analgesia codes or congenital anomaly codes. The Mother’s UR Number, Date of Confinement and Baby Number fields on the record identify the baby’s birth it is associated with and the Code Type field identifies the particular code involved. The Code Types are:

Code Type ‘I’ Induction/Augmentation
Code Type ‘A’ Pharmacological Analgesia
Code Type ‘S’ Anaesthesia
Code Type ‘R’ Resuscitation
Code Type ‘T’ Neonatal Treatment
Code Type ‘C’ Congenital Anomaly
Code Type ‘L’ Labour & Birth Complication
Code Type ‘M’ Neonatal Morbidity
Code Type ‘P’ Puerperium Complication
Code Type ‘N’ Non-Pharmacological Analgesia
Code Type ‘F’ Type of fluid received in 24 hours prior to discharge
Code Type ‘D’ Type of fluid received at anytime

For each baby’s birth and Code Type, there can be multiple code values and thus multiple records.

However, a particular code value can only occur once for a particular baby’s birth and Code Type. This is similar to the Mother’s Code records above.

1.3 Ordering of Records

The File Header record is the first record in the file and there must be only one file header record.

Following the File Header are the sets of records for each confinement. The confinement sets are ordered by increasing confinement date and within confinement date by increasing UR No. Each set of records for a confinement is made up in the following way:

- The Mother's Detail record is the first record in a confinement set.

  There must be only one Mother's Detail record per confinement set.

- Following the Mother's Detail record are the Mother's Code records if applicable. There can be zero to several records per code type and the records for each code type are grouped together. The ordering of the code types is C, T, M, P, O, L, A, E. Each group of records for a code type need not have any particular record order.

- Following the Mother's Code records (if any) are Baby's Birth record sets. There must be at least one Baby's Birth record set per confinement set, **with the number of Baby's Birth records matching the number of babies in the confinement**. These sets are ordered by increasing Baby Number. These sets are made up in the following way:

- The Baby's Birth Detail record is the first record in the set.

  There is only one Baby's Birth Detail record per Baby's Birth set.

- Following the Baby's Birth Detail record are the Baby's Birth Code records if there are any. There can be zero to several records per code type and the records for each code type are grouped together. The ordering of these types is I, A, S, R, T, C, L, M, P, N, F, D, E, B, G, V. Each group of records for a code type need not have any particular record order.

The last four rows of the file will contain the Type Detail records. These will show the counts of New, Amend and Delete records contained within the file. There is one of these records per each Data Type and the ordering of the Data Types is M, C, B, D.

1.4 Example of File Structure

Below is an example layout of a small file to demonstrate the ordering of records.

Note: The character '|' is a field separator to enhance readability of the example. It does not appear in a real file. The character '~' represents a space. Not all data fields are shown.

F|00003|20230701|20230731|20230901|202307|
M|N|00102374|20230701|.....
C|N|00102374|20230701|C|02~~~|
C|N|00102374|20230701|C|19~~~|
C|N|00102374|20230701|M|B373~~~|
C|N|00102374|20230701|M|E669~~~|
C|N|00102374|20230701|P|O440~~~|
C|N|00102374|20230701|P|O16~~~~|
C|N|00102374|20230701|L|03|
C|N|00102374|20230701|A|06|
C|N|00102374|20230701|E|ATDOCTOR UNAVAILABLE|
B|N|00102374|20230701|1|.....
D|N|00102374|20230701|1|I|1~~~~|
D|N|00102374|20230701|1|A|05~~~|
D|N|00102374|20230701|1|F|1|
D|N|00102374|20230701|1|D|1|
D|N|00102374|20230701|1|B|02|
D|N|00102374|20230701|1|G|1|
M|N|00102381|20230701|.....
C|N|00102381|20230701|M|0212~~~|
C|N|00102381|20230701|O|1370601|
B|N|00102381|20230701|1|.....
D|N|00102381|20230701|1|M|D649~|
D|N|00102381|20230701|1|P|O721~|
D|N|00102381|20230701|1|F|1|
D|N|00102381|20230701|1|D|1|
D|N|00102381|20230701|1|V|02|
B|N|00102381|20230701|2|.....
D|N|00102381|20230701|2|C|Q3511322|
D|N|00102381|20230701|2|M|P288~|
D|N|00102381|20230701|2|N|04|
D|N|00102381|20230701|2|F|1|
D|N|00102381|20230701|2|D|1|
D|N|00102381|20230701|2|D|2|
D|N|00102381|20230701|2|E|CALADD'S BANDS|
D|N|00102381|20230701|2|B|01|
D|N|00102381|20230701|2|V|02|
D|N|00102381|20230701|2|V|03|
T|M|00002|00000|00000|
T|C|00011|00000|00000|
T|B|00003|00000|00000|
T|D|00018|00000|00000|

1.5 Transaction Type

This version of the Perinatal Electronic Load system will only use New transaction type records therefore the Transaction Type field of all records will be 'N'. Amendments and deletions will be handled manually in this version.

In future versions the other transaction types of Amendment and Deletion will be accepted. For Mother's Detail records and Baby's Birth detail records, amendments will require the complete set of data for the record including both amended and non-amended fields. For these records deletions will only require the Record Type, Transaction Type, Mother's UR Number, Date of Confinement and, for Baby Birth records, Baby No. - the remaining fields can be truncated from the record. Deleting a detail record results in the deletion of subsidiary dependent records from the database. Deleting a Mother's detail record causes the deletion of associated Mother's Code records, Baby's Birth Detail records and Baby's Birth Code records. Deleting a Baby's Birth Detail record causes the deletion of associated Baby's Birth Code records.

For Mother's Code records and Baby's Birth Code records, amendments will not be used. In order to amend code values, a deletion transaction must be supplied to delete the complete code value set for the particular confinement or baby birth and the code type involved. A set of new Code records is then supplied including amended and non-amended code values. The deletion transaction requires only that the fields up to and including the Code type be supplied. The Code Value field can be truncated. The particular group of code values will be deleted.

The above assumes that the system supplying the data file can keep track of changes to its source data at the required level of detail. An alternative is, that when any change is made to a particular confinement's data set, to supply a deletion for the Mother's Detail which deletes all associated data and then resupply the complete set of confinement data as New transactions.

1.6 Physical Format

The file will be an ASCII text file with records terminated by the ASCII character no. 10 (Line Feed). Records are variable length and do not require padding by spaces to a fixed length except where noted. All alphabetic characters in the file should be uppercase.

1.7 File Naming, File Header and Logistics

The name of the file will be FFFFFYYYYMM.PDC where FFFFF is the facility no. relating to the data in the file, YYYY is the year of data in the file and MM is the month of data in the file. The file will be named in this way by the supplying facility and not by the Queensland Perinatal Data Collection. The extract period dates contained in the file header are considered to refer to the date of input completion (or date of amendment when amendments are in use) of any particular confinement data set and not the date of confinement. This ensures that the facility can extract mutually exclusive contiguous sets of data at any time, will allow flexibility for the facility in the inclusion of data in the file and flexibility for the future in that amendments may occur in a later time period than the original data. The extract period can be checked in the load process to ensure previous periods do not overlap.

It is envisaged that files will be supplied to Perinatal Data Collections on a monthly basis. In connection with this the nominal monthly period in the file header will assist in keeping track of the data.

An example of this is that the file for July 2023 is being prepared. The extract period is selected as occurring from 01/07/2023 to 31/07/2023, and the nominal monthly period for the File Header should be input as 202307 (July 2023). Any confinements where the baby has been discharged in July, or if not yet discharged, where the baby has reached 28 days old in July, should be selected for the file. Exceptions to this rule include where babies of a multiple birth are born across different months, all details for the confinement should be included with the “slowest” baby, i.e. in the month the last baby is discharged, or turns 28 days old, whichever occurs first. Confinements that have been entered for a previous time period and not previously extracted should also be included in this file, however, it should not include any confinements occurring after the extract period. It is suggested that the creating system also performs similar checks as above such as checking the extract period and nominal monthly period.

Once created, the file can be transferred to the QPDC using the Queensland Health approved secure file transfer application. For details on how to access this, contact the QPDC. A sizing study indicates that the total data for the largest hospital would be about 200 Kbytes and on average 11 Kbytes.

File Format

FILE HEADER RECORD

Data item	Format	Description	Validations
Record Type	1 char	F	
Place of birth	5 num Right adjusted and zero filled from left.		
Extract period start date	8 date YYYYMMDD	Date at which extract period starts.	Must be a valid date Must not be blank Must be less than or equal to Extract Period End Date
Extract period end date	8 date YYYYMMDD	Date at which extract period ends.	Must be a valid date Must not be blank Must be greater than or equal to Extract Period Start Date
Extract date	8 date YYYYMMDD	Date data extracted.	Must be a valid date Must not be blank Must be greater than Extract Period End Date

Nominal Monthly Period	6 date YYYYMM	Nominal Month of the data.	Must be a valid date Must not be blank Must not be greater than Extract Period End Date's period

TYPE DETAIL RECORD

Data item	Format	Description	Validations
Record type	1 char	T	
Data type	1 char	Code to identify data type. M Mother's Details C Mother's Code B Baby's Birth Details D Baby's Birth Code	Must be a valid Data Type (M, C, B, D). Must not be blank.
Number of new records	5 num Right adjusted and zero filled from left.	Number of new records. Zero if none.	Must not be blank.
Number of records for amendment	5 num Right adjusted and zero filled from left.	Number of records for amendment. Zero if none.	Must not be blank.

Number of records for deletion	5 num Right adjusted and zero filled from left.	Number of records for deletion. Zero if none.	Must not be blank.

MOTHER'S DETAILS RECORD

Data item	Format	Description	Validations
Record Type	1 char	M	
Transaction Type	1 char	N=new, A=amendment, D=deletion	Must be a valid value (N, A or D). Must not be blank.
Mothers UR number	8 char Right adjusted and zero filled from left.	Unique number assigned by the facility to identify the mother (e.g. Unit record number within the facility).	Must not be blank. Must be unique for each patient within a facility.
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby in multiple births).	Must not be blank. Must be a valid date. Must be after the date of LMP. Must be after the mother's date of birth. Must equal the date of birth of the baby (or first baby of a multiple birth).
Mother's country of birth	4 num Right adjusted and zero filled from left.	4 digit Person-country of birth (SACC 2016) for mother's country of birth.	Validated against person-country of birth (SACC 2016) codes from CRDS. Must not be blank.

Mother's date of birth	8 Date YYYYMMDD	Date of birth of the mother.	Must not be blank. Must be a valid date. Must not be more than 60 years prior to admission date. Must be greater than 10 years prior to admission date. Must not be in the future. Must not be after the admission date or LMP date.
Indigenous status (Mother)	1 num	Indigenous status of the mother. 1=Aboriginal 2=Torres Strait Islander 3=both Australian Aboriginal and Torres Strait Islander 4=neither Australian Aboriginal nor Torres Strait Islander 9=not stated/unknown	Validated against list of indigenous status codes. Must not be blank.
Marital status	1 num	Marital status of the mother. 1=never married 2=married (registered and de facto) 3=widowed 4=divorced	Validated against list of marital status codes. Must not be blank.

		5=separated 9=not stated/unknown	
Accommodation status of mother	1 num	The chargeable status elected by the mother. 1=public 4=private 9=not stated/unknown	Validated against list of accommodation status codes. Must not be blank.
Postcode of usual residence	4 num Right adjusted and zero filled from left.	4 digit Australian postcode of the usual residential address of mother Supplementary codes: 9301=Papua New Guinea 9302=New Zealand 9399=overseas 9799=at sea 9989=no fixed address 0989=not stated/unknown	Validated against list of postcodes and supplementary codes from CRDS. Must not be blank.

Locality of usual residence	40 char Left adjusted	Name of suburb or town of usual residence of mother (valid locality code from the CRDS Locality data set). If patient's usual residence is overseas, insert the country of usual residence. Supplementary localities: At sea New Zealand No fixed address Not stated Overseas-other Papua New Guinea Unknown	Validated against locality code from CRDS Locality data set. Must not be blank.
State of usual residence	1 num	State of usual residence of the mother. 0=overseas 1=New South Wales 2=Victoria 3=Queensland 4=South Australia	Validated against list of state codes from CRDS. Must not be blank.

		5=Western Australia 6=Tasmania 7=Northern Territory 8=Australian Capital Territory 9=not stated/unknown/no fixed address/at sea	
Filler (previously previous Statistical Local Area)	4	Blank.	Must be blank.
Transferred antenatally indicator	1 num	An indicator of whether a patient transferred antenatally, including transfers from planned home births to hospital, birthing centre to acute care etc. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.

Hospital transferred from	5 num Right adjusted and zero filled from left	5 digit facility identifier corresponding to the facility the mother was transferred from antenatally. Supplementary codes. Birthing Centres (BC): 05000=Cairns BC 00984=Sunshine Coast Uni BC 00988=Gold Coast Uni BC 00989=Townsville Uni BC 00990=Toowoomba BC 00994=RBWH BC 00995=Mackay BC 00998=planned homebirths 00999=emergency/unknown May be blank.	Validated against list of facility codes and supplementary codes if not blank. Must not be blank if transferred antenatally=2 Must be blank if transferred antenatally=1 or 9
Time of transfer	1 num	Time of antenatal transfer in relation to labour. 1=prior to onset of labour 2=during labour 9=not stated/unknown May be blank	Validated against list of time of transfer codes. Must not be blank if transferred antenatally=2 Must be blank if transferred antenatally=1 or 9

Date of admission	8 Date YYYYMMDD	Date of admission for this birth.	Must not be blank. Must be a valid date. Must not be in the future (i.e. past current date). Must not be before date of birth of the mother. Must not be after the separation date.
Previous pregnancies indicator	1 num	Indicator of any previous pregnancies. 1=no 2=yes 9=not stated/unknown	Must not be blank. Must be 1, 2 or 9 If previous pregnancy=2, total number of previous pregnancies must be greater than 0
Filler (previously previous livebirths)	2	Blank.	Must be blank.
Filler (previously previous stillbirths)	1	Blank.	Must be blank.
Filler (previously previous abortion/ miscarriage)	2	Blank.	Must be blank.
Last menstrual period	8 Date YYYYMMDD	Date of the first day of LMP May be blank.	May be blank. Otherwise must be a valid date.

Estimated date of confinement	8 Date YYYYMMDD	EDC as indicated by ultrasound scan, dates or clinical assessment. If only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. May be blank.	May be blank. Otherwise must be a valid date.
Filler (previously antenatal care)	1	Blank.	Must be blank.
Filler (previously Number of antenatal visits)	1	Blank.	Must be blank.
Medical conditions indicator	1 num	Indicator of pre-existing maternal 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. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.

Pregnancy complication indicator	1 num	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. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Procedures/operations during pregnancy, labour, birth or puerperium indicator	1 num	An indicator of whether any procedures or operations were performed on a female during the pregnancy, labour, birth or puerperium. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Filler (previously Ultrasound scan)	1	Blank.	Must be blank.

Assisted conception indicator	1 num	An indicator of whether this pregnancy was the result of assisted conception. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Discharge status - mother	1 num	The mode of formal separation of the mother. 1=discharged to usual residence 2=transferred 3=died 4=remaining in 9=not stated/unknown	Validated against list of separation types. Must not be blank.

Mother transferred to	5 num Right adjusted and zero filled from left.	5 digit facility identifier for the facility mother was transferred to after the birth. Supplementary codes. Birthing Centres (BC): 05000=Cairns BC 00984=Sunshine Coast Uni BC 00988=Gold Coast Uni BC 00989=Townsville Uni BC 00990=Toowoomba BC 00994=RBWH BC 00995=Mackay BC 00999=not stated/unknown May be blank.	Must be a valid facility identifier or 00999 Must not be blank if separation type-mother=2 Must be blank if separation type-mother=1, 3, 4 or 9
Date discharged - mother	8 Date YYYYMMDD	Date mother discharged from hospital. May be blank.	Must be a valid date if not blank. Blank if separation type-mother=4 Must not be blank if separation type-mother=1, 2 or 3 Must not be in the future (i.e. past current date). Must be on or after the date of admission.

Birth method of last birth event indicator	1 num	An indicator of whether there are birth methods of last birth event. 1=no 2=yes 9=not stated/unknown May be blank.	Must not be blank if previous pregnancies=2 Blank if previous pregnancies=1 or 9
Number of previous caesareans	2 num Right adjusted and zero filled from left.	Number of previous caesareans. 99=not stated/unknown May be blank.	Must be an integer 00-15 or 99 Must be >=1 if 04 ,05 exists in method of birth of last birth. Blank if previous pregnancies=1 or 9
Number of ultrasound scans	2 num Right adjusted and zero filled from left.	Number of ultrasound scans performed during this pregnancy. 99=not stated/unknown	Must be an integer 00-50 or 99 Must not be blank.
Early discharge program	1 num	Indicates whether mother discharged through an early discharge program. 1=no 2=yes	Validated against list of early discharge program codes. Must not be blank.

Last Menstrual Period estimation indicator	1 char	Indicates whether any part of the date (the day, month or year) of mother's Last Menstrual Period was intentionally estimated by a clinician. E=estimated N=not estimated	Validated against list of estimation indicators for last menstrual period codes. Must not be blank.
Estimated Date of Confinement estimation indicator	1 char	Indicates whether any part of the date (the day, month or year) of mother's Estimated Date of Confinement was intentionally estimated by a clinician. E=estimated N=not estimated	Validated against list of estimation indicators for estimated date of confinement codes. Must not be blank.
Filler (previously Cigarette Smoking indicator)	1 num	Blank.	Must be blank.
Filler (previously Average number of cigarettes smoked)	1 num	Blank.	Must be blank.

Mother's Family Name (previously Surname)	24 char	First 24 characters of surname of the mother.	Must not be blank.
Mother's First Given Name (previously First Name)	15 char	First 15 characters of first given name of the mother.	May be blank.
Mother's Second Given Name (previously Second Name)	15 char	First 15 characters of second given name of the mother.	May be blank.
Address of usual residence	40 char	Number and street of usual residential address of patient. Note: Post office box numbers/mail service numbers should NOT be recorded. Use a building/property number (or rural property name if applicable) and street name wherever possible.	May be blank.

Number of previous pregnancies resulting in ALL livebirths	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where ALL outcomes were livebirths. Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in ALL stillbirths	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where ALL outcomes were stillbirths (of at least 20 weeks gestation and/or at least 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in ALL abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where ALL outcomes were abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2

Number of previous pregnancies resulting in livebirths AND stillbirths	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where outcomes were a combination of livebirths AND stillbirths (of at least 20 weeks gestation and/or at least 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Number of previous pregnancies resulting in livebirths AND abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where outcomes were a combination of livebirths AND abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2

Number of previous pregnancies resulting in stillbirths AND abortion/ miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where outcomes were a combination of stillbirths (of at least 20 weeks gestation or at least 400 grams) AND abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2

Number of previous pregnancies resulting in livebirths AND stillbirths AND abortion/miscarriage/ectopic/ hydatiform moles	2 num Right adjusted and zero filled from left.	Number of previous pregnancies where outcome was at least one livebirth AND at least one stillbirth (of at least 20 weeks gestation and/or at least 400 grams) AND at least one abortion or miscarriage or ectopic or hydatiform moles (of less than 20 weeks gestation and less than 400 grams). Valid range 00-20, 99 99=not stated/unknown May be blank.	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2
Total number of previous pregnancies	2 num	Total number of previous pregnancies. Valid range 01-20, 99 99=not stated/unknown May be blank	Blank if previous pregnancies=1 or 9 Must not be blank if previous pregnancies = 2 Must equal total number of pregnancies reported in the above seven fields.

Mother's height	3 num Right adjusted and zero filled from left.	Height in total number of centimetres of the Mother – self reported at conception Valid range 100-250, 999 999=not stated/unknown	Must not be blank.
Mother's weight – Self reported at conception	3 num Right adjusted and zero filled from left.	Weight in total number of kilograms of the Mother – self reported at conception. Valid range 035-200, 999 999=not stated/unknown	Must not be blank.
Antenatal Care Indicator	1 num	Indicator of whether antenatal care was received for the current pregnancy. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Nuchal translucency ultrasound performed indicator	1 char	Indicates whether a nuchal translucency ultrasound was performed on the mother during the pregnancy. 1=no	Validated against list of nuchal translucency ultrasound performed indicator codes. Must not be blank.

		2=yes 9=not stated/unknown	
Morphology ultrasound performed indicator	1 char	Indicates whether a morphology ultrasound was performed on the mother during the pregnancy. 1=no 2=yes 9=not stated/unknown	Validated against list of morphology ultrasound performed indicator codes. Must not be blank.
Assessment for chorionicity ultrasound performed indicator	1 char	Indicates whether an assessment for chorionicity ultrasound was performed on the mother during the pregnancy. 1=no 2=yes 9=not stated/unknown	Validated against list of assessment for chorionicity ultrasound performed indicator codes. Must not be blank.

Smoking cessation advice during the first 20 weeks	1 num	Indicates whether the mother was offered tobacco smoking cessation advice by a health care provider during the first 20 weeks of pregnancy. 1=no 2=yes 9=not stated/unknown	Must not be blank if tobacco cigarette smoking during the first 20 weeks indicator =2 Must be blank if tobacco cigarette smoking during the first 20 weeks indicator =1 or 9
Extra text indicator	1 num	Indicator of whether there is extra text field(s) as a result of 'Other please specify' fields. 1=no 2=yes	Validated against list of Extra text indicator codes. Must not be blank.
Cigarette Smoking during the first 20 weeks indicator	1 num	Indicates whether tobacco cigarettes were smoked during the first 20 weeks of pregnancy. 1=no 2=yes 3=declined to answer 9=not stated/unknown	Must be 1,2, 3 or 9 Must not be blank.

Number of tobacco cigarettes smoked per day during the first 20 weeks	3 num Right adjusted and zero filled from left.	The number of tobacco cigarettes smoked per day during the first 20 weeks of pregnancy. 998= occasional smoking (less than one) 999=not stated/unknown	Must not be blank if cigarette smoking during the first 20 weeks indicator = 2 Blank if cigarette smoking during the first 20 weeks indicator = 1 or 9
Cigarette Smoking after 20 weeks indicator	1 num	Indicates whether tobacco cigarettes were smoked after 20 weeks of pregnancy. 1=no 2=yes 3=declined to answer 9=not stated/unknown	Must be 1,2, 3 or 9 Must not be blank.
Number of tobacco cigarettes smoked per day after 20 weeks	3 num Right adjusted and zero filled from left.	The number of tobacco cigarettes smoked per day after 20 weeks of pregnancy. 998= occasional smoking (less than one) 999=not stated/unknown	Must not be blank if cigarette smoking after 20 weeks indicator= 2 Blank if cigarette smoking after 20 weeks indicator = 1 or 9

Smoking cessation advice after 20 weeks	1 num	Indicates whether the mother was offered tobacco smoking cessation advice by a health care provider after 20 weeks of pregnancy. 1=no 2=yes 9=not stated/unknown	Must not be blank if tobacco cigarette smoking after 20 weeks indicator =2 Blank if cigarette smoking after 20 weeks indicator =1 or 9
Gestation at first antenatal visit	2 num Right adjusted and zero filled from left.	The gestational age, in completed weeks, at first contact for antenatal care. Valid range 02-45, 99 99=not stated/unknown	Must be blank if Antenatal Care indicator=1 Must not be blank if Antenatal Care indicator = 2 or 9 and must be less than 46 or 99
Mother's Date of Birth estimation indicator	1 char	Indicates whether any part of the Mother's date of birth (the day, month or year) was intentionally estimated by a clinician. E=estimated N=not estimated	Must be E or N Must not be blank.

Total number of antenatal visits	3 num Right adjusted and zero filled from left.	The total number of antenatal visits the mother has received during her pregnancy. Valid range 001 – 998, 999 999 =not stated/unknown	Must be blank if Antenatal Care indicator = 1 Must not be blank if Antenatal Care. indicator = 2 or 9 and must be between 001 and 999
Filler (previously Antenatal Screening performed for Edinburgh Depression Score and range)	1	Blank.	Must be blank.
Filler (previously Antenatal Screening performed for Domestic Violence)	1	Blank.	Must be blank.
Filler (previously Antenatal Screening performed for Alcohol Use)	1	Blank.	Must be blank.

Antenatal Screening performed for Illicit Drug Use indicator	1 num	Indicates whether antenatal screening was performed for Illicit Drug Use. 1=no 2=yes 3=declined to answer 9=not stated/unknown	Must be equal to 1, 2, 3 or 9 Must be equal to 1 if antenatal care indicator = 1 Must not be null.
Immunisation for influenza received during this pregnancy indicator	1 num	Indicates whether immunisation for Influenza received during this pregnancy. 1=no 2=yes 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be null.
Influenza immunisation received at gestation weeks	2 num Right adjusted and zero filled from left.	Gestational age in completed weeks when Influenza immunisation received. Valid range 01-45, 99 99=not stated/unknown	Must not be null if Immunisation for influenza received during this pregnancy indicator = 2 and must be less than 46 completed weeks or 99 Must be blank if Immunisation for influenza received during this pregnancy indicator = 1 or 9

Immunisation for pertussis received during this pregnancy indicator	1 num	Indicates whether immunisation for Pertussis received during this pregnancy. 1=no 2=yes 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be null.
Pertussis immunisation received at gestation	2 num Right adjusted and zero filled from left.	Gestational age in completed weeks when Pertussis immunisation received. Valid range 01-45, 99 99=not stated/unknown	Must not be null if Immunisation for pertussis received during this pregnancy indicator = 2 and must be less than 46 completed weeks or 99 Must be blank if Immunisation for pertussis received during this pregnancy indicator = 1 or 9
Antenatal Screening using Edinburgh Postnatal Depression Scale Indicator	1 num	Indicates whether antenatal screening using Edinburgh Postnatal Depression Scale was performed. 1=no 2=yes 3=declined to answer 9=not stated/unknown	Must be equal to 1, 2, 3 or 9 Must be equal to 1 if antenatal care indicator = 1 Must not be null.

Antenatal Screening for Edinburgh Postnatal Depression Score	2 num Right adjusted and zero filled from left.	The Edinburgh Postnatal Depression Score result Valid range 00-30, 99 99=not stated/unknown	Blank if Antenatal Screening using Edinburgh Postnatal Depression Scale Indicator = 1, 3 or 9 Must not be blank if Antenatal. Screening using Edinburgh Postnatal Depression Scale Indicator = 2
Antenatal Screening performed for Family Violence indicator	1 num	Indicates whether antenatal screening was performed for Family Violence. 1=no 2=yes 3=declined to answer 9=not stated/inadequately described	Must be equal to 1, 2, 3 or 9 Must be equal to 1 if antenatal care indicator = 1 Must not be null.
Alcohol consumption in the first 20 weeks of pregnancy indicator	1 num	Indicates whether alcohol was consumed in the first 20 weeks of pregnancy. 1=no 2=yes 3=declined to answer 9=not stated/inadequately described	Must be 1, 2, 3 or 9 Must not be blank.

Number of standard drinks consumed on a typical day when drinking alcohol in the first 20 weeks of pregnancy	3 num Right adjusted and zero filled from left.	The number of standard drinks consumed on a typical day when drinking alcohol in the first 20 weeks of pregnancy. Valid range 001-997 998=occasional drinking (less than one) 999=not stated/inadequately described	Must not be blank if alcohol consumption in the first 20 weeks of pregnancy indicator = 2 Blank if alcohol consumption in the first 20 weeks of pregnancy indicator =1, 3 or 9
Alcohol consumption frequency in the first 20 weeks of pregnancy	1 num	The alcohol consumption frequency in the first 20 weeks of pregnancy. 1=monthly or less 2=2-4 times a month 3=2-3 times per week 4=4 or more times a week 9=not stated/inadequately described	Must not be blank if alcohol consumption in the first 20 weeks of pregnancy indicator = 2 Blank if alcohol consumption in the first 20 weeks of pregnancy indicator =1, 3 or 9
Alcohol consumption after 20 weeks of pregnancy indicator	1 num	Indicates whether alcohol was consumed after 20 weeks of pregnancy. 1=no	Must be 1, 2, 3 or 9 Must not be blank.

		2=yes 3=declined to answer 9=not stated/inadequately described	
Number of standard drinks consumed on a typical day when drinking alcohol after 20 weeks of pregnancy	3 num Right adjusted and zero filled from left.	The number of standard drinks consumed on a typical day when drinking alcohol after 20 weeks of pregnancy. Valid range 001-997 998=occasional drinking (less than one) 999=not stated/inadequately described	Must not be blank if alcohol consumption after 20 weeks of pregnancy indicator = 2 Blank if alcohol consumption after 20 weeks of pregnancy indicator =1, 3 or 9

Alcohol consumption frequency after 20 weeks of pregnancy	1 num	The alcohol consumption frequency after 20 weeks of pregnancy. 1=monthly or less 2=2-4 times a month 3=2-3 times per week 4=4 or more times a week 9=not stated/inadequately described	Must not be blank if alcohol consumption after 20 weeks of pregnancy indicator = 2 Blank if alcohol consumption after 20 weeks of pregnancy indicator =1, 3 or 9
Primary maternity model of care identifier	6 num	The primary model of care code is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.	Must be blank if Antenatal Care Indicator = 1 or 9 Must not be blank if Antenatal Care Indicator = 2 Must be a valid unique Model of Care code for the facility using the MaCCS.

Maternity model of care at the onset of labour or non-labour caesarean section identifier	6 num	The model of care at the onset of labour or non-labour caesarean section is populated using the Maternity Care Classification System (MaCCS) and is the value of the unique model of care code.	Must be blank if Antenatal Care Indicator = 1 or 9 Must not be blank if Antenatal Care Indicator = 2 Must be a valid unique Model of Care code for the facility using the MaCCS.

MOTHER'S CODE RECORD

Data item	Format	Description	Validations
Record Type	1 char	C	
Transaction Type	1 char	N=new, D=deletion	Must be a valid value (N or D) Must not be blank.
Mother's UR number	8 char Right adjusted and zero filled from left.	A number unique within the facility to identify the patient. This number is not to be reused.	Must not be blank Must not be zero. Must be unique for each patient within a facility.
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby in multiple births).	Must not be blank. Must be a valid date. Must be after the date of LMP. Must be after the mother's date of birth.

Code Type	1 char	Identifies the type of code: C=conception method T=reason for antenatal transfer M=medical condition codes P=pregnancy complication codes O=procedure/operation codes L=method of birth of last birth A=antenatal care type E=extra text	Must be C, T, M, P, O, L, A, E.

Mother's code	7 char
	Left adjusted and space filled from right.
		If Code Type = T, M, P then an ICD-10-AM diagnosis code up to 5 characters (do not use punctuation).	If Code Type = T, M, P then
			Must be a valid ICD-10-AM diagnosis code
			If Code Type = T then
			Record must not exist if transferred antenatally indicator=1 or 9
			Record must exist if transferred antenatally indicator=2
			If Code Type = M then
			Record must not exist if medical conditions indicator=1 or 9
			Record must exist if medical conditions indicator=2
			If Code Type = P then
			Record must not exist if pregnancy complications

			indicator=1 or 9 Record must exist if pregnancy complications indicator=2
		If Code Type = O then an ICD-10-AM procedure code of 7characters (do not use punctuation).	If Code Type = O then Must be a valid ICD-10-AM procedure code. Record must not exist if procedures/operations indicator=1 or 9 Record must exist if procedures/operations indicator=2
		If Code Type = C then a 2 digit conception method code: 02=AIH/AID 03=ovulation induction 04=IVF 05=GIFT 07=ICSI 08=donor egg 09=FET/ET 19=other method 99=not stated/unknown	If Code Type = C then Validated against list of Conception Method codes. Record must not exist if assisted conception indicator=1 or 9 Record must exist if assisted conception indicator=2

		If Code Type = L then a 2 digit method of birth of last birth code: 10=vaginal non-instrumental 02=forceps 03=vacuum extractor 04=LSCS 05=Classical CS 98=other methods 99=not stated/unknown	If Code Type = L then Validated against list of Method of Birth of Last Birth codes. Record must not exist if method of birth of last birth indicator=1 or 9 Record must exist if method of birth of last birth indicator=2
		If Code Type = A then A 2 digit antenatal care type code: 06=public hospital/clinic midwifery practitioner 07=public hospital/clinic medical practitioner 08=general practitioner 03=private medical practitioner 04=private midwifery practitioner 99=not stated/unknown	If Code Type = A then Validated against list of Antenatal Care Type codes. Record must not exist if antenatal care indicator= 1 or 9 Record must exist if antenatal care indicator=2

		If Code Type = E then A 2 character extra text identifier followed by up to 120 characters of text. Extra text identifiers: AT=Antenatal transfer MC=Medical condition PC=Pregnancy complication PO=Procedure/operation	If Code Type = E then First 2 letters validated against list of Extra Text identifiers. Record must not exist if Extra Text indicator =1 Record must exist if Extra Text indicator=2

BABY'S BIRTH DETAIL RECORD

Data item	Format	Description	Validations
Record Type	1 char	B	
Transaction Type	1 char	N=new, A=amendment, D=deletion	Must be a valid value (N, A, D). Must not be blank.
Mother's UR number	8 char Right adjusted and zero filled from left.	A number unique within the facility to identify the mother. This number is not to be reused.	Must not be blank. Must not be zero. Must be unique for each patient within a facility.
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby of a multiple birth).	Must not be blank. Must be a valid date. Must be after the date of LMP. Must be after the mother's date of birth.
Baby number	1 num	The birth order of this baby. 1=singleton, twin 1, multiple 1 2=twin 2, multiple 2 3 =triplet 3, multiple 3 etc	Must not be blank. Must be 1-8 Must be unique for each mother's UR number and date of confinement. Must be consecutive numbers for each mother's UR number and date of confinement.

Baby's UR number	8 char Right adjusted and zero filled from left.	A number unique within the facility to identify the baby. This number is not to be reused.	Must not be blank. Must be unique for each patient within a facility.
Onset of labour	1 num	Indicates whether labour was spontaneous or induced. 1=spontaneous 2=induced 3=no labour (Caesarean section) 9=not stated/unknown	Validated against list of onset of labour codes. Must not be blank.
Induction/augmentation indicator	1 num	Indicates whether induction or augmentation was used during labour for this baby. 1=induction or augmentation not used 2=induction or augmentation used 9=not stated/unknown	Must be 1 or 2 if Onset of Labour=1 Must be 2 if Onset of Labour=2 Must be 1 if Onset of Labour=3 Must not be blank.
Filler (previously reason for induction)	5	Blank.	Must be blank.

Presentation at birth	1 num	Presentation of baby at birth. 1=vertex 2=breech 4=face 5=brow 6=other cephalic 7=transverse/shoulder 8=other (e.g. oblique/hand etc.) 9=not stated/unknown	Validated against list of presentation codes. Must not be blank.
Filler (Previously analgesia indicator)	1	Blank.	Must be blank.
Anaesthesia indicator	1 num	Indicates whether anaesthesia was used for operative/**instrumental** birth of the baby (caesarean, forceps or vacuum extraction). 1=none 2=anaesthesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.

Method of birth	2 num	Method of birth. 10=vaginal non-instrumental 02=forceps 03=vacuum extractor 04=LSCS (Inc. hysterotomy) 05=classical CS 98=other methods 99=not stated/unknown	Validated against list of method of birth codes Must not be blank. Must be 04 or 05 if onset of labour=3
Filler (Previously Reason for Caesarean)	5	Blank.	Must be blank.
Principal accoucheur	1 num	Principal accoucheur at birth. 1=obstetrician 2=other medical officer 3=registered midwife 4= midwife student 5=medical student 6=any other person 7=no attendant/self 9=not stated/unknown	Validated against list of principal accoucheur codes. Must not be blank.
Filler (previously Perineum)	1	Blank.	Must be blank.

Filler (previously Episiotomy)	1	Blank.	Must be blank.
Surgical repair	1 num	Indicates if surgical repair to perineum or vagina performed. 1=no repair performed 2=repair performed 9=not stated/unknown	Validated against list of surgical repair codes. Must not be blank.
Labour and birth complications indicator	1 num	Indicates if any labour or birth complications are present during this birth. 1=no complications 2=one or more complications 9=not stated/unknown	Must be equal to 1,2 or 9 Must not be blank.
Fetal scalp pH	1 num	Indicates if fetal scalp pH was measured. 1=not taken/unknown 2=fetal scalp pH taken	Must be equal to 1 or 2 Must not be blank.

Baby's date of birth	8 Date YYYYMMDD	Same as date of confinement if baby is a singleton or first baby of a multiple birth.	Must not be blank. Must be a valid date. Must be after date of LMP. Must be the same as date of confinement if baby is a singleton or the first of a multiple birth. Must be before or same as discharge date. Must be more than 10 years after mother's date of birth. Must be less than 60 years after mother's date of birth.
Time of birth	4 num HHMM	Baby's time of birth. 24 hour clock 0000 (midnight) - 2359 9999=not stated/unknown	Must be a valid time or 9999 Must not be blank.
Birthweight	4 num Right adjusted and zero filled from left.	Baby's weight at birth (grams) (Note that stillbirths less than 400 grams and less than 20 weeks gestation are beyond the scope of this collection). 9999=not stated/unknown	If born alive = 2 (stillborn), baby must be >= 400 grams if gestation <20 Must not be blank.

Gestation weeks	2 num Right adjusted and zero filled from left.	Gestational age of baby determined by clinical examination after birth (number of completed weeks). (Note that stillbirths less than 20 weeks and less than 400grams birthweight are beyond the scope of this collection). 99=not stated/unknown	If born alive = 2 (stillborn), baby must be >19 if birthweight<400 Must not be blank.
Plurality	1 num	Plurality of this pregnancy. 1=singleton 2=twins 3=triplets etc. 9=not stated/unknown	Must not be blank. Valid range 1-8 Must not be less than the baby number.
Baby's sex	1 num	Sex of the baby. 1=male 2=female **3= X** 9=not stated/unknown	Validated against list of baby's sex codes. Must not be blank.

Born alive/stillborn	1 num	Indicates whether the baby was born alive or a still birth. 1=born alive 2=stillbirth 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Macerated	1 num	Indicates whether a baby was macerated if stillborn. 1=not macerated 2=macerated 9=not stated/unknown May be blank.	Must be 1, 2 or 9 if not blank. Must be blank if born alive/stillborn=1 Must not be blank if born alive/stillborn=2
Vitamin K	1 num	Method of administering first dose of vitamin K to baby. 1=oral 2=IM 3=none 9=not stated/unknown	Validated against list of Vitamin K codes. Must not be blank.
Apgar score at 1 minute	2 num Right adjusted and zero filled from left.	Total Apgar score at 1 minute 00-10 99=not stated/unknown	Must not be blank. Must be less than 11 or 99 Must be 00 if born alive/stillborn=2

Apgar score at 5 minutes	2 num Right adjusted and zero filled from left.	Total Apgar score at 5 minutes 00-10 99=not stated/unknown	Must not be blank. Must be less than 11 or 99 Must be 00 if born alive/stillborn=2
Regular respirations	2 num Right adjusted and zero filled from left.	Number of minutes to establish regular respirations for livebirths. 00=at birth 97=respirations not established 98=intubated 99=not stated/unknown May be blank.	Must be less than 60 or equal to 97 or 98 or 99 Must not be blank if born alive/stillborn=1 Must be blank if born alive/stillborn=2
Arterial Cord pH measured indicator	1 num	Indicates whether **arterial** cord pH was measured. 1=not measured 2=measured	Must be equal to 1 or 2 Must not be blank. Must be 1 If born_alive/stillborn=2
Resuscitation used indicator	1 num	Indicates whether resuscitation was used for this baby. 1=no resuscitation used 2=resuscitation used for baby 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be blank.

Neonatal morbidity indicator	1 num	Indicates if any neonatal morbidity was present. 1=no neonatal morbidity 2=one or more neonatal morbidities 9=not stated/unknown	Must be equal to 1, 2, or 9 Must be 1 if born alive/stillborn=2 Must not be blank. Must be 2 if Neonatal Treatment indicator is 2
Neonatal treatment indicator	1 num	Indicates whether any neonatal treatment was applied. 1=no neonatal treatment 2=neonatal treatment given 9=not stated/unknown	Must be equal to 1, 2 or 9 Must be 1 if born alive/stillborn=2 Must not be blank.
Congenital anomaly indicator	1 num	Indicates the presence of any congenital anomalies in the baby. 1=no congenital anomaly 2=congenital anomaly present 3=suspected congenital anomaly 9=not stated/unknown	Must be 1,2, 3 or 9 Must not be blank.
Filler (previously Admitted to ICN/SCN)	3	Blank.	Must be blank.

Puerperium complications indicator	1 num	Indicates the presence of puerperium complications following birth. 1=no puerperium complications 2=one or more puerperium complications 9=not stated/unknown	Must be equal to 1, 2 or 9 Must not be blank.
Filler (previously Feeding method on discharge)	1	Blank.	Must be blank.
Separation type - baby	1 num	The type of separation of the baby. 1=discharged 2=transferred 3=died 4=remaining in 9=not stated/unknown	Validated against a list of separation type-baby codes. Must not be blank. Must be 3 if born alive/stillborn=2 Must be 4 if date discharged-baby is blank

Baby transferred to	5 num Right adjusted and zero filled from left	5 digit facility code of the facility to which the baby was transferred plus supplementary codes. Birthing centres (BC): 05000=Cairns BC 00984=Sunshine Coast Uni BC 00988=Gold Coast Uni BC 00989=Townsville Uni BC 00990=Toowoomba BC 00994=RBWH BC 00995=Mackay BC 00999=not stated/unknown May be blank.	Must be a valid facility number or 00999 if not blank. Must not be blank if separation type- baby=2 Must be blank if separation type- baby=1, 3, 4 or 9
Date discharged - baby	8 Date YYYYMMDD	Date of discharge, transfer or death of baby. May be blank.	Must be a valid date if not blank. Blank if separation type-baby=4 Must be on or after baby's date of birth. Must be equal to baby's date of birth if born alive/ stillborn=2
Intended Place of Birth	1 num	The intended place of birth at the onset of labour. 1=Hospital	Validated against list of Intended Place of Birth codes Must not be blank

		2=Birth centre, attached to hospital 3=Birth centre, free standing 4=Home 8=other 9=not stated/unknown	
Actual Place of Birth	1 num	The actual place where the birth occurred. 1=Hospital 2=Birth centre, attached to hospital 3=Birth centre, free standing 4=Home 5=Born before arrival 7=Community, non-medical (freebirth) 8=other 9=not stated/unknown	Validated against list of Actual Place of Birth codes. Must not be blank.
Membranes ruptured	5 num Right justified and zero filled from left.	The number of hours before birth the membranes ruptured. 99999=not stated/unknown	Must be an integer 00000-99999 Must not be blank.

Length of first stage of labour	5 num Right justified and zero filled from left.	The length of the first stage of labour (minutes). 00000=interrupted 99998=not measured 99999=not stated/unknown May be blank.	Must be an integer 00000-99999 Must not be blank if onset of labour = 1, 2 or 9 Must be blank if onset of labour=3
Length of second stage of labour	5 num Right justified and zero filled from left.	The length of the second stage of labour (minutes). 00000=interrupted 99998=not measured 99999=not stated/unknown May be blank.	Must be an integer 00000-99999 Must not be blank if onset of labour = 1,2 or 9 Must be blank if onset of labour=3
Reason for forceps/vacuum	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for instrumental birth. May be blank.	Must be a valid ICD-10-AM diagnosis code Must be blank if method of birth =04,05, 98,10 Must not be blank if method of birth=02 or 03
Cervical dilatation prior to caesarean	1 num	Cervical dilatation prior to caesarean. 1=3cm or less 2=more than 3cm 3=not measured May be blank	Validated against list of cervical dilatation codes. Must be blank if method of birth=02, 03,10 Must not be blank if method of birth=04 or 05 May be blank.

Head circumference at birth	(3,1) num Right adjusted and zero filled from left.	Head circumference of baby at birth. 99.8=not measured 99.9=not stated/unknown	Must be a number to one decimal place 00.0-99.9 Must not be blank. Do not transmit the decimal point.
Length at birth	(3,1) num Right adjusted and zero filled from left.	Length of baby at birth. 99.8=not measured 99.9=not stated/unknown	Must be a number to one decimal place 00.0-99.9 Must not be blank. Do not transmit the decimal point.
Admitted to ICN	3 num Right adjusted and zero filled from left.	Number of whole days or part there of the baby was present in intensive care nursery. If baby in for less than 24 hours report this as 001. Valid range 000-998 999=not stated/unknown	Must be an integer 000-999 Must not be blank.
Admitted to SCN	3 num Right adjusted and zero filled from left.	Number of whole days or part there of the baby was present in special care nursery. If baby in for less than 24 hours report this as 001. Valid range 000-998 999=not stated/unknown	Must be an integer 000-999 Must not be blank.

Reason for admission to ICN/SCN	5 char Left justified.	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for admission to intensive/special care nursery. May be blank	Must be a valid ICD-10-AM diagnosis code. Must not be blank if admitted to ICN is between 001 and 998 days or admitted to SCN is between 0001 and 998 days.
Hep B Vaccination	1 num	Indicates if baby was given birth dose of Hep B vaccination. 1=not given vaccination 2=given vaccination 9=not stated/unknown	Must be 1, 2, 9 Must not be blank.
CTG	1 num	Indicates if CTG was performed during labour. 1=not performed 2=CTG performed 9=not stated/unknown	Must be 1, 2, 9 Must not be blank.
FSE	1 num	Indicates if FSE was performed during labour. 1=not performed 2=FSE performed 9=not stated/unknown	Must be 1, 2, 9 Must not be blank.

Non-Pharmacological Analgesia indicator	1 num	Indicates whether non-pharmacological analgesia was used during labour/birth. 1=none 2=non-pharmacological analgesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Pharmacological Analgesia indicator	1 num	Indicates whether pharmacological analgesia was used during labour/birth. 1=none 2=pharmacological analgesia used 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Fetal scalp pH result	(3,2) num Left adjusted and zero filled from right.	Fetal scalp pH result 9.99=not stated/unknown May be blank.	Must be a valid number to two decimal places. Valid range 6.49 – 7.50 If Fetal scalp pH indicator = 2 then must not be blank. If Fetal scalp pH indicator =1 then must be blank. Do not transmit the decimal point.

Arterial Cord pH result	(3,2) num Left adjusted and zero filled from right.	**Arterial** Cord pH result 9.99=not stated/unknown May be blank.	Must be a valid number to two decimal places. Valid range 6.49 – 7.50 If **Arterial** Cord pH indicator =2 then must not be blank. If **Arterial** Cord pH indicator =1 then must be blank. Do not transmit the decimal point.
Water birth indicator	1 num	Indicates whether this birth was a water birth. 1=no 2=yes 9=not stated/unknown	Must be 1, 2 or 9 Must not be blank.
Water planned birth intent	1 num	Indicates whether this water birth was planned or unplanned. 1=unplanned 2=planned 9=not stated/unknown May be blank	If Water birth indicator = 2 then must not be blank. If Water birth indicator = 1 then must be blank. May be blank.
PPH volume	1 num	The volume of PPH loss. 1=500–999mls 3=1000-1499mls 4=>1500mls 9=not stated/unknown	Validated against list of PPH volume codes. If Labour and Birth complication code=O721 must not be blank. If Labour and Birth complication code <>O721 then must be blank.

Fluid(s) the baby received in the 24 hours prior to discharge indicator	1 num	Indicates whether the baby received fluid(s) in the 24 hours prior to discharge/transfer/death. 1=no fluid 2=fluid received 9=not stated/unknown	Must be 1,2 or 9 if born alive/stillborn=1 Must be 1 if born alive/stillborn=2
Fluid(s) the baby received at any time from birth to discharge indicator (previously during birth episode)	1 num	Indicates whether the baby received fluid(s) at any time from birth to discharge. 1=no fluid 2=fluid received 9=not stated/unknown	Must be 1,2 or 9 if born alive/stillborn=1 Must be 1 if born alive/stillborn=2
Filler (Previously fed by a bottle)	1	Blank.	Must be blank.
Extra text indicator	1 num	Indicates if there is extra text field(s) as a result of 'Other please specify' fields. 1=no 2=yes	Validated against list of Extra text indicator codes. Must not be blank.

Fetal scalp lactate indicator	1 num	Indicates if fetal scalp lactate was measured. 1=not measured 2=measured	Must be equal to 1 or 2 Must not be blank.
Fetal scalp lactate result	(3,1) num Right adjusted and zero filled from left.	Fetal scalp lactate result. 99.9=not stated/unknown May be blank.	Must be a valid number to one decimal place. Valid range 00.0 – 30.9 Must not be blank if fetal scalp lactate indicator = 2 Must be blank if fetal scalp lactate indicator =1 Do not transmit the decimal point.
Gestation days	1 num	Gestation days (used in conjunction with gestation weeks) of baby determined by clinical examination after birth. (Note that stillbirths less than 20 weeks and less than 400grams birthweight are beyond the scope of this collection). 9=not stated/unknown	Must be between 0 and 6 or 9 Must not be blank.
Antibiotics received at time of caesarean section	1 num	Indicates whether antibiotics were received at time of caesarean section. 1=no antibiotics administered	Must be equal to 1, 2, 3 or 9 if method of birth = 04, 05 Must be blank if method of birth = 10, 02, 03, 98, 99

		2=antibiotics administered - prophylactic 3=antibiotics administered – therapeutic 9=not stated/unknown May be blank	
Thromboprophylaxis received for caesarean section indicator	1 num	Indicates whether thromboprophylaxis was received for caesarean section. 1=no 2=yes 9=not stated/unknown	Must be equal to 1, 2 or 9 if method of birth = 04, 05 Must be blank if method of birth = 10, 02, 03, 98, 99
Alternative feeding method indicator	1 num	Indicates whether the baby has ever been fed by an alternative feeding method. 1=no 2=yes 9=not stated/unknown May be blank	Must be equal to 1,2 or 9 if born alive/stillborn = 1 Must be blank if born alive/stillborn = 2

Indigenous status (Baby)	1 num	The indigenous status of the baby. 1=Aboriginal 2=Torres Strait Islander 3=Aboriginal and Torres Strait Islander 4=neither Aboriginal nor Torres Strait Islander 9=not stated/unknown	Must be equal to 1, 2, 3, 4 or 9 Must not be blank.
Hepatitis B Immunoglobulin	1 num	Whether baby was given Hepatitis B immunoglobulin. 1=hepatitis B immunoglobulin not given 2=hepatitis B immunoglobulin given 9=not stated/unknown	Must be 1, 2, 9 Must not be blank.
Perineal Damage indicator	1 num	Indicates whether the perineum sustained any damage during birth. 1=no (perineum intact) 2=yes	Must be equal to 1 or 2 Must not be blank.

Main Reason for Caesarean	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate main reason for Caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if method of birth=10, 02, 03, 98, 99 Must not be blank if method of birth=04 or 05 Validated against main reason for caesarean codes.
Main Reason for Caesarean identifier	1 num	1=previous shoulder dystocia 2=previous perineal trauma/4th degree tear 3=previous adverse fetal/neonatal outcome 8=other	Must be blank if method of birth=10, 02, 03, 98, 99 May be blank if method of birth =04 or 05 Validated against list of main reason for caesarean identifier codes. Must not be blank if main reason for caesarean code=Z352 Must be blank if main reason for caesarean code is not Z352
First Additional Reason for Caesarean	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate first additional reason for caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if method of birth=10, 02, 03, 98, 99 May be blank if method of birth =04 or 05 Must be blank if main reason for caesarean is blank. Must not be blank if second additional reason for caesarean is not blank. Validated against list of first reason for caesarean codes.

First Additional Reason for Caesarean identifier	1 num	1=previous shoulder dystocia 2=previous perineal trauma/4th degree tear 3=previous adverse fetal/neonatal outcome 8=other	Must be blank if method of birth=10,02,03,98,99 May be blank if method of birth =04 or 05 Validated against list of first additional reason for caesarean identifier codes. Must not be blank if first additional reason for caesarean code=Z352 Must be blank if first additional reason for caesarean code is not Z352
Second Additional Reason for Caesarean	5 char Left adjusted	An ICD-10-AM diagnosis code up to 5 characters to indicate second additional reason for caesarean. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if method of birth=10, 02, 03, 98, 99 May be blank if method of birth =04 or 05 Must be blank if main reason for caesarean is blank. Must be blank if first additional reason for caesarean is blank. Validated against list of second reason for caesarean codes.
Second Additional Reason for Caesarean identifier	1 num	1=previous shoulder dystocia 2=previous perineal trauma/4th degree tear 3=previous adverse fetal/neonatal outcome 8=other	Must be blank if method of birth=10, 02, 03, 98, 99 May be blank if method of birth =04 or 05 Validated against list of second additional reason for caesarean identifier codes. Must not be blank if second additional reason for caesarean code=Z352

			Must be blank if second additional reason for caesarean code is not Z352
Main Reason for Induction	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate main reason for induction. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if onset of labour=1, 3, 9 Must not be blank if onset of labour=2 Validated against main reason for induction codes.
Reason for Induction Additional 1	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for induction additional 1. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if onset of labour=1, 3, 9 May be blank if onset of labour =2 Must be blank if main reason for induction is blank. Must not be blank if reason for induction additional 2 is not blank. Validated against list of reason for additional 1 codes
Reason for Induction Additional 2	5 char Left adjusted.	An ICD-10-AM diagnosis code up to 5 characters to indicate reason for induction additional 2. May be blank.	Must be a valid ICD-10-AM diagnosis code. Must be blank if onset of labour=1, 3, 9 May be blank if onset of labour =2 Must be blank if main reason for induction is blank. Must be blank if reason for induction additional 1 is blank. Validated against list of reason for additional 2 codes

BABY'S BIRTH CODE RECORD

Data item	Format	Description	Validations
Record Type	1 char	D	
Transaction Type	1 char	N=new, D=deletion	Must be a valid value (N, D). Must not be blank.
Mother's UR number	8 char Right adjusted and zero filled from left	A number unique within the facility to identify the mother. This number is not to be reused.	Must not be blank. Must not be zero. Must be unique for each patient within a facility.
Date of confinement	8 Date YYYYMMDD	Corresponds to date of birth of the baby (or the first baby of a multiple birth).	Must not be blank Must be a valid date. Must be after the date of LMP. Must be after the mother's date of birth.
Baby number	1 num	The birth order of this baby. e.g. 1=twin 1, 2=twin 2, 1=singleton.	Must not be blank Must be less than 10. Must be unique for each mother's UR number and date of confinement. Must be consecutive numbers for each mother's UR number and date of confinement.
Code Type	1 char	Identifies the type of code: I=Induction/Augmentation A=Pharmacological Analgesia S=Anaesthesia	Must be I, A, S, R, T, C, L, M, P, N, F, D, E, B, G, V

		R=Resuscitation T=Neonatal Treatment C=Congenital Anomaly L=Labour and Birth Complication M=Neonatal Morbidity P=Puerperium Complication N=Non-pharmacological analgesia F=Type of fluid baby received in the 24 hours prior to discharge/transfer/death D=Type of fluid baby received at any time during the birth episode E=Extra text B=Alternative Feeding Method G=Thromboprophylaxis received for caesarean section V=Perineal Status Code	

Baby's birth code	5 char
	Left adjusted and space filled from right.
		If Code Type = L, P, M then an ICD-10-AM diagnosis code up to 5 characters.	If Code Type = L, P, M then
			Must be a valid ICD-10-AM diagnosis code.
			If Code Type = L then
			Record must not exist if labour and birth complication indicator=1 or 9
			Record must exist if labour and birth complication indicator=2

			If Code Type = P then
			Record must not exist if puerperium complications indicator=1 or 9
			Record must exist if puerperium complications indicator=2
			If Code Type = M then
			Record must not exist if neonatal morbidity indicator=1 or 9
			Record must exist if neonatal morbidity indicator=2

	8 char - made up of 5 char ICD-10-AM code left adjusted and space filled from right, 1 char identifying position,	If Code Type = C then 5 char - an ICD-10-AM diagnosis code up to 5 characters in range Q00 – Q999 or D181 or R294 1 char – position – this is the position of the anomaly as collected by the NPDC 1=right 2=left	If Code Type = C then Record must not exist if congenital anomaly indicator=1 or 9 Record must exist if congenital anomaly indicator=2 or 3 Must be a valid ICD-10-AM diagnosis code in range Q00 – Q9999 or D181 or R294 Must contain position and status following the ICD-10-AM code.

	1 char identifying status,	3=bilateral 4=unilateral (unspecified) 5=anterior 6=posterior 7=central/midline 8=not applicable 9=not stated 1 char – status code – This is the current status of the anomaly 1=suspected 2=confirmed 3=suspected and cannot confirm 9=not stated/unknown	
	1 char identifying diagnosed prior to birth indicator	1 char – diagnosed prior to birth indicator – This shows if the congenital anomaly was diagnosed prior to birth or not. 1=not diagnosed prior to birth 2=diagnosed prior to birth 9=not stated/unknown	Must contain diagnosed prior to birth indicator code following the position and status.

		If Code Type = I then a 1 digit code for Method of induction or augmentation of labour: 1=artificial rupture of membranes 2=oxytocin 3=prostaglandins 6=mechanical cervical dilatation 7=antiprogestogen 8=other 9=not stated/unknown	If Code Type = I then Validated against list of induction/augmentation codes. Record must not exist if onset of labour=1 or 3 Record must not exist if induction/augmentation indicator=1 or 9 Record must exist if onset of labour=2 Record must exist if induction/augmentation indicator=2
		If Code Type = A then a 2 digit code for pharmacological Analgesia: 02=nitrous oxide 08=systemic opioid (inc IM/IV narcotic) 04=epidural 05=spinal 10=combined spinal-epidural 07=caudal 19=other 99=not stated/unknown	If Code Type = A then Validated against list of pharmacological analgesia codes. Record must not exist if pharmacological analgesia indicator=1 or 9 Record must exist if pharmacological analgesia indicator=2

		If Code Type = S then a 2 digit code for Anaesthesia: 02=local anaesthetic to perineum 03=pudendal 04=epidural 05=spinal 10=combined spinal-epidural 06=general anaesthesia 07=caudal 19=other 99=not stated/unknown	If Code Type = S then Validated against list of anaesthesia codes. Record must not exist if anaesthesia indicator=1 or 9 Record must exist if anaesthesia indicator=2
		If Code Type = R then a 2 digit code for Resuscitation Method: 02=suction (oral, pharyngeal etc.) 03=suction of meconium (oral, pharyngeal etc.) 04=suction of meconium via ETT 05=facial O2 (or head box) 06=bag and mask 07=IPPV via ETT 08=narcotic antagonist injection 09=external cardiac massage 11=adrenalin/sodium bic/calcium 12=other drugs	If Code Type = R then Validated against list of Resuscitation codes. Record must not exist if resuscitation used indicator=1 or 9 Record must exist if resuscitation used indicator=2

		13=CPAP ventilation 14=intubation 19=other stimulations 99=not stated/unknown	
		If Code Type = T then a 2 digit code for Neonatal Treatment: 02=oxygen for >4 hours 03=phototherapy 04=IV/IM antibiotics 05=IV fluid 06=mechanical ventilation 07=IA line 08=exchange transfusion 10=blood glucose monitoring 11=CPAP 12=oro/nasogastric feeds 19=other 99=not stated/unknown	If Code Type = T then Validated against list of Neonatal treatment codes. Record must not exist if neonatal treatment indicator=1 or 9 Record must exist if neonatal treatment indicator=2 If treatment code not null or 99 then neonatal morbidity to indicate reason for treatment must be provided.
		If Code Type = N then a 2 digit code for Non-pharmacological Analgesia: 02=heat pack 03=birth ball	If Code Type = N then Validated against list of non-pharmacological analgesia codes. Record must not exist if non- pharmacological

		04=massage 05=shower 06=water immersion 07=aromatherapy 08=homoeopathy 09=acupuncture 10=TENS 11=water injection 98=other 99=not stated/unknown	analgesia indicator=1 or 9 Record must exist if non- pharmacological analgesia indicator=2
		If Code Type = F then a 1 digit code for the type of fluid the baby received during the 24 hours prior to discharge/transfer/death 1=breast milk/colostrum 2=infant formula 3=water, fruit juice or water-based products 4=nil fluids by mouth 9=not stated/unknown	If Code Type = F then Validated against a list of type of fluid the baby received during 24 hours prior to discharge/transfer/death codes if not blank Record must not exist if Fluid(s) the baby received in the 24 hours prior to discharge indicator = 1 or 9 Record must exist if Fluid(s) the baby received in the 24 hours prior to discharge indicator = 2 Must be blank if born alive/stillborn=2 Must not be blank if born alive/stillborn=1 Must be blank if separation type – baby=4

		If Code Type = D then a 1 digit code for the type of fluid the baby received at any time from birth to discharge if not blank 1=breast milk/colostrum 2=infant formula 3=water, fruit juice or water-based products 4=nil fluids by mouth 9=not stated/unknown	If Code Type = D then Validated against a list of type of fluid the baby received at any time from birth to discharge if not blank Record must not exist if Fluid(s) the baby received at any time prior to discharge indicator 1 or 9 Record must exist if Fluid(s) the baby received at any time prior to discharge indicator=2 Must be blank if born alive/stillborn=2 Must not be blank if born alive/stillborn=1 Must be blank if separation type – baby=4
		If Code Type = E then a 2 character extra text identifier followed by up to 120 characters of text Extra text identifiers: IM=Main reason for induction IO=Reason for Induction Additional 1 IT=Reason for Induction Additional 2 FV=Reason forceps/vacuum CM=Main reason for caesarean CO= First Additional Reason for Caesarean CT= Second Additional Reason for Caesarean LD=Labour/Birth complication	If Code Type = E then First 2 letters validated against list of Extra Text identifiers. Record must not exist if Extra Text indicator=1 Record must exist if Extra Text indicator=2

		PU=Puerperium complication NM=Neonatal morbidity CA=Congenital anomaly RN=Reason admission to ICN/SCN	
		If Code Type = B then a 2 digit code for Alternative Feeding Method: 02=bottle 03=cup 04=syringe 98=other 99=not stated/unknown	If Code Type = B then Validated against a list of Alternative Feeding Methods if not blank. Record must not exist if Alternative Feeding Method indicator = 1 or 9 Record must exist if Alternative Feeding Method indicator = 2 Must be blank if born alive/stillborn=2
		If Code Type = G then a 1 digit code for Thromboprophylaxis for caesarean section: 2=pharmacological thromboprophylaxis 3=intermittent calf compression 4=TED Stockings 8=other thromboprophylaxis 9=not stated/Unknown	If Code Type = G then Validated against list of thromboprophylaxis codes. Record must exist if thromboprophylaxis received for caesarean section = 2 Record must not exist if thromboprophylaxis received for caesarean section =1 or 9
		If Code Type = V then a 2 digit code for Perineal Code: 02=1st degree laceration/vaginal graze	If Code Type = V then Validated against list of Perineal Codes. Record must exist if Perineal Damage

		03=2nd degree laceration 04=3rd degree laceration 05=4th degree laceration 06=episiotomy 98=other 99=Not stated/Unknown	indicator=2 Record must not exist if Perineal Damage indicator=1