hiso Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Maternity Care Summary Standard

HISO 10050.2:2019

Draft for public comment 2019

New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

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Contents

1 Introduction

To provide high quality maternity care in New Zealand we need to underpin maternity practice with information that supports the care of women, babies and their family/whanaū, continuity of care, best practice, and analytics.

1.1 Purpose

This standard is designed to ensure that information related to maternity care is consistently recorded. Standardised data will enable services to be meaningfully benchmarked against each other. A meaningful data set reflecting maternity information and services can be shared between community and hospital providers to support continuity of care.

This standard, HISO 10050.2:2019 Maternity Care Summary Standard, will supersede HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which will be placed in a 'Contained' state (only able to be used for existing systems but not for any significant enhancement to systems). A time frame for this action is yet to be determined. There will be a period of overlap, after which HISO 10050.1:2016 will be 'Withdrawn' and not used for any related systems.

1.2 Scope

The standard defines the minimum data to be recorded by maternity service providers in New Zealand.

The maternity care summary identifies the pregnant woman and includes administrative and clinical information about the pregnancy, the labour and birth, the baby(ies), and the postnatal period. The summary standard covers the time period from first contact with a health professional in regards to the current pregnancy, up until around six weeks after the birth of the baby(ies).

The maternity care summary standard does not include referrals and discharge summaries.

1.3 New Zealand Legislation

The following Acts of Parliament and Regulations are relevant to this standard. Readers must consider other Acts and Regulations and any amendments that are relevant to their own organisation, when implementing or using this standard.

- Health Act 1956
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health Information Privacy Code 1994
- Health Practitioners Competence Assurance Act 2003

- New Zealand Public Health and Disability Act 2000
- Privacy Act 1993 (revised 2008)
- Public Records Act 2005
- Retention of Health Information Regulations 1996.

1.4 Related specifications

The following documents were used to develop or are referenced in, this standard:

- HISO 10042.1 Medication Charting Standard published September 2012
- HISO 10042.2 Medicine Reconciliation standard published September 2012

Both documents are available at:
https://www.health.govt.nz\publication\hiso-10042-medication-charting-and-medicine-reconciliation-standards-charting-and-medicine-reconciliation-standards

- HISO 10045:2019 Healthcare Provider Index Standard (the HPI standard).

Note: this standard is currently in development, with an expectation that the draft version will be out for public comment during the latter part of 2019.

The current HISO Health Practitioner Index standards are listed below. These standards were published in 2008 and while they can provide guidance on the particular HPI values referred to in this standard, they are not suitable for any other purpose.

- HISO 10005:2008 Health Practitioner Index (HPI) Data Set
  https://www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set
- HISO 10006:2008 Health Practitioner Index (HPI) Code Set
  https://www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set
- HISO 10046 Consumer Health Identity Standard
  https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard

HISO has endorsed SNOMED CT as the clinical terminology for use in New Zealand. Accordingly, the SNOMED code system is used in the data elements documented in this standard. Access to the detail behind each SNOMED CT code is available via the SNOMED CT browser. SNOMED International (http://www.snomed.org/)

Note: Where a SNOMED code has not been provided, either a suitable code does not currently exist, or code choices for the particular domain option are still under consideration and will be added at a later date. These entries are indicated by 'To Be Advised' (TBA) in the SNOMED CT Code column.

To review individual SNOMED codes (Internet Explorer):

- open the browser (https://browser.ihtsdotools.org/index-ie.html?) and confirm acceptance of the access terms
- select 'Go browsing International Edition' (under the "International Editions" heading, Blue box, left edge, middle of screen)
- select 'Search' (second option, near top left of screen)
- copy and paste the SNOMED CT Code (from the Data element / Data Domain to be reviewed) into the search box (under the text "Type at least 3 characters"). The system will provide a list of available options
- Select (click) one option; review the 'Concept detail' presented in the right-hand side of the screen

New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information. For more detail, refer to the bottom of Page 3 in the following report:
https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf

1.5 Information interoperability messaging

This standard provides the data set specification for maternity care. It does not specify how information sharing is to occur. This will be described in a separate implementation guide that defines the data structures and exchange protocols required to share the data.

HISO has endorsed the use of HL7 FHIR as the messaging standard.

See https://www.health.govt.nz/our-work/ehealth/digital-health-sector-architecture-standards-and-governance/health-information-standards/approved-standards/interoperability-standards?page=1

1.6 Data element definitions

Data element specifications in this standard conform to the requirements of *ISO/IEC 11179 Information Technology – Metadata Registries (MDR)*.[1]

Definition	A statement that expresses the essential nature of the data element and its differentiation from other elements in the data set.		
Source standards	Established data definitions or guidelines pertaining to the data element.		
Data type	Alphabetic (A) Date Date/time Numeric (N) Alphanumeric (X) Boolean	**Representational class**	Code, free text, value or identifier. For date and time data types, use full date or partial date.
Field size	Maximum number of characters	**Representational layout**	The formatted arrangement of characters in alphanumeric elements, eg: • 'A(50)' means up to 50 alphabetic characters • 'NNAAAA' means two numeric followed by four alphabetic characters • Full date/time representation is CCYYMMDD HH:MM All times are recorded in a 24 hour format i.e. 8:30 pm is recorded as 20:30
Data domain	The valid values or codes that are acceptable for the data element. Each coded data element has a specified code set.		
Obligation	Indicates if the data element is mandatory or optional in the context, or whether its appearance is conditional		
Guide for use	Additional guidance to inform the use of the data element. Where a 'multiple instance' is noted, this requires the system to be able to capture up to the specified number of instances		
Verification rules	Quality control mechanisms that preclude invalid values.		

[1] See https://standards.iso.org/ittf/PubliclyAvailableStandards/index.html

2 Maternity care summary related information

The following sections define the data elements that constitute supporting detail related to a maternity event. This contains information related to both the woman's individual data, those involved in health care provision (people, organisations, facilities) and medicines.

Data element	Data element
2.1 Personal information 2.2 Health care provider information	2.3 Medicines information

2.1 Personal information

Personal information related to the woman should only be obtained from the National Health Index (NHI) system. Similarly, personal information related to the baby is or will, in due course, be available in the NHI system – in particular the baby's NHI number and sex.

This information is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in HISO 10046:2019 Consumer Health Identity Standard

The following fields relate to the woman (and for some fields, the baby) and are appropriate for use in the maternity situation. This information must be recorded as part of each maternity event.

Data element	HISO 10046:2019 reference
NHI number	2.1
Name	2.2
Date and place of birth	2.3
Ethnicity	2.5
Address information	3.1.3
Language	4.0
Contact information	5.0

2.2 Health care provider information

This section incorporates health care provider information that is related to the woman's particular maternity event. It should only be obtained from the Healthcare Provider Index (HPI) system. This is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in HISO

10005:2008 Health Practitioner Index (HPI) Data Set and HISO 10006:2008 Health Practitioner Index (HPI) Code Set.

The following fields relate to the woman and are appropriate for use in the individual maternity situation. 'Provider person' is information related to the Lead Maternity Carer (LMC) and the woman's General Practitioner. This information must be recorded as part of each maternity event. The source of the information is as documented below.

Data element	HISO 10005:2008 Data set	HISO 10006:2008 Code set
Provider person:		
Common Person Number (CPN)	3.3	2.1
Address	6.0	4.0
Language	3.9	2.5
Contact	7.0	5.0
Qualifications	3.10	
Registration and related information	3.7	
Provider organisation:		
Identification Number	4.3.1	3.2
Name	4.4.2	3.1
Address		4.0
Contact		
Provider facility:		
Identification Number	5.2.1	3.2
Name	5.3.2	3.1
Address		4.0
Contact		

Blank fields in this table are under development and expected to be published as part of a major update to the two standards. The update is intended to merge these standards and is expected to be issued in 2019 and called HISO 10046:2019 Provider Health Index Standard.

2.3 Medicines information

This section covers medicine information directly related to the woman and baby. Medicines information is to be managed as described in the related HISO standards (see below).

Specific medication information about a woman and baby(ies) must be sourced from existing electronic records held in the New Zealand ePrescription Service (NZePS) and accessed via an Application Program Interface (API). The maternity system must be capable of capturing and recording the process of medicines reconciliation.

Prescribing must:

- integrate with the NZePS

  https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-eprescription-service

- the NZePS API

  <Web reference to be provided>

- use the New Zealand Universal List of Medicines (NZULM).

  https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/nz-universal-list-medicines

  Further assistance is available at: http://info.nzulm.org.nz/contact/

- conform to HISO standards,

  https://www.health.govt.nz/our-work/ehealth/digital-health-sector-architecture-standards-and-governance/health-information-standards/approved-standards/medicines-information-standards

  - HISO 10030.1:2008 Electronic Pharmaceutical Business Process Standard
  - HISO 10030.2:2008 Electronic Pharmaceutical Messaging Standard
  - HISO 10042 Medication Charting and Medicine Reconciliation Standards

- Conform to Medical Council of New Zealand prescribing guidelines

  https://www.mcnz.org.nz/our-standards/current-standards/

More information on the inclusion of data is available from the New Zealand Formulary.

https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-formulary

3 Booking information

This section covers core data elements recording information about the woman's current pregnancy, including the estimated due date (EDD).

Data element		Data element	
3.1	Pregnancy intention	3.9	Estimated due date by ultrasound scan (USS)
3.2	Assisted reproduction	3.10	Agreed estimated due date
3.3	Method of assisted reproduction	3.11	Height
3.4	Method of assisted reproduction – 'Other' – detail	3.12	Weight
3.5	Gravida	3.13	Body Mass Index
3.6	Parity	3.14	Eligibility
3.7	Last menstrual period (LMP)	3.15	Lead Maternity Carer type (LMC)
3.8	Estimated due date by dates (EDD)		

3.1 Pregnancy intention

Definition	Pregnancy planning		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Planned pregnancy / 169565003 Unplanned pregnancy / 83074005 Ambivalent / 169569009		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

3.2 Assisted reproduction

Definition	Whether this pregnancy was conceived via assisted reproduction		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

3.3 Method of assisted reproduction

Definition	Method of assisted reproduction		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Hormonal stimulation – TBA Intrauterine insemination (IUI) – 265064001 In vitro fertilisation (IVF) – 52637005 Other – 63487001		
Obligation	Conditional on a '1 – Yes' response to section 3.2 Assisted reproduction		
Guide for use			
Verification rules	Valid code only		

3.4 Method of assisted reproduction – 'Other' – detail

Definition	Other method of assisted reproduction		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of 'Other' for section 3.3 Method of assisted reproduction		
Guide for use			
Verification rules			

3.5 Gravida

Definition	The total number of times the woman has been pregnant		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	01 to 99		
Obligation	Mandatory		
Guide for use	This includes the current pregnancy. For example, a woman who has had one prior pregnancy and is currently pregnant is designated Gravida 2 (G2) This number is self-reported and may not be accurate, as the woman may not know or wish to disclose the full number An integer greater than zero		
Verification rules			

3.6 Parity

Definition	Parity is the number of previous pregnancies where the outcome was a birth with a gestation greater than or equal to 20 weeks and zero days		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	01 to 99		
Obligation	Mandatory		
Guide for use	Count twins or multiple births as one birth This number is self-reported and may not be accurate, as the woman may not wish to disclose the full number		
Verification rules	An integer value required		

3.7 Last menstrual period (LMP)

Definition	First day of the last menstrual period		
Source Standards			
Data type	Date	**Representational class**	Full date
Field size	Max: 8	**Representational layout**	CCYYMMDD
Data domain	Valid date		
Obligation	Optional		
Guide for use	This is reliant on the woman recalling the date, and may not be accurate		
Verification rules	This must be a valid date that is less than or equal to the current date		

3.8 Estimated due date by dates (EDD)

Definition	Estimated due date (EDD) as calculated from the first day of the last menstrual period (LMP) (EDD by LMP)		
Source Standards			
Data type	Date	**Representational class**	Full Date
Field size	Max: 8	**Representational layout**	CCYYMMDD
Data domain	Valid dates		
Obligation	Conditional on a valid response to section 3.7 Last menstrual period (LMP)		
Guide for use			
Verification rules	This must be a valid date		

3.9 Estimated due date by ultrasound scan (USS)

Definition	Estimated due date based on ultrasound scan calculations (EDD by USS)		
Source Standards			
Data type	Date	**Representational class**	Full Date
Field size	Max: 8	**Representational layout**	CCYYMMDD
Data domain	Valid dates		
Obligation	Optional		
Guide for use			
Verification rules	This must be a valid date		

3.10 Agreed estimated due date

Definition	Estimated due date as agreed by the woman and the Lead Maternity Carer considering all pertinent information		
Source Standards			
Data type	Date	**Representational class**	Full Date
Field size	Max: 8	**Representational layout**	CCYYMMDD
Data domain	Valid dates		
Obligation	Mandatory		
Guide for use			
Verification rules	This must be a valid date greater than or equal to the current date		

3.11 Height

Definition	The measured height of the woman in metres		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	N.NN
Data domain	Metres		
Obligation	Mandatory		
Guide for use	Record height to two decimal places		
Verification rules	A value greater than zero		

3.12 Weight

Definition	The pre-pregnancy weight of the woman in kilograms		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 5	**Representational layout**	NNN.N
Data domain	Kilograms		
Obligation	Mandatory		
Guide for use	If this is not available, capture the earliest recorded weight of the woman during this pregnancy		
Verification rules	A value greater than zero		

3.13 Body Mass Index

Definition	Calculation of Body Mass Index (BMI)		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NN.N
Data domain	Calculated on the basis of BMI = kg/m^2 – that is: kilograms of weight (see section 3.12 Weight) divided by height in metres squared (see section 3.11 Height)		
Obligation	Optional		

Guide for use	The BMI calculation is recorded if requested by the LMC. The result of the calculation may be stored within the maternity database or created 'on-the-fly' as a result of the LMC request
Verification rules	

3.14 Eligibility

Definition	Whether the woman is eligible for publicly funded maternity care in New Zealand		
Source Standards	https://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services/pregnancy-services		
Data type	Alphabetic	**Representational class**	Code
Field size	Max: 1	**Representational layout**	A
Data domain	'Y' – Eligible 'N' – Not eligible		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

3.15 Lead Maternity Carer type (LMC)

Definition	The registration of the Lead Maternity Carer (LMC) with the Medical Council or the Midwifery Council		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Registrant with the Medical Council of New Zealand 2 – Registrant with the Midwifery Council of New Zealand		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

4 Previous pregnancies

This section covers information about the woman's obstetric history, ie, her previous pregnancies and births. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

This section contains the data elements that must be captured for each previous pregnancy. The corresponding text block for display is structured as a table, with one row of cells per pregnancy.

Data element		Data element	
4.1	Previous miscarriage	4.11	Maternal complications in previous labours
4.2	Previous termination	4.12	Maternal complications in previous labours – 'Other' – detail
4.3	Termination reason	4.13	Mode of birth
4.4	Termination reason – 'Other reason' – detail	4.14	Type of Caesarean section
4.5	Maternal antenatal complications in previous pregnancy	4.15	Indications for planned Caesarean section
4.6	Maternal complication – Other complication – detail	4.16	Indications for planned Caesarean section – 'Other malpresentation' – detail
4.7	Onset of labour in previous pregnancy	4.17	Indications for unplanned Caesarean section
4.8	Induction reason	4.18	Previous labour analgesia
4.9	Induction reason – 'Other clinical reason' – detail	4.19	Previous labour anaesthesia
4.10	Length of previous labour(s)	4.20	Maternal complications immediately postpartum

4.1 Previous miscarriage

Definition	The miscarriages the woman has had (if known)		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** First trimester miscarriage / 19169002 Second trimester miscarriage / 85116003 Ectopic pregnancy / 34801009 Molar pregnancy / 44782008		
Obligation	Conditional on a value greater than 1 for section 3.5 Gravida		
Guide for use	Up to ten instances of this field may be recorded		
Verification rules	Valid code only		

4.2 Previous termination

Definition	The type of termination		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Medical termination of pregnancy / 285409006 Surgical termination of pregnancy / 302375005		
Obligation	Conditional on a termination having occurred		
Guide for use	Up to ten instances of this field may be recorded		
Verification rules	Valid code only		

4.3 Termination reason

Definition	The reason(s) a previous pregnancy was terminated		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Congenital anomaly</td><td>702709008</td></tr><tr><td>Chromosomal anomaly</td><td>267253006</td></tr><tr><td>Unplanned pregnancy</td><td>83074005</td></tr><tr><td>Other reason</td><td>289203002</td></tr></table>		
Obligation	Mandatory on a response for section 4.2 Previous termination		
Guide for use	One response should be recorded for each instance identified in section 4.2 Previous termination		
Verification rules	Valid code only		

4.4 Termination reason – 'Other reason' – detail

Definition	The detail of the 'Other reason' for termination		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of 'Other reason' for section 4.3 Termination reason		
Guide for use	One response should be recorded for each 'Other' instance identified in section 4.3 Termination reason		
Verification rules			

4.5 Maternal antenatal complications in previous pregnancy

<table>
<tr><td>Definition</td><td colspan="3">Complications the woman may have experienced during any previous pregnancy</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>No previous complications</td><td>TBA</td></tr>
<tr><td>Antenatal depression</td><td>TBA</td></tr>
<tr><td>Antepartum haemorrhage</td><td>161804005</td></tr>
<tr><td>Eclampsia</td><td>161806007</td></tr>
<tr><td>Gestational diabetes</td><td>472971004</td></tr>
<tr><td>Infection</td><td>161413004</td></tr>
<tr><td>Influenza</td><td>TBA</td></tr>
<tr><td>Obstetric cholestasis</td><td>16216781000119107</td></tr>
<tr><td>Placental abruption</td><td>TBA</td></tr>
<tr><td>Pre-eclampsia</td><td>105651000119100</td></tr>
<tr><td>Preterm labour</td><td>441493008</td></tr>
<tr><td>Other complication occurring during pregnancy</td><td>161803004</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">The last option above is only to be selected when none of the preceding options in this category are clearly correct
Up to six instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

4.6 Maternal complication – Other complication – detail

Definition	The detail of the 'Other complication' that occurred during the pregnancy		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other complication occurring during pregnancy' for section 4.5 Maternal antenatal complications in previous pregnancy		
Guide for use			
Verification rules			

4.7 Onset of labour in previous pregnancy

Definition	How labour began for the previous pregnancy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Induction of labour	725954003
No labour	301728005
Spontaneous labour	726597008

Obligation	Conditional on a response greater than 'zero' for section 3.6 Parity
Guide for use	
Verification rules	Valid code only

4.8 Induction reason

Definition	Reason for the previous induction of labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Pre-labour rupture of membranes without spontaneous labour / 44223004 Prolonged pregnancy / 310594001 Other clinical reason / TBA		
Obligation	Mandatory on a response of 'Induction of Labour' for section 4.7 Onset of labour in previous pregnancy		
Guide for use			
Verification rules	Valid code only		

4.9 Induction reason – 'Other clinical reason' – detail

Definition	The detail of the 'Other clinical reason' for induction		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other clinical reason' for section 4.8 Induction reason		
Guide for use			
Verification rules			

4.10 Length of previous labour(s)

Definition	Length of previous labour(s) recorded in hours and minutes		
Source Standards			
Data type	Time	**Representational class**	Value
Field size	Max: 5	**Representational layout**	HH:MM
Data domain	Up to 99 hours, 59 minutes		
Obligation	Mandatory on a response of 'Spontaneous labour ' OR 'Induction of labour' to section 4.7 Onset of labour in previous pregnancy		
Guide for use	This is a value provided by the woman		
Verification rules			

4.11 Maternal complications in previous labours

Definition	Any complications the woman may have experienced in previous labours		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
No previous complications	TBA
Third degree perineal tear	10217006
Fourth degree perineal tear	399031001
Hypertension	38341003
Infection	66844003
Intrapartum haemorrhage	38010008
Obstructed labour	199746004
Prolonged first stage of labour	33627001
Prolonged ruptured membranes	12729009
Prolonged second stage of labour	77259008
Other	118216002

Obligation	Mandatory

Guide for use	Up to eight instances of this field may be recorded
Verification rules	Valid code only

4.12 Maternal complications in previous labours – 'Other' – detail

Definition	The detail of the 'Other' reason for Maternal complications in previous labours		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 4.11 Maternal complications in previous labours		
Guide for use			
Verification rules			

4.13 Mode of birth

Definition	How the previous baby(ies) was/were born		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Spontaneous vaginal birth</td><td>48782003</td></tr><tr><td>Caesarean section</td><td>200144004</td></tr><tr><td>Forceps</td><td>200130005</td></tr><tr><td>Vacuum extraction</td><td>200138003</td></tr></table>		
Obligation	Mandatory on a response for section 5.1 Outcome of previous baby(ies)		
Guide for use	Up to three instances of this field may be recorded This is to be reported in terms of spontaneity or assistance required		
Verification rules	Valid code only		

4.14 Type of Caesarean section

Definition	The type of Caesarean section incision the woman had in any previous pregnancy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Classical / 84195007 Lower uterine segment (LUSCS) / 398307005		
Obligation	Conditional on a response of 'Caesarean section' to section 4.13 Mode of birth		
Guide for use			
Verification rules	Valid code only		

4.15 Indications for planned Caesarean section

Definition	The clinical indication for performing a planned Caesarean section as an elective procedure when the woman was not in labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Breech presentation</td><td>712654009</td></tr><tr><td>Congenital anomaly</td><td>276654001</td></tr><tr><td>Chromosomal anomaly</td><td>409709004</td></tr><tr><td>Medical or obstetric complication</td><td>609496007</td></tr><tr><td>Previous third degree perineal tear</td><td>10217006</td></tr><tr><td>Previous fourth degree perineal tear</td><td>399031001</td></tr><tr><td>Previous Caesarean section</td><td>200151008</td></tr><tr><td>Transverse lie</td><td>TBA</td></tr><tr><td>Unstable lie</td><td>TBA</td></tr><tr><td>Other malpresentation (e.g. brow)</td><td>TBA</td></tr></table>
Obligation	Conditional on a response of 'Caesarean section' to section 4.13 Mode of birth
Guide for use	Up to eight instances of this field may be recorded
Verification rules	Valid code only

4.16 Indications for planned Caesarean section – 'Other malpresentation' – detail

Definition	The detail of the 'Other malpresentation' reason for Indications for planned Caesarean section		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of 'Other malpresentation' for section 4.15 Indications for planned Caesarean section		
Guide for use			
Verification rules			

4.17 Indications for unplanned Caesarean section

Definition	The clinical indication for performing an unplanned Caesarean section during labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Antepartum haemorrhage	34842007
Failed induction of labour	42571002
Failed instrumental/assisted delivery	772006002
Fetal distress	130955003
Intrapartum haemorrhage	38010008
Malposition	199747008
Malpresentation	15028002
Obstructed Labour	199746004

Obligation	Conditional on a response of 'Caesarean section' to section 4.13 Mode of birth
Guide for use	Up to eight instances of this field may be recorded
Verification rules	Valid code only

4.18 Previous labour analgesia

Definition	The type of analgesia the woman may have had during previous labours		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No previous analgesia 2 – Pharmacological – non opiate 3 – Pharmacological – opiate 4 – Non pharmacological		
Obligation	Mandatory		

Guide for use	Up to three instances of this field may be recorded
Verification rules	Valid value only

4.19 Previous labour anaesthesia

Definition	The type of anaesthesia the woman may have had during previous labours		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Local anaesthetic	386761002
Pudendal block	231208005
Epidural	27372005
Spinal	231249005
Combined spinal/epidural	231261002
General anaesthetic	50697003
No previous anaesthesia	TBA

Obligation	Mandatory
Guide for use	Up to three instances of this field may be recorded
Verification rules	Valid code only

4.20 Maternal complications immediately postpartum

<table>
<tr><td>Definition</td><td colspan="3">Any complications the woman may have experienced in the first 2-4 hours following previous births</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3"><table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>No previous complications</td><td>TBA</td></tr><tr><td>Perineal haematoma</td><td>199945007</td></tr><tr><td>Postpartum haemorrhage (greater than 1000mls or treated)</td><td>161809000</td></tr><tr><td>Retained placenta</td><td>725948004</td></tr><tr><td>Other</td><td>80113008</td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

5 Previous babies

This section covers information related to babies from previous pregnancies. It should be left blank unless the woman has previously given birth at 20 weeks gestation or later. Information must be collected at the booking visit unless the woman has had earlier contact with acute services during this pregnancy.

The section contains the data elements that are required to be captured for each previous baby. The corresponding text block for display is structured as a table, with one row of cells to be recorded for each baby.

Data element		Data element	
5.1	Outcome of previous baby(ies)	5.10	Stillbirth cause
5.2	Antenatal fetal complications	5.11	Neonatal concerns
5.3	Antenatal fetal complications – 'Other' – detail	5.12	Neonatal concerns – 'Other' – detail
5.4	Intrapartum fetal complications	5.13	Neonatal care admissions
5.5	Intrapartum fetal complications – 'Other' – detail	5.14	Reason for admission to neonatal care
5.6	Mode of birth	5.15	Feeding history
5.7	Gestation previous baby(ies)	5.16	Duration of breastfeeding
5.8	Sex of previous baby(ies)	5.17	Cause of death
5.9	Birth weight previous baby(ies)		

5.1 Outcome of previous baby(ies)

Definition	The outcome for each baby in previous pregnancies		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Live born	726001007
Stillborn	161743003
Neonatal death	726626004
Infant death	739682007

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

5.2 Antenatal fetal complications

Definition	Complications related to the fetus during the previous pregnancy(ies)		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
None	TBA
Fetal heart rate abnormality	312668007
Fetal growth abnormality	276604007
Congenital anomaly	276654001
Chromosomal anomaly	409709004
Polyhydramnios	86203003
Oligohydramnios	59566000
Other	206035009

Obligation	Mandatory
Guide for use	Up to five instances of this field may be recorded
Verification rules	Valid code only

5.3 Antenatal fetal complications – 'Other' – detail

Definition	The detail of the 'Other' reason for Indications for Antenatal fetal complications section		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 5.2 Antenatal fetal complications		
Guide for use	One response should be recorded for each 'Other' instance identified in section 5.2 Antenatal fetal complications		
Verification rules			

5.4 Intrapartum fetal complications

Definition	Complications related to the fetus during previous labour(s)		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			
Obligation	Mandatory		
Guide for use	Up to four instances of this field may be recorded		

SNOMED Concept	SNOMED CT Code
None	TBA
Fetal heart rate abnormality	267257007
Fetal blood sample abnormality	199597005
Meconium stained liquor	199595002
Other	76012002

Verification rules	Valid code only

5.5 Intrapartum fetal complications – 'Other' – detail

Definition	The detail of the 'Other' reason for Indications for Intrapartum fetal complications section		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 5.4 Intrapartum fetal complications		
Guide for use	One response should be recorded for each 'Other' instance identified in section 5.4 Intrapartum fetal complications		
Verification rules			

5.6 Mode of birth

Definition	How the previous baby(ies) was/were born		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Spontaneous vaginal birth / 48782003 Caesarean section / 200144004 Forceps / 200130005 Vacuum extraction / 200138003		
Obligation	Mandatory on a response to section 5.1 Outcome of previous baby(ies)		
Guide for use	Up to three instances of this field may be recorded This is to be reported in terms of spontaneity or assistance required		
Verification rules	Valid code only		

5.7 Gestation previous baby(ies)

Definition	The gestation of previous babies, in weeks and days		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NN.N
Data domain			
Obligation	Mandatory on a response to section 5.1 Outcome of previous baby(ies)		
Guide for use	Up to 20 instances of this field may be recorded		
Verification rules			

5.8 Sex of previous baby(ies)

Definition	The sex of a previous baby(ies) as recorded at birth		
Source Standards	Refer to the gender code set of HISO 10046 Consumer Health Identity Standard		
Data type	Alphabetic	**Representational class**	Code
Field size	Max: 1	**Representational layout**	A
Data domain	'M' – Male 'F' – Female 'I' – Indeterminate		
Obligation	Mandatory on a response not equal to 'N/A – No previous baby(ies)' for section 5.1 Outcome of previous baby(ies)		
Guide for use	**Note:** Values to populate this field are to be obtained from the NHI system. This will require knowledge of the baby's NHI number as this is the access key to the correct record. At this time, the NHI does not record a value for Sex. However, the NHI does populates a Gender field with a Sex value. A change is being planned to rectify this situation Up to 20 instances of this field may be recorded		
Verification rules	Valid code only		

5.9 Birth weight previous baby(ies)

Definition	The birth weight in grams of previous babies		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NNNN
Data domain	Grams		
Obligation	Mandatory on a response to section 5.1 Outcome of previous baby(ies)		
Guide for use	Up to 20 instances of this field may be recorded		
Verification rules	An integer greater than zero		

5.10 Stillbirth cause

Definition	The causes or factors that contributed to or led to the stillbirth of a previous baby		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Stillborn' for section 5.1 Outcome of previous baby(ies)		
Guide for use	Record this information if known		
Verification rules			

5.11 Neonatal concerns

Definition	Complications with the baby(ies) in the immediate postpartum period		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
None	102500002
Large for gestational age	15635491000119102
Low birth weight	276610007
Respiratory distress syndrome (RDS)	46775006
Small for gestational age	199612005
Transient tachypnoea	7550008
Other	276707008

Obligation	Mandatory on a response to section 5.1 Outcome of previous baby(ies)
Guide for use	Up to five instances of this field may be recorded
Verification rules	Valid code only

5.12 Neonatal concerns – 'Other' – detail

Definition	The detail of the 'Other' reason for Indications for Neonatal concerns		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 5.11 Neonatal concerns		
Guide for use	One response should be recorded for each 'Other' instance identified in section 5.11 Neonatal concerns		
Verification rules			

5.13 Neonatal care admissions

Definition	This is to record if previous baby(ies) required admission to the neonatal intensive care or special care baby unit		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No, not needed 2 – Yes, admitted to Neonatal Intensive Care Unit (NICU) 3 – Yes, admitted to Special Care Baby Unit (SCBU) 4 – Yes, but remained on Ward		
Obligation	Mandatory on a response to section 5.1 Outcome of previous baby(ies)		
Guide for use	Up to 20 instances of this field may be recorded		
Verification rules	Valid code only		

5.14 Reason for admission to neonatal care

Definition	The reason previous babies were admitted to the neonatal intensive care or special care baby unit		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Asphyxia</td><td>413654009</td></tr><tr><td>Cardiovascular disease</td><td>49601007</td></tr><tr><td>Congenital anomaly</td><td>276654001</td></tr><tr><td>Chromosomal anomaly</td><td>409709004</td></tr><tr><td>Hypoglycaemia</td><td>52767006</td></tr><tr><td>Hypothermia</td><td>13629008</td></tr><tr><td>Infection</td><td>128271002</td></tr><tr><td>Jaundice</td><td>387712008</td></tr><tr><td>Respiratory distress syndrome (RDS)</td><td>46775006</td></tr><tr><td>Seizures</td><td>87476004</td></tr><tr><td>Weight loss</td><td>267024001</td></tr></table>
Obligation	Mandatory on a response other than '1 – No, not needed' for section 5.13 Neonatal care admissions
Guide for use	Up to ten instances of this field may be recorded
Verification rules	Valid code only

5.15 Feeding history

Definition	The feeding history of previous babies in the first six months of life		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed 2 – Fully breastfed 3 – Partially breastfed 4 – Artificially fed		
Obligation	Mandatory on a response other than 'Stillborn' to section 5.1 Outcome of previous baby(ies)		
Guide for use			
Verification rules	Valid code only		

5.16 Duration of breastfeeding

Definition	The number of months previous babies were breastfed		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain			
Obligation	Mandatory on a response other than 'Stillborn' to section 5.1 Outcome of previous baby(ies)		
Guide for use			
Verification rules	An integer greater than zero		

5.17 Cause of death

Definition	The cause of death of previous baby(ies) or child(ren)		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Neonatal death' OR 'Infant death' for section 5.1 Outcome of previous baby(ies)		
Guide for use			
Verification rules			

6 Woman's comprehensive health history

This section covers information related to the woman's health history. It has four categories – medical, surgical, gynaecological and mental health information. It records relevant current or past conditions to help recognise maternity risk factors.

This information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

Data element	Data element
6.1 Medical history	6.3 Gynaecological history
6.2 Surgical history	6.4 Mental health history

6.1 Medical history

This section only covers information related to the woman's medical history. It includes relevant current or past medical conditions, and risk factors for congenital abnormalities.

Data element	Data element
6.1.1 Medical conditions	6.1.2 Medical conditions – 'Other' – detail

6.1.1 Medical conditions

Definition	Any medical conditions the woman has		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Autoimmune disorder	85828009
Cardiac disorder	56265001
Congenital abnormality(ies)	276654001
Diabetes mellitus type 1	46635009
Diabetes mellitus type 2	44054006

	Endocrine disorder	362969004
	Gastrointestinal disorder	119292006
	Haematological disorder	34093004
	Hypertension	38341003
	Infectious diseases	40733004
	Liver disorder	235856003
	Malignancy	363346000
	Mental health disorder	74732009
	Monogenic diabetes (MODY)	609561005
	Musculoskeletal disorder	928000
	Neurological disorder	118940003
	Respiratory disorder	50043002
	Skin disorder	95320005
	Thrombosis and related disorder	439127006
	Other medical disorder	64572001
Obligation	Mandatory	
Guide for use	Up to 20 instances of this field may be recorded	
Verification rules	Valid code only	

6.1.2 Medical conditions – 'Other' – detail

Definition	The detail of the 'Other medical disorder' reason for Indications for Medical conditions		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other medical disorder' for section 6.1.1 Medical conditions		
Guide for use			
Verification rules			

6.2 Surgical history

This section covers information related to the woman's surgical history.

Data element		Data element	
6.2.1	Operations	6.2.4	Anaesthetic complications
6.2.2	Operations – 'Other' – detail	6.2.5	Anaesthetic complications detail
6.2.3	Previous anaesthetic		

6.2.1 Operations

Definition	The types of operations the woman has undergone		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
No previous surgery	TBA
Breast	392090004
Genital tract	12658000
Uterine	79876008
Other	387713003

Obligation	Mandatory
Guide for use	Up to four instances of this field may be recorded
Verification rules	Valid code only

6.2.2 Operations – 'Other' – detail

Definition	The detail of the 'Other' reason for Operations		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 6.2.1 Operations		

Guide for use	One response should be recorded for each 'Other' instance identified in section 6.2.1 Operations
Verification rules	

6.2.3 Previous anaesthetic

Definition	The types of anaesthetic previously administered to the woman, except during childbirth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Local anaesthetic – 386761002 Pudendal block – 231208005 Epidural – 27372005 Spinal – 231249005 Combined spinal/epidural – 231261002 General anaesthetic – 50697003 No previous anaesthesia – TBA		
Obligation	Mandatory		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

6.2.4 Anaesthetic complications

Definition	Has the woman had complications when she was previously administered an anaesthetic		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid value only

6.2.5 Anaesthetic complications detail

Definition	Detail of anaesthetic complications		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of '1 – Yes' for section 6.2.4 Anaesthetic complications		
Guide for use			
Verification rules			

6.3 Gynaecological history

This section covers gynaecological history information.

Data element	Data element
6.3.1 Cervical smear date	6.3.3 Gynaecological history – diagnosis
6.3.2 Cervical smear results	6.3.4 Gynaecological history – procedures

6.3.1 Cervical smear date

Definition	To record when the most recent cervical smear was taken		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Within last year 2 – Within the last 2 years 3 – Within the last 3 years 4 – More than 3 years ago 5 – Never had smear 6 – Not documented 7 – Unknown		

Obligation	Optional – This information is recorded when available
Guide for use	The default is '7 – Unknown'
Verification rules	Valid code only

6.3.2 Cervical smear results

Definition	The results from the most recent previous cervical smear		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Normal	269958004
Abnormal (not specified)	309081009
ACIS Adenoma carcinoma in situ	TBA
Cervical intraepithelial neoplasia (CIN I)	285836003
Cervical intraepithelial neoplasia (CIN II)	285838002
Cervical intraepithelial neoplasia (CIN III)	92564006
Invasive carcinoma	423973006
Unknown	3219008

Obligation	Mandatory on a response other than '7 – Unknown' being recorded for section 6.3.1 Cervical smear date
Guide for use	
Verification rules	Valid code only

6.3.3 Gynaecological history – diagnosis

Definition	The woman's gynaecological history		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain

SNOMED Concept	SNOMED CT Code
Bacterial vaginosis	419760006
Bicornuate uterus	31401003
Chlamydia	105629000
Endometriosis	129103003
Female Genital Mutilation (FGM)	129103003
Fibroids	95315005
Gonorrhoea	15628003
Polycystic ovarian syndrome (PCOS)	237055002
Syphilis	76272004
Trichomonas_vaginalis	276877003
Uterine anomalies	37849005
Vaginismus	79012001
Other gynaecological disorder	310789003
Unknown	3219008

Obligation	Mandatory
Guide for use	Up to 16 instances of this field may be recorded
Verification rules	Valid code only

6.3.4 Gynaecological history – procedures

Definition	The history of the woman's gynaecological procedures		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Cone biopsy	108941000119102
Hysterotomy	275573000
Large loop excision of transformation zone (LLETZ/LEEP)	TBA
Myomectomy	275574006
Other uterine surgery	TBA
Unknown	281337006

Obligation	Mandatory
Guide for use	Up to 16 instances of this field may be recorded
Verification rules	Valid code only

6.4 Mental health history

This section covers information related to the woman's mental health history. If the woman has had previous mental health issues they are more likely to become ill again during pregnancy or in the year following birth.

Data element	Data element
6.4.1 Mental health risk factors	6.4.3 Current mental illness treatment
6.4.2 Previous mental illness treatment	6.4.4 Serious mental illness treatment

6.4.1 Mental health risk factors

Definition	Any mental health risk factors		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

6.4.2 Previous mental illness treatment

Definition	Has the woman previously received treatment for mental illness		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

6.4.3 Current mental illness treatment

Definition	Is the woman currently receiving treatment for mental illness		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

6.4.4 Serious mental illness treatment

Definition	Indication of whether the woman has received any treatment from a psychiatrist or specialist mental health team in the past		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

7 Allergies and adverse reactions

This section records any allergies and adverse reactions the woman has experienced. This includes the type of reaction, the type of substance that caused the reaction and the severity of the reaction. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

Data element		Data element	
7.1	Allergies present	7.4	Allergies – substances – 'Other' – detail
7.2	Allergies – medicines	7.5	Adverse reactions
7.3	Allergies – substances		

7.1 Allergies present

Definition	Any allergies to medicines or other substances that the woman is known to have		
Source Standards	HISO 10042.2 Medicine Reconciliation standard published September 2012 SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** No known allergies / 716186003 Allergy to medicine / 416098002 Allergy to substance / 419199007		
Obligation	Mandatory		
Guide for use	Use section 7.3 Allergies – substances for any substance other than medicine.		
Verification rules	Valid code only		

7.2 Allergies – medicines

Definition	Specific medicines that the woman is known to be allergic to		
Source Standards	HISO 10042.2 Medicine Reconciliation standard published September 2012 https://www.health.govt.nz/system/files/documents/publications/medication-reconciliation-standard-v3-sep12.pdf		
Data type	Alphanumeric	**Representational class**	Value
Field size	Max: 250	**Representational layout**	X(250)
Data domain	Record the relevant medicine		
Obligation	Conditional on a response of Allergy to medicine' to section 7.1 Allergies present		
Guide for use	Up to nine instances of this field may be recorded for this field		
Verification rules	Valid code only		

7.3 Allergies – substances

Definition	Substances that the woman is known to be allergic to		
Source Standards	HISO 10042.2 Medicine Reconciliation standard published September 2012 SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			
Obligation	Conditional on a response of 'Allergy to substance' for section 7.1 Allergies present		

SNOMED Concept	SNOMED CT Code
Dairy allergy	226760005
Egg allergy	102263004
Latex allergy	111088007
Nuts allergy	13577000
Seafood allergy	44027008
Other	TBA

Guide for use	Record the substances the women is allergic to, other than medicines. Up to five instances of this field may be recorded for this field
Verification rules	

7.4 Allergies – substances – 'Other' – detail

Definition	The detail of the 'Other' substance allergies		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 7.3 Allergies – substances		
Guide for use	One response should be recorded for each 'Other' instance identified in section 7.3 Allergies – substances		
Verification rules			

7.5 Adverse reactions

Definition	Any adverse drug reaction (ADR) to a medicine the woman has experienced		
Source Standards	HISO 10042.2 Medicine Reconciliation standard published September 2012		
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response other than 'No known allergies' to section 7.1 Allergies present		
Guide for use	Up to nine instances may be recorded for this field		
Verification rules			

8 Alcohol and other drugs

This section includes information about the woman's consumption of alcohol and other drugs. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

Data element		Data element	
8.1	Alcohol consumption	8.6	Referred to alcohol free services
8.2	Current consumption	8.7	Drug use
8.3	Timing of alcohol cessation	8.8	History of drug use
8.4	Amount of alcohol consumed	8.9	Current drugs used
8.5	Brief alcohol reduction advice	8.10	Current drugs used – 'Other' – detail

8.1 Alcohol consumption

Definition	A record of whether the woman has consumed alcohol in the six months before this pregnancy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Non-drinker – 228274009 Admits alcohol use – 704197006 Declined to answer – 426544006		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

8.2 Current consumption

Definition	A record of whether the woman currently drinks alcohol		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Does not drink alcohol / 105542008 Current drinker / 219006 Declined to answer / 426544006		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

8.3 Timing of alcohol cessation

Definition	When the woman stopped drinking alcohol		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Pre-pregnancy 2 – First trimester of pregnancy 3 – Second trimester of pregnancy 4 – Third trimester of pregnancy		
Obligation	Mandatory on a response of 'Admits alcohol use' in section 8.1 Alcohol consumption		
Guide for use			
Verification rules	Valid code only		

8.4 Amount of alcohol consumed

Definition	The units of alcohol consumed by the woman per week		
Source Standards	https://www.alcohol.org.nz/help-advice/standard-drinks/whats-a-standard-drink		
Data type	Numeric	**Representational class**	Value
Field size	Max: 3	**Representational layout**	NNN
Data domain			
Obligation	Conditional on a response of 'Current drinker' to section 8.2 Current consumption		
Guide for use	An approximate number of units is acceptable		
Verification rules			

8.5 Brief alcohol reduction advice

Definition	Brief advice offered regarding reducing alcohol consumption		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Conditional on a response of 'Current drinker' to section 8.2 Current consumption		
Guide for use			
Verification rules	Valid value only		

8.6 Referred to alcohol free services

Definition	Were alcohol free services offered to the woman		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Conditional on a response of 'Current drinker' to section 8.1 Alcohol consumption		
Guide for use			
Verification rules	Valid value only		

8.7 Drug use

Definition	Whether the woman has used drugs in the six months before this pregnancy		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Yes 2 – No 3 – Declined to answer		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

8.8 History of drug use

<table>
<tr><td>Definition</td><td colspan="3">Whether the woman has used drugs in the past</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Does not misuse drugs</td><td>228367002</td></tr>
<tr><td>Current drug user</td><td>417284009</td></tr>
<tr><td>Ex-drug user</td><td>44870007</td></tr>
<tr><td>Misuse of prescription drugs</td><td>191939002</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid value only</td></tr>
</table>

8.9 Current drugs used

<table>
<tr><td>Definition</td><td colspan="3">The drug(s) the woman is currently using</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Amphetamines</td><td>703842006</td></tr>
<tr><td>Aromatic solvent</td><td>117499009</td></tr>
<tr><td>Benzodiazepine sedative</td><td>372616003</td></tr>
<tr><td>Cannabis</td><td>398705004</td></tr>
<tr><td>Cocaine</td><td>387085005</td></tr>
<tr><td>Codeine phosphate</td><td>261000</td></tr>
<tr><td>Crack cocaine</td><td>229003004</td></tr>
<tr><td>Drug or medicament</td><td>410942007</td></tr>
<tr><td>Gas (nitrous oxide)</td><td>111132001</td></tr>
<tr><td>Hallucinogenic agent</td><td>373469002</td></tr>
<tr><td>Heroin</td><td>387341002</td></tr>
<tr><td>Methadone</td><td>387286002</td></tr>
<tr><td>Methamphetamine</td><td>387499002</td></tr>
<tr><td>Morphine</td><td>373529000</td></tr>
<tr><td>Other</td><td>TBA</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Current drug user’ to section 8.8 History of drug use</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

8.10 Current drugs used – 'Other' – detail

Definition	The detail of the 'Other' drugs currently in use		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 8.9 Current drugs used		
Guide for use	One response should be recorded for each 'Other' instance identified in section 8.9 Current drugs used		
Verification rules			

9 Smoking status

This section records information about the smoking status of the woman. Smoking tobacco during pregnancy can have harmful effects on both the woman and baby. Pregnancy also provides motivation to stop smoking. For both these reasons it is important to collect information on the tobacco smoking rates of pregnant women and to offer them support and smoking cessation advice. Information about the tobacco smoking status (amount of cigarettes smoked per day) of the woman and smoking cessation support received is collected at the booking visit.

Data element		Data element	
9.1	Ever smoked	9.5	Referred to smoke free services
9.2	Current smoker	9.6	Brief smoking advice
9.3	Date quit smoking	9.7	Exposure to second hand smoke
9.4	Number of cigarettes smoked per day	9.8	Change to vaping

9.1 Ever smoked

Definition	Has the woman ever smoked tobacco		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Never smoked	266919005
Ex smoker, greater than 12 months abstinent	48031000119106
Ex smoker, less than 12 months abstinent	735128000

Obligation	Mandatory
Guide for use	This information is recorded when available
Verification rules	Valid value only

9.2 Current smoker

Definition	Does the woman currently smoke tobacco or vaping substance		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Current smoker</td><td>77176002</td></tr><tr><td>Current non-smoker</td><td>160618006</td></tr><tr><td>Vaper with nicotine electronic cigarette user</td><td>TBA</td></tr><tr><td>Vaper with non-nicotine electronic cigarette user</td><td>TBA</td></tr></table>		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

9.3 Date quit smoking

Definition	The date the woman stopped smoking tobacco		
Source Standards			
Data type	Date	**Representational class**	Full or Partial Date
Field size	Max: 8	**Representational layout**	CCYY[MM[DD]]
Data domain	Valid date or valid partial date		
Obligation	Optional – This information is recorded when available		
Guide for use	Conditional on a response other than 'Never smoked' to section 9.1 Ever smoked The day or month can be left blank if either cannot be ascertained with reasonable accuracy and in a timely manner, or the full date is unknown at time of data entry. If the day is populated, the month must be populated. If the month is populated, the year must be recorded		
Verification rules	This field must be a valid date that is less than or equal to the current date		

9.4 Number of cigarettes smoked per day

Definition	The number of tobacco cigarettes smoked by the woman per day		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 3	**Representational layout**	NNN
Data domain			
Obligation	Mandatory on a response of 'Current smoker' for section 9.2 Current smoker		
Guide for use	An approximate number is acceptable		
Verification rules	An integer greater than zero		

9.5 Referred to smoke free services

Definition	Whether the woman has been referred to smoke free services		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory on a response of 'Current smoker' for section 9.2 Current smoker		
Guide for use			
Verification rules	Valid value only		

9.6 Brief smoking advice

Definition	Whether the woman has been given brief advice regarding smoking cessation		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory on a response of 'Current smoker' for section 9.2 Current smoker		
Guide for use			
Verification rules	Valid value only		

9.7 Exposure to second hand smoke

Definition	Identifies if and where the woman has been exposed to second hand tobacco smoke on a regular basis		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** No known exposure to tobacco smoke / 711563001 Yes at home / 228524006 Yes at place of work / 228523000 Yes in the car or while commuting / TBA		
Obligation	Mandatory		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

9.8 Change to vaping

Definition	Whether the woman changed from smoking cigarettes to vaping during this pregnancy		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory on a response of either 'Vaper with nicotine electronic cigarette user' or 'Vaper with non-nicotine electronic cigarette user' to section 9.2 Current smoker		
Guide for use			
Verification rules	Valid value only		

10 Family health

This section records the medical history of both the woman's family members and the family members of the baby's father. Current and past medical conditions and any risk factors for congenital abnormalities should be noted. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

Data element		Data element	
10.1	Maternal family history	10.4	Paternal family history – Other
10.2	Maternal family history – other	10.5	Consanguinity
10.3	Paternal family history	10.6	Degree of relationship

10.1 Maternal family history

Definition	The relevant medical history of the woman's close family		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain

SNOMED Concept	SNOMED CT Code
Allergies	160417009
Asthma	160377001
Congenital anomaly	160417009
Chromosomal anomaly	160425006
Diabetes mellitus	160303001
Hypertensive disorders of pregnancy	160401003
Intellectual disability	763598005
Mental illness	160324006
Multiple pregnancy	266906006
Not known	407559004
No relevant family history	160266009
Other relevant condition	281666001

Obligation	Mandatory
Guide for use	Up to ten instances of this field may be recorded
Verification rules	Valid code only

10.2 Maternal family history – other relevant condition

Definition	Additional field to describe the 'Other relevant conditions' related to maternal family history		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other relevant condition' for section 10.1 Maternal family history		
Guide for use			
Verification rules			

10.3 Paternal family history

Definition	The relevant medical history of the baby's father and his close family		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Allergies</td><td>160469004</td></tr><tr><td>Congenital anomaly</td><td>64731000119106</td></tr><tr><td>Chromosomal anomaly</td><td>160425006</td></tr><tr><td>Intellectual disability</td><td>763598005</td></tr><tr><td>Mental illness</td><td>160324006</td></tr><tr><td>No relevant family history</td><td>160266009</td></tr><tr><td>Not known</td><td>407559004</td></tr><tr><td>Other relevant condition</td><td>281666001</td></tr></table>
Obligation	Mandatory
Guide for use	Up to six instances of this field may be recorded
Verification rules	Valid code only

10.4 Paternal family history – Other relevant condition

Definition	Additional field to describe the 'Other relevant condition' related to paternal family history		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of 'Other relevant condition' for section 10.3 Paternal family history		
Guide for use			
Verification rules			

10.5 Consanguinity

Definition	Are the baby's parents related to each other		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Not known		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

10.6 Degree of relationship

Definition	The degree of blood relationship between the parents of the baby		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
First cousin	4577005
Second cousin	13443008
Other	125679009

Obligation	Mandatory on a response of '2 – Yes' to section 10.5 Consanguinity
Guide for use	
Verification rules	Valid code only

11 Tuberculosis risk assessment

Information about tuberculosis (TB) risk factors is collected to determine whether the baby will require the BCG vaccine. This information is collected at the booking visit.

Data element	Data element
11.1 Lives with person with tuberculosis 11.2 Lives in country with tuberculosis	11.3 Lived in country with tuberculosis

11.1 Lives with person with tuberculosis

Definition	Information to record if the infant will be living in a house or with a person with either current TB or a past history of TB		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Unknown		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

11.2 Lives in country with tuberculosis

Definition	Whether during their first five years, the infant will be living for three months or longer in a country with high rates of tuberculosis		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Unknown		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid value only

11.3 Lived in country with tuberculosis

Definition	Whether one or both parents or household members or carers, has within the last five years, lived in a country with high rates of TB		
Source Standards	https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf (page 3)		
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Unknown		
Obligation	Mandatory		
Guide for use	As per page 3 of the report specified above, the World Health Organization considers the following "high burden countries" for tuberculosis: Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe		
Verification rules	Valid value only		

12 Current pregnancy

This section collates information about the woman's current pregnancy. The information is collected throughout the pregnancy and must be summarised at the end of the pregnancy.

Data element		Data element	
12.1	Blood tests	12.11	Current alcohol consumption
12.2	Antenatal screening	12.12	Drug use
12.3	Family violence screening	12.13	Current drugs used
12.4	Fetal anomaly screening	12.14	Current smoker
12.5	Chorionic villus sampling (CVS)	12.15	Antenatal prescriptions
12.6	Amniocentesis	12.16	Antenatal prescriptions – other
12.7	Pregnancy complications	12.17	Antenatal complementary therapies
12.8	Antenatal referrals	12.18	Antenatal visits – first trimester
12.9	Antenatal referral code	12.19	Antenatal visits – second trimester
12.10	Antenatal admissions	12.20	Antenatal visits – third trimester

12.1 Blood tests

<table>
<tr><td>Definition</td><td colspan="3">Blood tests the woman has had during the current pregnancy</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3"><table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Antenatal first blood tests (AN1)</td><td>TBA</td></tr>
<tr><td>Antenatal subsequent blood tests (AN2)</td><td>TBA</td></tr>
<tr><td>Coagulation studies</td><td>3116009</td></tr>
<tr><td>Iron studies (IR)</td><td>TBA</td></tr>
<tr><td>OGTT - Oral glucose tolerance test</td><td>113076002</td></tr>
<tr><td>Pre-eclampsia tests (PET)</td><td>TBA</td></tr>
<tr><td>Other blood tests</td><td>396550006</td></tr>
<tr><td>Declined blood tests</td><td>116471000119100</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to seven instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

12.2 Antenatal screening

<table>
<tr><td>Definition</td><td colspan="3">Screening tests the woman has had during the pregnancy</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Red blood cell antibodies</td><td>89754000</td></tr>
<tr><td>Declined screening tests</td><td>31021000119100</td></tr>
<tr><td>Gestational diabetes</td><td>TBA</td></tr>
<tr><td>Group B streptococcus</td><td>118001005</td></tr>
<tr><td>Hepatitis A (Hep A)</td><td>252404004</td></tr>
<tr><td>Hepatitis B (Hep B)</td><td>252405003</td></tr>
<tr><td>Hepatitis C (Hep C)</td><td>413107006</td></tr>
<tr><td>Human immunodeficiency virus (HIV)</td><td>390786002</td></tr>
<tr><td>Multi-drug resistant organisms (MDRO)</td><td>14788002</td></tr>
<tr><td>Syphilis (VDRL)</td><td>169698000</td></tr>
<tr><td>Other</td><td>243787009</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to ten instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

12.3 Family violence screening

Definition	Whether the woman has been screened for family violence		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Declined to answer		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

12.4 Fetal anomaly screening

Definition	Fetal anomaly screening tests the woman had during the pregnancy		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Declined fetal anomaly screening 2 – Non-invasive prenatal screening (NIPS) 3 – First trimester combined screening 4 – Second trimester maternal serum screening		
Obligation	Mandatory		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

12.5 Chorionic villus sampling (CVS)

Definition	Whether the woman has undergone a CVS		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

12.6 Amniocentesis

Definition	Whether the woman has undergone an amniocentesis		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

12.7 Pregnancy complications

Definition	Complications the woman experienced during the current pregnancy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Antepartum haemorrhage	34842007
Eclampsia	198992004
Gestational diabetes	11687002
Hypertensive disorders of pregnancy	20753005
Infection	40609001
Mental health concerns	10211000132109
No complications	TBA
Placental conditions	273983009
Preterm labour	6383007
Other	609496007

Obligation	Mandatory
Guide for use	Up to nine instances of this field may be recorded
Verification rules	Valid code only

12.8 Antenatal referrals

Definition	Whether the woman has been referred to specialist services during her pregnancy		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid value only

12.9 Antenatal referral code

Definition	Unique antenatal referral code		
Source Standards	https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines see table 2 Conditions and referral categories		
Data type	Number	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	Codes as per table 2		
Obligation	Conditional on a '1 – Yes' response to section 12.8 Antenatal referrals		
Guide for use	The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes		
Verification rules	Valid code only		

12.10 Antenatal admissions

Definition	Whether the woman had been admitted to hospital for antenatal care during the current pregnancy		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

12.11 Current alcohol consumption

Definition	Does the woman currently drink alcohol		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Does not drink alcohol / 105542008 Drinks alcohol / 219006 Declined to answer / 426544006		
Obligation	Mandatory		
Guide for use	The information is distinct from that recorded in section 8.2 Current consumption. That is, this section (12.11 Current alcohol consumption), records a value at the end of the pregnancy		
Verification rules	Valid code only		

12.12 Drug use

Definition	A record of whether the woman currently uses drugs		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Current drug user / 417284009 Declined to answer / 426544006 Does not misuse drugs / 228367002		
Obligation	Mandatory		
Guide for use	The information is distinct from that recorded in section 8.8 History of drug use. That is, this section (12.12 Drug use), records a value at the end of the pregnancy		
Verification rules	Valid value only		

12.13 Current drugs used

<table>
<tr><td>Definition</td><td colspan="3">Drugs the woman is currently using</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Amphetamines</td><td>703842006</td></tr>
<tr><td>Aromatic solvent</td><td>117499009</td></tr>
<tr><td>Benzodiazepine sedative</td><td>372616003</td></tr>
<tr><td>Cannabis</td><td>398705004</td></tr>
<tr><td>Cocaine</td><td>387085005</td></tr>
<tr><td>Codeine phosphate</td><td>261000</td></tr>
<tr><td>Crack cocaine</td><td>229003004</td></tr>
<tr><td>Drug or medicament</td><td>410942007</td></tr>
<tr><td>Gas (nitrous oxide)</td><td>111132001</td></tr>
<tr><td>Hallucinogenic agent</td><td>373469002</td></tr>
<tr><td>Heroin</td><td>387341002</td></tr>
<tr><td>Methadone</td><td>387286002</td></tr>
<tr><td>Methamphetamine</td><td>387499002</td></tr>
<tr><td>Morphine</td><td>373529000</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Current drug user’ to section 12.12 Drug use</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to nine instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

12.14 Current smoker

Definition	Does the woman currently smoke tobacco		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Current smoker	77176002
Current non-smoker	160618006
Declined to answer	426544006

Obligation	Mandatory
Guide for use	The information is distinct from that recorded in section 9.2 Current smoker. That is, this section (12.14 Current smoker), records a value at the end of the pregnancy
Verification rules	Valid value only

12.15 Antenatal prescriptions

Definition	The prescriptions supplied to the woman by the LMC during the current pregnancy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Analgesics</td><td>373265006</td></tr><tr><td>Antacids</td><td>372794006</td></tr><tr><td>Antibacterials</td><td>419241000</td></tr><tr><td>Antifungals</td><td>373219008</td></tr><tr><td>Minerals</td><td>373460003</td></tr><tr><td>Non-steroidal anti-inflammatories (NSAIDs)</td><td>372665008</td></tr><tr><td>Vitamins</td><td>87708000</td></tr><tr><td>Other</td><td>105590001</td></tr><tr><td>No prescriptions</td><td>TBA</td></tr></table>
Obligation	Mandatory
Guide for use	Up to nine instances of this field may be recorded
Verification rules	Valid code only

12.16 Antenatal prescriptions – other

Definition	Additional field to describe the 'Other' Antenatal prescriptions		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 12.15 Antenatal prescriptions		
Guide for use			
Verification rules			

12.17 Antenatal complementary therapies

<table>
<tr><td>Definition</td><td colspan="3">The type of complementary therapies used by the woman during the current pregnancy</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Acupressure</td><td>231107005</td></tr>
<tr><td>Acupuncture</td><td>231081007</td></tr>
<tr><td>Chiropractic</td><td>182548004</td></tr>
<tr><td>Herbal medicine</td><td>414392008</td></tr>
<tr><td>Homeopathy</td><td>182968001</td></tr>
<tr><td>Massage</td><td>387854002</td></tr>
<tr><td>Naturopathy</td><td>439809005</td></tr>
<tr><td>Osteopathy</td><td>182549007</td></tr>
<tr><td>No complementary therapies</td><td>TBA</td></tr>
<tr><td>Rongoā Māori</td><td>TBA</td></tr>
<tr><td>Other</td><td>225423004</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to ten instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

12.18 Antenatal visits – first trimester

Definition	The number of antenatal visits received by the woman during the first trimester		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	00-99		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

12.19 Antenatal visits – second trimester

Definition	The number of antenatal visits received by the woman during the second trimester		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	00-99		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

12.20 Antenatal visits – third trimester

Definition	The number of antenatal visits received by the woman during the third trimester		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	00-99		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

13 Labour and birth

Information regarding the details of the labour and birth relating to the woman.

Data element		Data element	
13.1	Onset of labour	13.18	Date and time pushing commenced
13.2	Planned place of birth	13.19	Complications – second stage
13.3	Planned place of birth – Other	13.20	Length of second stage of labour
13.4	Actual place of birth	13.21	Date and time of rupture of membranes
13.5	Actual place of birth – Other	13.22	Meconium present
13.6	Gestation at onset of labour	13.23	Number of babies born
13.7	Date and time labour established	13.24	Type of birth
13.8	Maternity facility admission date/time	13.25	Birth position
13.9	Labour augmented – first stage	13.26	Water birth
13.10	Reason labour augmented – first stage	13.27	Vaginal birth after Caesarean
13.11	Reason labour augmented – other	13.28	Length of third stage of labour
13.12	Complications – first stage	13.29	Analgesia in labour
13.13	Date and time cervix fully dilated	13.30	Anaesthesia in labour
13.14	Length of active first stage of labour	13.31	Analgesia for the birth
13.15	Labour augmentation – second stage	13.32	Anaesthesia for the birth
13.16	Reason labour augmented – second stage	13.33	Coping strategies
13.17	Reason labour augmented – second stage – other	13.34	Coping strategies – Other

13.1 Onset of labour

Definition	The manner by which the woman's labour started		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Induced / 112070001 Planned Caesarean section before labour / 177141003 Spontaneous / 84457005		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

13.2 Planned place of birth

Definition	The place or facility where the woman planned to give birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Home 2 – Primary facility 3 – Secondary facility 4 – Tertiary facility 5 – Other		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

13.3 Planned place of birth – Other – detail

Definition	Additional field to describe the 'Other' planned place of birth		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of '5 – Other' for section 13.2 Planned place of birth		
Guide for use			
Verification rules			

13.4 Actual place of birth

Definition	The actual place or facility where the woman gave birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Home 2 – Primary facility 3 – Secondary facility 4 – Tertiary facility 5 – In transit 6 – Other		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

13.5 Actual place of birth – Other – detail

Definition	Additional field to describe the 'Other' actual place of birth		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of '6 – Other' for section 13.4 Actual place of birth		
Guide for use			
Verification rules			

13.6 Gestation at onset of labour

Definition	Gestation at the onset of labour		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain			
Obligation	Mandatory		
Guide for use	Record the number of completed weeks of this pregnancy		
Verification rules	Valid value only The value must be greater than or equal to 20		

13.7 Date and time labour established

Definition	The date and time labour established, as measured by duration, frequency, and strength of contractions		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Conditional on response of 'Spontaneous' OR 'Induced' for section 13.1 Onset of labour		
Guide for use	Used to calculate the length of the first stage of labour		
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

13.8 Maternity facility admission date/time

Definition	The date and time the woman was admitted to a maternity facility, if admitted to a facility		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Optional		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

13.9 Labour augmented – first stage

Definition	Was the first stage of labour was augmented with an artificial rupture of membranes (ARM) and/or oxytocin		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No augmentation 2 – Augmented with ARM 3 – Augmented with oxytocin 4 – Augmented with both ARM and oxytocin		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

13.10 Reason labour augmented – first stage

Definition	The reason the woman's labour was augmented during the first stage of labour		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Delay in first stage of labour 2 – Other		
Obligation	Mandatory on a response other than '1 – No augmentation' for section 13.9 Labour augmented – first stage		
Guide for use			
Verification rules	Valid code only		

13.11 Reason labour augmented – other – detail

Definition	Additional field to describe the 'Other' reason for the augmentation of labour		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 250	**Representational layout**	X(250)
Data domain			
Obligation	Conditional on a response of '2 – Other' for section 13.10 Reason labour augmented – first stage		
Guide for use			
Verification rules			

13.12 Complications – first stage

Definition	Type of complications experienced during the first stage of labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Complications of an anaesthetic</td><td>200046004</td></tr><tr><td>Cord prolapse</td><td>270500004</td></tr><tr><td>Deep transverse arrest</td><td>1343000</td></tr><tr><td>Fetal distress</td><td>130955003</td></tr><tr><td>Infection</td><td>32801000119106</td></tr><tr><td>Intrapartum haemorrhage</td><td>38010008</td></tr><tr><td>Malposition</td><td>698554000</td></tr><tr><td>Malpresentation</td><td>698791008</td></tr><tr><td>Meconium liquor</td><td>199595002</td></tr><tr><td>No fetal complications</td><td>TBA</td></tr><tr><td>No maternal complications</td><td>TBA</td></tr><tr><td>Obstructed labour</td><td>199746004</td></tr><tr><td>Other</td><td>199745000</td></tr></table>
Obligation	Mandatory
Guide for use	Up to six instances of this field may be recorded
Verification rules	Valid code only

13.13 Date and time cervix fully dilated

Definition	The date and time the cervix was fully dilated		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Optional		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

13.14 Length of active first stage of labour

Definition	The calculated length of first stage of labour – presented and stored in hours and minutes		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 5	**Representational layout**	HH:MM
Data domain	Up to 99 hours, 59 minutes		
Obligation	Mandatory if a valid date/time is provided at section 13.13 Date and time cervix fully dilated		
Guide for use	**Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created 'on-the-fly' as a result of the LMC request The value for this field is created by: subtracting the: time labour commenced (a time value recorded in section 13.7 Date and time labour established) from the recorded time for the end of first stage labour (a value recorded in section 13.13 Date and time cervix fully dilated)		
Verification rules			

13.15 Labour augmentation – second stage

Definition	A record of whether the labour was augmented with an artificial rupture of membranes (ARM) and/or oxytocic during the second stage of labour		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No augmentation 2 – Augmented with ARM 3 – Augmented with oxytocin 4 – Augmented with both ARM and oxytocin		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid value only

13.16 Reason labour augmented – second stage

Definition	The reason the woman's labour was augmented during the second stage of labour		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Delay in second stage of labour 2 – Other		
Obligation	Mandatory on any other response than '1 – No augmentation' for section 13.15 Labour augmentation – second stage		
Guide for use			
Verification rules			

13.17 Reason labour augmented – second stage – other

Definition	Additional field to describe the 'Other' reason labour augmented – second stage		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Conditional on a response of '2 – Other' for section 13.16 Reason labour augmented – second stage		
Guide for use			
Verification rules			

13.18 Date and time pushing commenced

Definition	The date and time the woman actively started pushing during the second stage		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Optional		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

13.19 Complications – second stage

Definition	Type of complications the woman had during the second stage of labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Complications of an anaesthetic</td><td>200046004</td></tr><tr><td>Cord prolapse</td><td>270500004</td></tr><tr><td>Deep transverse arrest</td><td>1343000</td></tr><tr><td>Fetal distress</td><td>130955003</td></tr><tr><td>Infection</td><td>32801000119106</td></tr><tr><td>Intrapartum haemorrhage</td><td>38010008</td></tr><tr><td>Malposition</td><td>698554000</td></tr><tr><td>Malpresentation</td><td>698791008</td></tr><tr><td>Meconium liquor</td><td>199595002</td></tr><tr><td>No fetal complications</td><td>TBA</td></tr><tr><td>No maternal complications</td><td>TBA</td></tr><tr><td>Obstructed labour</td><td>199746004</td></tr><tr><td>Other</td><td>199745000</td></tr></table>
Obligation	Mandatory
Guide for use	Up to six instances of this field may be recorded
Verification rules	Valid code only

13.20 Length of second stage of labour

Definition	The calculated length of second stage of labour – presented and stored in hours and minutes		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 5	**Representational layout**	HH:MM
Data domain	Zero to 99 hours, 59 minutes		
Obligation	Mandatory if a valid date/time is provided at section 13.13 Date and time cervix fully dilated		
Guide for use	**Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created 'on-the-fly' as a result of the LMC request The value for this field is created by: Subtracting the time value recorded for the start of the second stage of labour (a time value recorded in 13.13 Date and time cervix fully dilated) from the recorded time of the birth of the baby (a time value recorded in section 17.1 Date and time of birth)		
Verification rules			

13.21 Date and time of rupture of membranes

Definition	The date and time of the membranes rupturing		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

13.22 Meconium present

Definition	Was there any meconium present in the amniotic fluid		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Yes 2 – No 3 – Amniotic fluid not present		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

13.23 Number of babies born

Definition	The number of babies born during this labour and birth, including stillbirths		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 1	**Representational layout**	N
Data domain			
Obligation	Mandatory		
Guide for use			
Verification rules	An integer greater than zero		

13.24 Type of birth

Definition	Type of birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Spontaneous vaginal birth	48782003
Caesarean section	200144004
Forceps	200130005
Vacuum extraction	200138003

Obligation	Mandatory
Guide for use	Up to four instances may be recorded for this field
Verification rules	Valid code only

13.25 Birth position

Definition	The position the woman gave birth in		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Supine	40199007
Semi-reclined	272580008
Lithotomy	14205002
Standing	10904000
Squatting	408797004
Kneeling	277773003
Lateral	32185000
Sitting (eg birth stool)	33586001

Obligation	Mandatory
Guide for use	Record one entry for each baby born
Verification rules	Valid code only

13.26 Water birth

Definition	Indicates whether the baby was born into water		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use	Record one entry for each baby born		
Verification rules	Valid code only		

13.27 Vaginal birth after Caesarean

Definition	Identifies whether the birth was the first vaginal birth after a previous Caesarean section		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

13.28 Length of third stage of labour

Definition	The calculated length of third stage of labour – presented and stored in hours and minutes		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 5	**Representational layout**	HH:MM
Data domain	Zero to 99 hours, 59 minutes		
Obligation	Mandatory		
Guide for use	**Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created 'on-the-fly' as a result of the LMC request. The value for this field is created by: subtracting the recorded time of the birth of the baby (a value recorded in 17.1 Date and time of birth) from the recorded time for the end of third stage of labour (a time value recorded in section 16.3 Placenta delivery date and time		
Verification rules			

13.29 Analgesia in labour

Definition	The types of analgesia used by the woman during labour		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No analgesia 2 – Pharmacological – non opiate 3 – Pharmacological – opiate 4 – Non pharmacological		
Obligation	Mandatory		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

13.30 Anaesthesia in labour

Definition	The types of anaesthesia administered to the woman during labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Local anaesthetic	386761002
Pudendal block	231208005
Epidural	27372005
Spinal	231249005
Combined spinal/epidural	231261002
General anaesthetic	50697003
No previous anaesthesia	TBA

Obligation	Mandatory
Guide for use	Up to three instances of this field may be recorded
Verification rules	Valid code only

13.31 Analgesia for the birth

Definition	The types of analgesia used by the woman for the birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No analgesia 2 – Pharmacological – non opiate 3 – Pharmacological – opiate 4 – Non pharmacological		
Obligation	Mandatory		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

13.32 Anaesthesia for the birth

Definition	The types of anaesthesia administered to the woman for the birth of the baby(ies)		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Local anaesthetic	386761002
Pudendal block	231208005
Epidural	27372005
Spinal	231249005
Combined spinal/epidural	231261002
General anaesthetic	50697003
No previous anaesthesia	TBA

Obligation	Mandatory
Guide for use	Up to three instances of this field may be recorded
Verification rules	Valid code only

13.33 Coping strategies

Definition	Description of the types of coping strategies and complementary therapies used by the woman during labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Acupressure</td><td>231107005</td></tr><tr><td>Acupuncture</td><td>231081007</td></tr><tr><td>Aromatherapy</td><td>394615007</td></tr><tr><td>Herbal medicine</td><td>414392008</td></tr><tr><td>Homeopathy</td><td>182968001</td></tr><tr><td>Hypnobirthing techniques</td><td>19997007</td></tr><tr><td>Massage</td><td>387854002</td></tr><tr><td>Naturopathy</td><td>439809005</td></tr><tr><td>Positional techniques</td><td>226048001</td></tr><tr><td>Rongoā Māori</td><td>TBA</td></tr><tr><td>Support people</td><td>TBA</td></tr><tr><td>TENS machine</td><td>229559001</td></tr><tr><td>Water immersion</td><td>229204004</td></tr><tr><td>Other</td><td>TBA</td></tr></table>
Obligation	Optional
Guide for use	Up to 13 instances of this field may be recorded
Verification rules	Valid code only

13.34 Coping strategies – Other – detail

Definition	Additional field to describe the 'Other' coping strategies		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 13.33 Coping strategies		
Guide for use			
Verification rules			

14 Induction of labour

Information about the woman's induction of labour, if she had one during this labour and birth.

Data element		Data element	
14.1	Induction date and time	14.3	Induction reason
14.2	Induction method(s)		

14.1 Induction date and time

Definition	The date and time induction of labour was commenced		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory on a response of 'Induced' for section 13.1 Onset of labour		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

14.2 Induction method(s)

Definition	The method(s) by which the labour was induced		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Artificial rupture of membranes (ARM)	408816000
Cervical ripening balloon	425861005
Oxytocin infusion	177135005
Prostaglandin	177136006

Obligation	Mandatory on a valid response being recorded for section 14.1 Induction date and time
Guide for use	Up to four instances of this field may be recorded
Verification rules	Valid code only

14.3 Induction reason

Definition	Reason for the induction of labour		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain

SNOMED Concept	SNOMED CT Code
Abnormal cardiotochogram (CTG)	735205007
Abnormal dopplers	312370006
Advanced maternal age	416413003
Antepartum haemorrhage	34842007
Blood group antibodies	166167002
Congenital anomalies	64731000119106
Diabetes mellitus	10754881000119104
Eclampsia	15938005
Gestational hypertension	288250001
Hypertension	106005003
In vitro fertilisation	10231000132102
Intrauterine fetal death	14022007
Intrauterine growth restriction (IUGR)	22033007
Large for gestational age	199616008
Long latent phase	387700009
Maternal medical condition	106007006
Maternal request	408855004
Multiple pregnancy	16356006
Obesity	10750551000119100
Obstetric cholestasis	10750161000119106

	Oligohydramnios	59566000
	Polyhydramnios	86203003
	Poor obstetric history	161803004
	Pre-eclampsia	398254007
	Prelabour rupture of membranes	44223004
	Preterm rupture of membranes	237266003
	Previous shoulder dystocia	TBA
	Prolonged pregnancy	90968009
	Reduced fetal movements	276369006
	Congenital anomaly of fetus	702709008
	Chromosomal anomaly of fetus	267253006
	Termination of pregnancy	57797005
	Unstable lie	86356004
	Other	106007006
Obligation	Mandatory on a valid response being recorded for section 14.1 Induction date and time	
Guide for use	Up to five instances of this field may be recorded	
Verification rules	Valid code only	

15 Caesarean section

Information about the woman's Caesarean section, if she had one during this labour and birth.

Data element		Data element	
15.1	Caesarean section type	15.7	Caesarean section primary indication – Other fetal reason – detail
15.2	Caesarean grade	15.8	Caesarean section primary indication – Other maternal detail
15.3	Caesarean category	15.9	Complications during Caesarean section
15.4	Dilation before Caesarean section	15.10	Complications during Caesarean section – Other
15.5	Caesarean section primary indication	15.11	Complications post Caesarean section
15.6	Caesarean section primary indication – detail		

15.1 Caesarean section type

Definition	The type of uterine incision if there was a Caesarean section for this birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Classical / 84195007 Lower uterine segment (LUSCS) / 398307005 Other / 11466000		
Obligation	Conditional on a response of 'Caesarean section' for section 13.24 Type of birth		
Guide for use			
Verification rules	Valid code only		

15.2 Caesarean grade

Definition	The grade of urgency under which the Caesarean section was initiated		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Planned (elective) / 177141003 Unplanned (emergency) / 274130007		
Obligation	Conditional on a valid response being recorded for section 15.1 Caesarean section type		
Guide for use			
Verification rules	Valid code only		

15.3 Caesarean category

Definition	The category of the Caesarean section		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Category 1 – Urgent threat to the life of a woman or fetus 2 – Category 2 – Maternal or fetal compromise but not immediately life threatening 3 – Category 3 – Needing earlier than planned delivery but without evident maternal or fetal compromise 4 – Category 4 – At a time acceptable to both the woman and the caesarean section team, understanding that this can be affected by a number of factors		
Obligation	Conditional on a response of 'Unplanned (emergency)' for section 15.2 Caesarean grade		
Guide for use			
Verification rules	Valid code only		

15.4 Dilation before Caesarean section

Definition	The extent of cervical dilation in centimetres as last measured prior to Caesarean section.		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain			
Obligation	Optional		
Guide for use			
Verification rules	An integer		

15.5 Caesarean section primary indication

Definition	Primary indication for Caesarean section		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Planned/prelabour (Maternal) 2 – Planned/prelabour (Fetal) 3 – Unplanned (Maternal) 4 – Unplanned (Fetal)		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

15.6 Caesarean section primary indication – detail

Definition	The detail of the primary indication for performing the Caesarean section		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain

SNOMED Concept	SNOMED CT Code
Antepartum haemorrhage	34842007
Augmentation causing uterine hyperstimulation	34981006
Chorioamnionitis	11612004
Chronic hypertension	8218002
Cord presentation	237305004
Cord prolapse	270500004
Diabetes mellitus type 1	46635009
Diabetes mellitus type 2	44054006
Efficient uterine action – obstructed labour	TBA
Failed induction of labour	42571002
Failed instrumental delivery	772006002
Fetal anomaly	702709008
Fetal distress	12867002
Fetal distress – intolerance of augmented labour	TBA
Fetal distress – spontaneous labour	288274003
Gestational diabetes	11687002
Inefficient uterine action – no oxytocin	TBA
Large for gestational age	199616008
Malposition	289365005
Malpresentation	15028002
Maternal age	416413003
Maternal medical condition	106007006

	Multiple pregnancy	16356006
	Other fetal reason	106009009
	Other maternal reason	106008001
	Placenta praevia	36813001
	Placental abruption	415105001
	Poor uterine response to optimal augmentation	TBA
	Pre-eclampsia	398254007
	Previous Caesarean section	200151008
	Small for gestational age	267258002
	Suboptimal augmentation	91484005
	Unknown	281337006
	Uterine rupture	34430009
Obligation	Mandatory	
Guide for use		
Verification rules	Valid code only	

15.7 Caesarean section primary indication – Other fetal reason – detail

Definition	A description of the type of 'Other fetal reason' caesarean information		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other fetal reason' in section 15.6 Caesarean section primary indication – detail		
Guide for use			
Verification rules			

15.8 Caesarean section primary indication – Other maternal detail

Definition	A description of the type of 'Other maternal' caesarean information		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other maternal reason' in section 15.6 Caesarean section primary indication – detail		
Guide for use			
Verification rules			

15.9 Complications during Caesarean section

Definition	Complications that occurred during the Caesarean section		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
No complications	TBA
Eclampsia	15938005
Uterine complications	289618005
Bowel injury	125625000
Bladder injury	77165001
Ureteric injury	24850009
Adhesions	TBA
Intrapartum haemorrhage	38010008
Other	78408007

Obligation	Optional
Guide for use	Up to nine instances of this field may be recorded
Verification rules	Valid code only

15.10 Complications during Caesarean section – Other – detail

Definition	A description of the type of 'Other' complications during Caesarean section		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other' for section 15.9 Complications during Caesarean section		
Guide for use			
Verification rules			

15.11 Complications post Caesarean section

Definition	Complications that occurred in the first six weeks post operatively as a result of the Caesarean section		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Wound infection</td><td>76844004</td></tr><tr><td>Uterine infection</td><td>301775005</td></tr><tr><td>UTI - Urinary tract infection</td><td>68566005</td></tr></table>		
Obligation	Optional		
Guide for use			
Verification rules	Valid code only		

16 Post birth

Information about the woman during the third stage of labour and up to 24 hours postnatally. There is one set of coded entries and the corresponding text block for display is structured as a table.

Data element		Data element	
16.1	Placenta mode of delivery	16.8	Non perineal genital tract trauma type
16.2	Uterotonic drug	16.9	Repair required
16.3	Placenta delivery date and time	16.10	Placenta and membranes
16.4	Perineal status	16.11	Placenta appearance
16.5	Episiotomy type	16.12	Number of cord vessels
16.6	Episiotomy reason	16.13	Placenta kept by the woman
16.7	Episiotomy reason– Other	16.14	Total blood loss

16.1 Placenta mode of delivery

Definition	The mode of delivery of the placenta		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Caesarean section	TBA
Controlled cord traction with uterotonic	302384005
Manual removal	28233006
Physiological	177212000

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

16.2 Uterotonic drug

Definition	Uterotonic drugs administered as part of the third stage of labour		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – None 2 – Yes, as part of active management 3 – Yes, as treatment		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

16.3 Placenta delivery date and time

Definition	The date and time the placenta was delivered		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory		
Guide for use	This field is also the 'end of third stage labour'		
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

16.4 Perineal status

<table>
<tr><td>Definition</td><td colspan="3">The status of the woman's perineum after the birth</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>Perineum intact</td><td>289854007</td></tr>
<tr><td>First degree tear
– injury to perineal skin and vaginal wall only</td><td>57759005</td></tr>
<tr><td>Second degree tear
– injury to perineal skin, vaginal wall and superficial perineal muscles</td><td>6234006</td></tr>
<tr><td>Third degree tear (3a)
– injury to perineal skin, vaginal wall and perineal muscles and less than 50% of external anal sphincter (EAS) thickness torn</td><td>449807005</td></tr>
<tr><td>Third degree tear (3b)
– injury to perineal skin, vaginal wall and perineal muscles and more than 50% of EAS thickness torn</td><td>449808000</td></tr>
<tr><td>Third degree tear (3c)
– both EAS and internal anal sphincter (IAS) torn</td><td>449809008</td></tr>
<tr><td>Fourth degree tear
– anal sphincter complex (EAS and IAS) and anal epithelium torn</td><td>399031001</td></tr>
<tr><td>Episiotomy</td><td>TBA</td></tr>
<tr><td>Not known</td><td>TBA</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to four instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

16.5 Episiotomy type

Definition	The episiotomy type		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Anterior	255549009
J shaped	260666003
Mediolateral	261129000
Midline	399488007

Obligation	Mandatory on a response of 'Episiotomy' for section 16.4 Perineal status
Guide for use	
Verification rules	Valid code only

16.6 Episiotomy reason

Definition	The clinical indication for performing the episiotomy		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Fetal distress</td><td>130955003</td></tr><tr><td>Female Genital Mutilation (FGM)</td><td>95041000119101</td></tr><tr><td>Instrumental birth</td><td>TBA</td></tr><tr><td>Maternal distress</td><td>87383005</td></tr><tr><td>Previous perineal damage</td><td>15758941000119102</td></tr><tr><td>Rigid perineum</td><td>289875004</td></tr><tr><td>Shoulder dystocia</td><td>89700002</td></tr><tr><td>Other</td><td>TBA</td></tr></table>
Obligation	Mandatory on response of 'Episiotomy' to section 16.4 Perineal status
Guide for use	
Verification rules	Valid code only

16.7 Episiotomy reason– Other

Definition	A description of the type of 'Other' episiotomy reason		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other' for section 16.6 Episiotomy reason		
Guide for use			
Verification rules			

16.8 Non perineal genital tract trauma type

Definition	Description of any non-perineal genital tract trauma		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Cervical laceration / 289794001 Labial graze or tear / 289488005 Vaginal laceration / 410062001		
Obligation	Conditional on non-perineal genital tract trauma being present		
Guide for use			
Verification rules	Valid code only		

16.9 Repair required

Definition	Perineal or genital tract trauma suturing or repair		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** No repair required / 418014008 Repair episiotomy / 177222006 Repair perineal tear / 237026005 Repair genital tract laceration / 372455009		
Obligation	Mandatory on a response other than 'Perineum intact' OR 'Not known' for section 16.4 Perineal status		
Guide for use	Up to three instances of this field may be recorded		
Verification rules	Valid code only		

16.10 Placenta and membranes

Definition	Was the placenta complete		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Complete / 249170006 Incomplete / 268479002 Ragged membranes / 249182002		
Obligation	Mandatory		
Guide for use	Up to two instances of this field may be recorded		
Verification rules	Valid code only		

16.11 Placenta appearance

Definition	Description of the appearance of the placenta		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Calcifications</td><td>249174002</td></tr><tr><td>Fetus papyraceous</td><td>90127001</td></tr><tr><td>Gritty</td><td>249173008</td></tr><tr><td>Infarctions</td><td>271403007</td></tr><tr><td>Normal</td><td>289279004</td></tr><tr><td>Oedematous</td><td>56425003</td></tr><tr><td>Offensive</td><td>289275005</td></tr><tr><td>Retroplacental clot</td><td>249177009</td></tr><tr><td>Succenturiate lobe</td><td>82664003</td></tr><tr><td>Velamentous insertion of cord</td><td>77278008</td></tr></table>
Obligation	Mandatory
Guide for use	Up to five instances of this field may be captured
Verification rules	Valid code only

16.12 Number of cord vessels

Definition	The number of vessels identified in the umbilical cord		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 1	**Representational layout**	N
Data domain	2 or 3		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

16.13 Placenta kept by the woman

Definition	Was the placenta kept by the woman		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

16.14 Total blood loss

Definition	The estimated and/or measured total blood loss within two hours of the birth recorded in millilitres		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NNNN
Data domain			
Obligation	Mandatory		
Guide for use			
Verification rules	An integer greater than zero		

17 Newborn baby

Information about the baby(ies) resulting from the birth. This includes information about each baby and its care immediately after birth. There is one set of coded entries per baby born.

Data element		Data element	
17.1	Date and time of birth	17.18	Apgar 1 minute
17.2	Gestation at birth	17.19	Apgar 5 minutes
17.3	Birth outcome	17.20	Apgar 10 minutes
17.4	Place of birth	17.21	Neonatal resuscitation
17.5	Place of birth – Other	17.22	Vitamin K
17.6	Mode of birth	17.23	Skin to skin
17.7	Presenting part of baby	17.24	Skin to skin – start date/time
17.8	Presenting part of baby – other – detail	17.25	Skin to skin – end date/time
17.9	Type of breech	17.26	Skin to skin – reason for end
17.10	Mode of breech birth	17.27	Skin to skin end – Other – detail
17.11	Shoulder dystocia	17.28	Infant feeding method
17.12	Shoulder dystocia procedures	17.29	Breastfeeding – start date/time
17.13	Shoulder dystocia procedures – Other manoeuvre – detail	17.30	Initial breastfeed – end date/time
17.14	Cord blood sample	17.31	Consultations or referrals
17.15	Baby sex	17.32	Reason for referral to specialist
17.16	Birth weight	17.33	Admission to neonatal intensive care (NICU) or special care baby unit (SCBU)
17.17	Baby NHI number		

17.1 Date and time of birth

Definition	The date and time the baby was born		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

17.2 Gestation at birth

Definition	The gestation of the baby at birth, recorded in weeks and days		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NN:N
Data domain			
Obligation	Mandatory		
Guide for use	For example: 38 weeks and 4 days would be recorded as 38:4 (W:D)		
Verification rules	Weeks and days		

17.3 Birth outcome

Definition	What was the outcome of the birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Live born – 281050002 Stillborn – antepartum – 44174001 Stillborn – intrapartum – 1762004 Neonatal death – 276506001		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

17.4 Place of birth

Definition	The type of place where the birth occurred		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Home 2 – Primary maternity facility 3 – Secondary maternity facility 4 – Tertiary maternity facility 5 – In transit 6 – Other		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

17.5 Place of birth – Other – detail

Definition	A description of the type of 'Other' place of birth		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of '6 – Other' for section 17.4 Place of birth		
Guide for use			
Verification rules			

17.6 Mode of birth

Definition	How the baby(ies) was/were born		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Spontaneous vaginal birth	48782003
Caesarean section	200144004
Forceps	200130005
Vacuum extraction	200138003

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

17.7 Presenting part of baby

Definition	The presenting part of the baby at time of birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Breech	6096002
Cephalic	70028003
Compound	124736009
Shoulder	23954006
Other	15028002

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

17.8 Presenting part of baby – other – detail

Definition	A description of the type of 'Other' presenting part of the baby		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other' for section 17.7 Presenting part of baby		
Guide for use			
Verification rules			

17.9 Type of breech

Definition	The type of breech presentation		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Complete / 49168004 Extended (frank) / 18559007 Footling / 249097002 Kneeling / TBA Incomplete / 38049006		
Obligation	Mandatory on a response of 'Breech' for section 17.7 Presenting part of baby		
Guide for use			
Verification rules	Valid code only		

17.10 Mode of breech birth

Definition	The mode of the breech birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Assisted vaginal breech / 177158008 Caesarean section / 712654009 Spontaneous vaginal breech / 271373005		
Obligation	Mandatory on a response of 'Breech' for section 17.7 Presenting part of baby		
Guide for use			
Verification rules	Valid code only		

17.11 Shoulder dystocia

Definition	Was there a shoulder dystocia during the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

17.12 Shoulder dystocia procedures

Definition	The procedures required to deliver the baby during the shoulder dystocia		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Maternal position change – 229824005 McRoberts' position – 237009004 Suprapubic pressure (Rubin's I) – 23701000 Internal manoeuvres (Rubin's II/Wood's screw/Reverse Wood's screw) – 237011008 Delivery of posterior arm – 237012001 Other manoeuvre – 237008007		
Obligation	Mandatory on a response of '1 – Yes' for section 17.11 Shoulder dystocia		
Guide for use	Up to six instances of this field may be recorded		
Verification rules	Valid code only		

17.13 Shoulder dystocia procedures – Other manoeuvre – detail

Definition	A description of the type of 'Other manoeuvre'		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of 'Other manoeuvre' for section 17.12 Shoulder dystocia procedures		
Guide for use			
Verification rules			

17.14 Cord blood sample

Definition	To record the cord blood tests taken if any		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

SNOMED Concept	SNOMED CT Code
Blood gases	167018008
Blood group type and antibodies	20099001
Lactate	3926003
Laboratory test not necessary	165330008

17.15 Baby sex

Definition	Baby sex is recorded as either male, female or indeterminate		
Source Standards	HISO 10046 Consumer Health Identity Standard, section 2.4 Gender https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard		
Data type	Alphabetic	**Representational class**	Code
Field size	Max:1	**Representational layout**	A
Data domain	'M' – Male 'F" – Female 'I' – Indeterminate		
Obligation	Mandatory This value is to be obtained directly from the NHI system. This will require knowledge of the baby's NHI number as a key – see section 17.17 Baby NHI number At this time, the NHI does not record a value for Sex. However, the NHI does populate a Gender field with a Sex value. A change is being planned to address this situation		
Guide for use			
Verification rules	Valid value		

17.16 Birth weight

Definition	The weight of the baby at birth (or the earliest weight recorded) in grams		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 4	**Representational layout**	NNNN
Data domain	Grams		
Obligation	Mandatory		
Guide for use			
Verification rules	An integer greater than 400 grams		

17.17 Baby NHI number

Definition	National Health Index (NHI) number – a unique identifier allocated by the NHI system to all babies		
Source standards	HISO 10046 Consumer Health Identity Standard: www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard See also NHI data dictionary: www.health.govt.nz/publication/national-health-index-data-dictionary		
Data type	Alphanumeric	**Representational class**	Identifier
Field size	Max: 7	**Representational layout**	AAANNNN
Data domain	NHI numbers		
Obligation	Mandatory. This number must be obtained from the NHI system		
Guide for use	Only the NHI system generates the NHI number that is allocated to a baby. NHI numbers are not re-used once allocated to an identity Where more than one number exists for an identity, one number is declared 'live' and all other numbers are made 'dormant' and attached to the live record. The NHI number is the primary key for the woman's records		
Verification rules	See the source standards for the check digit algorithm and NHI number validation rules		

17.18 Apgar 1 minute

Definition	The Apgar score the baby received at one minute of age		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 2	**Representational layout**	NN
Data domain	00-10		
Obligation	Optional		
Guide for use	Apgar scores indicate the physical health of a newborn infant, determined after examination of the adequacy of respiration, heart rate, muscle tone, skin colour and reflexes		
Verification rules	Valid code only		

17.19 Apgar 5 minutes

Definition	The Apgar score the baby received at five minutes of age		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 2	**Representational layout**	NN
Data domain	00-10		
Obligation	Optional		
Guide for use	Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes		
Verification rules	Valid code only		

17.20 Apgar 10 minutes

Definition	The Apgar score the baby received at ten minutes of age		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 2	**Representational layout**	NN
Data domain	00-10		
Obligation	Optional		
Guide for use	Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes		
Verification rules	Valid code only		

17.21 Neonatal resuscitation

Definition	Was neonatal resuscitation required, including the outcome		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Not performed	262008008
Successful	385669000
Unsuccessful	385671000

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

17.22 Vitamin K

Definition	Prophylactic Vitamin K administration, including the route of administration		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Intramuscular	736388004
Oral	698350008
Declined	15651391000119108

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

17.23 Skin to skin

Definition	Did the baby(ies) receive skin to skin contact with the woman at the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

17.24 Skin to skin – start date/time

Definition	The start time of the initial skin to skin contact with the woman		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory on a response of '1 – Yes' for section 17.23 Skin to skin		
Guide for use			
Verification rules	This field must be a valid date and time that is less than the current date and time		

17.25 Skin to skin – end date/time

Definition	The end time of the initial skin to skin contact with the woman		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory on a response of '1 – Yes' for section 17.23 Skin to skin		
Guide for use			

Verification rules	This field must be a valid date and time that is less than or equal to the current date and time and greater than the date and time specified in section 17.24 Skin to skin – start date/time

17.26 Skin to skin – reason for end

Definition	The reason why initial skin to skin contact was ended		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – One hour or more skin to skin contact had been achieved 2 – Maternal request 3 – Health professional decision 4 – Medical reason 5 – Other reason		
Obligation	Conditional on a response of '1 – Yes' for section 17.23 Skin to skin		
Guide for use			
Verification rules	Valid code only		

17.27 Skin to skin end – Other – detail

Definition	To record the 'Other reason' that the skin to skin time ended		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory upon a response of '5 – Other reason' for section 17.26 Skin to skin – reason for end		
Guide for use			
Verification rules			

17.28 Infant feeding method

Definition	The method by which the baby was first fed after the birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed at the mother's breast ('exclusively breastfed') 2 – Freshly expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 3 – Antenatally expressed breast milk from the mother's breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 4 – Breastfeeding at someone else's breast ('exclusively breastfed') 5 – Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 6 – Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube ('artificially fed') 7 – Parenteral nutrition		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

17.29 Breastfeeding – start date/time

Definition	The date and time that breastfeeding was initiated after the birth		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory on any response other than '6 – Infant formula …' or '7 – Parenteral nutrition' to section 17.28 Infant feeding method		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

17.30 Initial breastfeed – end date/time

Definition	The date and time the initial breastfeed ended after the birth		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Mandatory on a valid response to section 17.29 Breastfeeding – start date/time		
Guide for use			
Verification rules	This field must be a valid date and time that is: • less than or equal to the current date and time, and • greater than the date and time recorded in section 17.29 Breastfeeding – start date/time		

17.31 Consultations or referrals

Definition	Did the baby(ies) require a consultation with, or referral to, a specialist in the immediate post birth period		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

17.32 Reason for referral to specialist

Definition	The reason for a consultation with or referral to a specialist in the immediate post birth period		
Source Standards	https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines: (Table 2 Conditions and referral categories)		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			
Obligation	Mandatory on a response of '1 – Yes' for section 17.31 Consultations or referrals		
Guide for use	The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes Up to ten instances for this field may be recorded		
Verification rules	Valid code only		

17.33 Admission to neonatal intensive care (NICU) or special care baby unit (SCBU)

Definition	Did the baby require admission to a NICU or SCBU following birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Yes, but kept on the ward		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

18 Postnatal baby

Postnatal information about the baby(ies) resulting from the birth. This summarises information about each baby over the six weeks following the birth. There is one set of coded entries per baby born.

Data element		Data element	
18.1	Maternity facility discharge date/time	18.11	Infant feeding – 48 hours
18.2	Infant feeding on discharge from facility	18.12	Infant feeding – 2 weeks
18.3	Baby sleep information	18.13	Infant feeding at discharge from LMC
18.4	Baby sleep environment	18.14	Neonatal referrals
18.5	Red eye reflex screening – right eye	18.15	Neonatal referral code
18.6	Red eye reflex screening – left eye	18.16	Neonatal admission
18.7	Metabolic screening	18.17	Well Child provider referral
18.8	Right ear hearing	18.18	Well Child provider
18.9	Left ear hearing	18.19	General practice referral
18.10	Infant feeding	18.20	Neonatal death

18.1 Maternity facility discharge date/time

Definition	The date and time the baby was discharged from a maternity facility, if admitted to a facility		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Conditional on the baby's admission to a maternity facility		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

18.2 Infant feeding on discharge from facility

Definition	Infant feeding method on discharge from maternity facility		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed at the mother's breast ('exclusively breastfed') 2 – Freshly expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 3 – Antenatally expressed breast milk from the mother's breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 4 – Breastfeeding at someone else's breast ('exclusively breastfed') 5 – Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 6 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed') 7 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula ('partially breastfed') 8 – Infant formula, fed via bottle ('artificially fed')		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.3 Baby sleep information

Definition	Was safe sleep information provided to the parents		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid value only

18.4 Baby sleep environment

Definition	Was the baby's sleep environment assessed for safety		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

18.5 Red eye reflex screening – right eye

Definition	The result of the baby's red eye reflex screening test, right eye		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Normal	439064003
Abnormal	247079003
Screening declined	31021000119100
Not completed	394908001

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

18.6 Red eye reflex screening – left eye

Definition	The result of the baby's red eye reflex screening test, left eye		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Normal / 439063009 Abnormal / 247079003 Screening declined / 31021000119100 Not completed / 394908001		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.7 Metabolic screening

Definition	The result of the baby's newborn metabolic screening test (also known as the heel prick or Guthrie test)		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Normal / 17621005 Abnormal / 263654008 Screening declined / 31021000119100 Not completed / 394908001		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.8 Right ear hearing

Definition	The result of the baby's newborn hearing screening for the right ear.		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Normal / 17621005 Abnormal / 263654008 Screening declined / 31021000119100 Not completed / 394908001		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.9 Left ear hearing

Definition	The result of the baby's newborn hearing screening for the left ear		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Normal / 17621005 Abnormal / 263654008 Screening declined / 31021000119100 Not completed / 394908001		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.10 Infant feeding

Definition	Has the baby ever fed at the mother's breast		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules			

18.11 Infant feeding – 48 hours

Definition	The method by which the baby was being fed at 48 hours of age		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed at the mother's breast ('exclusively breastfed') 2 – Freshly expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 3 – Antenatally expressed breast milk from the mother's breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 4 – Breastfeeding at someone else's breast ('exclusively breastfed') 5 – Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 6 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed') 7 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula ('partially breastfed') 8 – Infant formula, fed via bottle ('artificially fed') Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube ('artificially fed')		

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

18.12 Infant feeding – 2 weeks

Definition	The method by which the baby was being fed at two weeks of age		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed at the mother's breast ('exclusively breastfed') 2 – Expressed breast milk from the mother's breast, fed via supplemental nursing system (SNS) tube 3 – Breastfeeding at someone else's breast ('exclusively breastfed') 4 – Donor breast milk, fed via bottle or nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 5 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed') 6 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula ('partially breastfed') 7 – Infant formula, fed via bottle ('artificially fed')		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.13 Infant feeding at discharge from LMC

Definition	The method by which the baby was being fed at the time of discharge from LMC		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Exclusively breastfed at the mother's breast ('exclusively breastfed') 2 – Expressed breast milk from the mother's breast, fed via supplemental nursing system (SNS) tube ('exclusively breastfed') 3 – Breastfeeding at someone else's breast ('exclusively breastfed') 4 – Donor breast milk, fed via bottle or nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube ('exclusively breastfed') 5 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed') 6 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula ('partially breastfed') 7 – Infant formula, fed via bottle ('artificially fed')		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.14 Neonatal referrals

Definition	Has the baby been referred to specialist services during the six weeks following the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

18.15 Neonatal referral code

Definition	To capture the referral unique code		
Source Standards	https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelinese: Table 2 Conditions and referral categories)		
Data type	Number	**Representational class**	Code
Field size	Max: 4	**Representational layout**	N(4)
Data domain			
Obligation	Mandatory on a '1 – Yes' response to section 18.14 Neonatal referrals		
Guide for use	The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes See table 2 from the above source		
Verification rules	Valid code only		

18.16 Neonatal admission

Definition	To record if the baby was admitted to a facility at any time in the six weeks following the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

18.17 Well Child provider referral

Definition	Was the baby referred to a Well Child provider		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Yes 2 – No 3 – Declined		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.18 Well Child provider

Definition	The Well Child provider the baby was referred to		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – General practice 2 – Māori provider 3 – Pasifika provider 4 – Plunket		
Obligation	Mandatory on a response of '1 – Yes' for section 18.17 Well Child provider referral		
Guide for use			
Verification rules	Valid code only		

18.19 General practice referral

Definition	Was the baby referred to general practice		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – Yes 2 – No 3 – Declined		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

18.20 Neonatal death

Definition	Did the baby die during the 28 days after the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

19 Postnatal woman

Postnatal summary of information about the woman, over the six weeks following the birth.

Data element		Data element	
19.1	Maternity facility discharge date and time	19.9	Current smoker
19.2	Postnatal complications	19.10	Current drug use
19.3	Postnatal referrals	19.11	Drugs used
19.4	Postnatal admissions	19.12	Drugs used – 'Other' – detail
19.5	Postnatal prescriptions	19.13	Postnatal visits
19.6	Postnatal complementary therapies	19.14	General practice notification
19.7	Family violence screening	19.15	Maternal death
19.8	Current alcohol consumption		

19.1 Maternity facility discharge date and time

Definition	The date and time the woman was discharged from a maternity facility, if she was admitted to a facility during the labour and birth or in the immediate postpartum period		
Source Standards			
Data type	Date	**Representational class**	Full date and time
Field size	Max: 14	**Representational layout**	CCYYMMDD HH:MM
Data domain	Valid date and time		
Obligation	Conditional on the admission of the woman to a maternity facility		
Guide for use			
Verification rules	This field must be a valid date and time that is less than or equal to the current date and time		

19.2 Postnatal complications

<table>
<tr><td>Definition</td><td colspan="3">Complications the woman may have experienced during the six weeks after the birth</td></tr>
<tr><td>Source Standards</td><td colspan="3">SNOMED International</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>Max: 18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Data domain</td><td colspan="3">
<table>
<tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr>
<tr><td>None</td><td>TBA</td></tr>
<tr><td>Breastfeeding issues</td><td>289084000</td></tr>
<tr><td>Breast infection</td><td>198108005</td></tr>
<tr><td>Wound infection</td><td>76844004</td></tr>
<tr><td>Uterine infection</td><td>301775005</td></tr>
<tr><td>Urinary tract infection</td><td>68566005</td></tr>
<tr><td>Other infection</td><td>40733004</td></tr>
<tr><td>Postnatal depression</td><td>58703003</td></tr>
<tr><td>Postnatal distress</td><td>300894000</td></tr>
<tr><td>Postpartum psychosis</td><td>18260003</td></tr>
<tr><td>Secondary postpartum haemorrhage</td><td>23171006</td></tr>
<tr><td>Other</td><td>198609003</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Up to nine instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

19.3 Postnatal referrals

Definition	Has there been a referral to specialist services for the woman during the six weeks after the birth		
Source Standards	https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines (see: Table 2 Conditions and referral categories)		
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use	The above source reference provides access to a separate code list of specialist services. This is as a guide to aid the Yes/No response required for this data element This list is in the process of being updated to provide SNOMED codes		
Verification rules	Valid value only		

19.4 Postnatal admissions

Definition	Were there any postnatal admissions for the woman to a facility in the six weeks after the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

19.5 Postnatal prescriptions

Definition	The number of prescriptions supplied to the woman by the LMC in the six weeks after the birth		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 2	**Representational layout**	NN
Data domain	00-99		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

19.6 Postnatal complementary therapies

Definition	The complementary therapies used by the woman in the six weeks after the birth		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Acupressure	231107005
Acupuncture	231081007
Chiropractic	182548004
Herbal medicine	414392008
Homeopathy	182968001
Massage	387854002
Lactation support	408883002
Naturopathy	439809005
No complementary therapies	TBA
Rongoā Māori	TBA
Osteopathy	182549007
Other	243120004

Obligation	Mandatory
Guide for use	Up to ten instances of this field may be recorded
Verification rules	Valid code only

19.7 Family violence screening

Definition	A record of whether the woman has been screened postnatally for family violence		
Source Standards			
Data type	Numeric	**Representational class**	Code
Field size	Max: 1	**Representational layout**	N
Data domain	1 – No 2 – Yes 3 – Declined to answer		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

19.8 Current alcohol consumption

Definition	Does the woman currently drink alcohol		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Does not drink alcohol / 105542008 Current drinker / 219006 Declined to answer / 426544006		
Obligation	Mandatory		
Guide for use	The information is distinct from that recorded in section 12.11 Current alcohol consumption, in that this section 19.8 Current alcohol consumption, records a value at the end of the postnatal period		

Verification rules	Valid value only

19.9Current smoker

Definition	Does the woman currently smoke tobacco or vaping substance		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain			

SNOMED Concept	SNOMED CT Code
Current smoker	77176002
Current non-smoker	160618006
Vaper with nicotine electronic cigarette user	TBA
Vaper non-nicotine electronic cigarette user	TBA

Obligation	Mandatory
Guide for use	The information is distinct from that recorded in section 12.14 Current smoker, in that this section 19.9 Current smoker, records a value at the end of the postnatal period
Verification rules	Valid value only

19.10 Current drug use

Definition	Whether the woman currently uses drugs		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)
Data domain	**SNOMED Concept** / **SNOMED CT Code** Does not misuse drugs / 228367002 Current drug user / 417284009 Declined to answer / 426544006		
Obligation	Mandatory		
Guide for use	The information is distinct from that recorded in section 8.8 History of drug use. That is, this section (19.10 Current drug use), records a value at the end of the pregnancy		
Verification rules	Valid value only		

19.11 Drugs used

Definition	A record of the drug(s) the woman is currently using		
Source Standards	SNOMED International		
Data type	Numeric	**Representational class**	Code
Field size	Max: 18	**Representational layout**	N(18)

Data domain	<table><tr><th>SNOMED Concept</th><th>SNOMED CT Code</th></tr><tr><td>Amphetamines</td><td>703842006</td></tr><tr><td>Aromatic solvent</td><td>117499009</td></tr><tr><td>Benzodiazepine sedative</td><td>372616003</td></tr><tr><td>Cannabis</td><td>398705004</td></tr><tr><td>Cocaine</td><td>387085005</td></tr><tr><td>Codeine phosphate</td><td>261000</td></tr><tr><td>Crack cocaine</td><td>229003004</td></tr><tr><td>Drug or medicament</td><td>410942007</td></tr><tr><td>Gas (nitrous oxide)</td><td>111132001</td></tr><tr><td>Hallucinogenic agent</td><td>373469002</td></tr><tr><td>Heroin</td><td>387341002</td></tr><tr><td>Methadone</td><td>387286002</td></tr><tr><td>Methamphetamine</td><td>387499002</td></tr><tr><td>Morphine</td><td>373529000</td></tr><tr><td>Other</td><td>TBA</td></tr></table>
Obligation	Conditional on a response of 'Current drug user' to section 19.10 Current drug use
Guide for use	
Verification rules	Valid value only

19.12 Drugs used – 'Other' – detail

Definition	The detail of the 'Other' drugs currently in use		
Source Standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	Max: 1000	**Representational layout**	X(1000)
Data domain			
Obligation	Mandatory on a response of 'Other' for section 19.11 Drugs used		
Guide for use	One response should be recorded for each 'Other' instance identified in section 19.11 Drugs used		
Verification rules			

19.13 Postnatal visits

Definition	The number of postnatal visits received by the woman from the LMC in the six weeks after the birth		
Source Standards			
Data type	Numeric	**Representational class**	Value
Field size	Max: 2	**Representational layout**	NN
Data domain	00-99		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

19.14 General practice notification

Definition	Was notification forwarded to the woman's general practice		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			

Verification rules	Valid code only

19.15 Maternal death

Definition	Did the woman die during the pregnancy or during the six weeks after the birth		
Source Standards			
Data type	Boolean	**Representational class**	N/A
Field size	Max: 1	**Representational layout**	N(1,0)
Data domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use	A maternal death is the death of a woman while pregnant or within 42 days of birth, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management It does not include accidental or incidental causes of death of a pregnant woman		
Verification rules	Valid value only		