**Maternity Care Summary Standard**

HISO 10050:2022

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# Introduction

## Purpose

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

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

## Scope

The standard defines the minimum data set to be recorded by maternity service providers in New Zealand. Such providers include midwives (community-based and hospital-employed), general practitioners, obstetricians, other medical specialists and appropriate administrative or support staff.

A maternity care summary identifies an individual pregnant woman and includes administrative and clinical information about her pregnancy, labour and birth, baby or babies and the postnatal period.

The standard covers the time period from first contact with a health professional in regard to the current pregnancy up until around six weeks after the birth of the baby or babies.

This standard provides the data set specification for maternity care. It does not specify how information sharing is to occur. The Ministry will specify this in a separate implementation guide that will define the required data structures and exchange protocols using the HL7® FHIR® standard.

HISO 10050:2022 Maternity Care Summary Standard supersedes HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which is now withdrawn. The present standard was previously numbered HISO 10050.2.

## 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 2020
* Health Practitioners Competence Assurance Act 2003
* New Zealand Public Health and Disability Act 2000
* Privacy Act 2020
* Public Records Act 2005
* Retention of Health Information Regulations 1996.

## Related specifications

The Ministry used or referenced the following documents to develop this standard:

* [HISO 10046:2022 Consumer Health Identity Standard](https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard)
* [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)

The above two HPI standards, published in 2008, are due for replacement; while they can provide guidance on the particular HPI data elements referred to in this standard, they are not suitable for any other purpose.

* [HISO 10033 SNOMED CT](https://www.health.govt.nz/publication/hiso-10033-snomed-ct)

SNOMED CT is the standard clinical terminology for use in New Zealand. Accordingly, this standard uses SNOMED CT in various data elements. The [SNOMED NZ Edition](https://www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps) includes all content from the SNOMED International Edition alongside New Zealand-specific content in the SNOMED NZ Extension. See the Ministry of Health website for relevant information regarding SNOMED releases and terminology services.

Where a data element in this standard uses SNOMED CT, the implementing application is to display the agreed SNOMED preferred term to the user and record the correct SNOMED concept identifier. Active SNOMED CT concepts must be selected when determining values for data elements.

## Acknowledgement of gender

Not all people who become pregnant identify with the female gender. This document uses terms specific to female identity for ease of understanding, while acknowledging that this is a cis and heteronormative approach. The Ministry does not intend to exclude people of diverse gender identity, gender expression or sex characteristics where this document uses the words ‘wahine’, ‘woman’, ‘she’ or ‘her’. Pregnant people should advise the health professionals involved in their care of their preferred pronouns so that these are used correctly and documented in their records. Health professionals should make every effort to use people’s preferred pronouns.

## Data element template

Data element specifications in this standard conform to the requirements of ISO/IEC 11179 Information Technology – Metadata Registries (MDR).[[1]](#footnote-2) The following table sets out terms that appear in these standards.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Data element name | | |
| **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  SNOMED CT identifier (SCTID) | **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:   * X(50) for a 50-character alphanumeric string * NNN for a 3-digit number * NNAAAA for a formatted alphanumeric identifier |
| **Value domain** | The valid values or codes that are acceptable for the data element  Each coded data element has a specified code set  Code sets use the SNOMED CT clinical terminology standard where possible. Enumerated SNOMED concepts are denoted by preferred term and linked to descriptions in the [SNOMED International browser](http://browser.ihtsdotools.org/). Where there are many member concepts, a reference set is published in the [SNOMED NZ Edition](https://www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps), available from the [SNOMED Member Licensing and Distribution Service](https://mlds.ihtsdotools.org/#/landing/NZ?lang=en).  New Zealand Medicines Terminology (NZMT) is the standard used to identify medicines | | |
| **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 | | |
| **Verification rules** | Quality control mechanisms that preclude invalid values | | |

#### Date and time value domain

As the date/time value domain is used many times in this document, its specification is stated once here.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Date/time | | |
| **Definition** | The date and time for the associated data element | | |
| **Source standards** | ISO 8601-1:2019 *Date and time. Representations for information interchange – Part 1: Basic rules* | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | 14 | **Representational layout** | YYYYMMDD:[HH:MM] |
| **Value domain** | Valid date and/or time where full date and/or time is specified | | |

# Maternity care summary data set specification

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 the woman’s medicines.

|  |  |  |  |
| --- | --- | --- | --- |
| **Section** | | **Section** | |
| 2.1 | Personal information | 2.11 | Family health |
| 2.2 | Health care provider information | 2.12 | Tuberculosis risk assessment |
| 2.3 | Medicines information | 2.13 | Current pregnancy |
| 2.4 | Booking test information | 2.14 | Labour and birth |
| 2.5 | Previous pregnancies | 2.15 | Caesarean section |
| 2.6 | Previous babies | 2.16 | Post-birth |
| 2.7 | Woman’s comprehensive health history | 2.17 | Newborn baby |
| 2.8 | Allergies and adverse reactions | 2.18 | Postnatal baby |
| 2.9 | Alcohol and other drugs | 2.19 | Postnatal woman |
| 2.10 | Smoking and vaping status |  |  |

## Personal information

Personal information related to the woman should only be obtained from the National Health Index (NHI) system. 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.

Information from the NHI is available to registered health care providers; it includes demographic and other generic information. The format and content of available fields is documented in [HISO 10046:2022 Consumer Health Identity Standard](https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard).

The following data elements relate to the woman (and, for some data elements, the baby) and are appropriate for use in the maternity situation.

|  |
| --- |
| **Required data element** |
| NHI number |
| Name |
| Date and place of birth |
| Ethnicity |
| Address information |
| Language |
| Contact information |

## Health care provider information

This section specifies the health care provider information that is related to the woman’s particular maternity event. The information should only be obtained from the 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 data elements 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 General Practitioner (GP). This information must be recorded as part of each maternity event.

| **Required data element** |
| --- |
| **Provider person:** |
| Common Person Number (CPN) |
| Address |
| Language |
| Contact |
| Qualifications |
| Registration and related information |
| **Provider organisation:** |
| Identification Number |
| Name |
| Address |
| Contact |
| **Provider facility:** |
| Identification Number |
| Name |
| Address |
| Contact |

## Medicines information

This section covers medicine information directly related to the woman and baby.

Specific medication information about a woman and baby or babies must be sourced from existing records held in the New Zealand ePrescription Service (NZePS).

Prescribing must:

* integrate with the NZePS [New Zealand ePrescription service](https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-eprescription-service)
* use the NZePS application programming interface (API)

available on request to the Ministry of Health’s Online Helpdesk: email onlinehelpdesk@health.govt.nz

* use the [New Zealand Universal List of Medicines (NZULM) and New Zealand Formulary (NZF)](file:///C:\Users\tchristi\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\QNWQN935\HISO%2010024.1:2018%20New%20Zealand%20Universal%20List%20of%20Medicines%20and%20New%20Zealand%20Formulary)
* conform to [HISO 10030.1:2008 Electronic Pharmaceutical Business Process Standard](https://www.health.govt.nz/publication/hiso-1003012008-electronic-pharmaceutical-business-process-standard)
* conform to [HISO 10042 Medication Charting and Medicine Reconciliation Standards](https://www.health.govt.nz/publication/hiso-10042-medication-charting-and-medicine-reconciliation-standards)
* conform to New Zealand prescribing guidelines in the Medicines Regulations 1984

## Booking test information

This section covers core data elements pertaining to the woman’s current pregnancy, including the estimated due date (EDD).

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.4.1 | Pregnancy intention | 2.4.10 | Agreed estimated due date |
| 2.4.2 | Assisted reproduction | 2.4.11 | Height |
| 2.4.3 | Method of assisted reproduction | 2.4.12 | Weight |
| 2.4.4 | Method of assisted reproduction – ‘Other’ – detail | 2.4.13 | Eligibility |
| 2.4.5 | Gravida | 2.4.14 | Lead Maternity Carer type |
| 2.4.6 | Parity | 2.4.15 | Planned place of birth |
| 2.4.7 | Last menstrual period | 2.4.16 | Planned place of birth – ‘Other’ – detail |
| 2.4.8 | Estimated due date by dates | 2.4.17 | Planned place of birth – facility |
| 2.4.9 | Estimated due date by ultrasound scan |  |  |

### Pregnancy intention

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Pregnancy planning | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Ambivalent | 169569009 | | Planned pregnancy | 169565003 | | Unplanned pregnancy | 83074005 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Assisted reproduction

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Conception via assisted reproduction | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Method of assisted reproduction

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method of assisted reproduction | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Hormonal stimulation | 71841000210107 | | Intrauterine insemination (IUI) | 71851000210105 | | In vitro fertilisation (IVF) | 10231000132102 | | Other | 71861000210108 | |  |  | | | |
| **Obligation** | Mandatory on a ‘1 – Yes’ response to section **2.4.2 Assisted reproduction** | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Method of assisted reproduction – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Other method of assisted reproduction | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.4.3 Method of assisted reproduction** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Gravida

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Total number of times the woman has been pregnant | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | 01–99 | | |
| **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 | | |
| **Verification rules** | Valid value only | | |

### Parity

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of previous pregnancies where the outcome was a birth with a gestation greater than or equal to 20 weeks and 0 days | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | 00–99 | | |
| **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** | A value less than or equal to the value reported in section **2.4.5 Gravida** is required | | |

### Last menstrual period

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | First day of the last menstrual period (LMP) | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | YYYYMMDD |
| **Value domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** | This is reliant on the woman recalling the date, and may not be accurate | | |
| **Verification rules** | A valid date that is less than or equal to the current date | | |

### Estimated due date by dates

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date as calculated from the first day of the LMP (EDD by LMP) | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | YYYYMMDD |
| **Value domain** | Valid date | | |
| **Obligation** | Mandatory on a valid response to section **2.4.7 Last menstrual period** | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid future date | | |

### Estimated due date by ultrasound scan

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date based on ultrasound scan (USS) calculations (EDD by USS) | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | YYYYMMDD |
| **Value domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date that is greater than the current date | | |

### Agreed estimated due date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date as agreed by the woman and the LMC considering all pertinent information | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | 8 | **Representational layout** | YYYYMMDD |
| **Value domain** | Valid date | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | A valid date greater than or equal to the current date | | |

### Height

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Measured height of the woman | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | N.NN |
| **Value domain** | Metres | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record height to two decimal places | | |
| **Verification rules** | A value greater than zero | | |

### Weight

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Pre-pregnancy weight of the woman | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 5 | **Representational layout** | NNN.N |
| **Value domain** | Kilograms | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | If this is not available, capture the earliest recorded weight of the woman during this pregnancy  Record weight to one decimal place | | |
| **Verification rules** | A value greater than zero | | |

### Eligibility

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Eligibility 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** | 1 | **Representational layout** | A |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Eligible | Y | | Not eligible | N | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The Ministry of Health’s website provides information about publicly funded health services including maternity: see <https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services> | | |
| **Verification rules** | Valid code only | | |

### Lead Maternity Carer type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Registration type of the LMC with the Medical Council or the Midwifery Council | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Registrant with the Medical Council of New Zealand | 1 | | Registrant with the Midwifery Council of New Zealand | 2 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Planned place of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Place or facility where the woman plans to give birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Home | 310586008 | | Primary birthing facility | 91731000210104 | | Secondary birthing facility | 91741000210107 | | Tertiary birthing facility | 91751000210105 | | Other | 310585007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Planned place of birth – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ planned place of birth | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.4.15 Planned place of birth** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Planned place of birth – facility

This element provides the planned place of birth facility detail. The information to be recorded is the Provider facility identification number as specified in section **2.2 Health care** provider information.

The data element is mandatory upon any response other than ‘Home’ or ‘Other’ to section **2.4.15 Planned place of birth**.

## Previous pregnancies

This section covers information about the woman’s obstetric history; that is, her previous pregnancies and births. Information is collected at the first full contact the woman has with a maternity service provider. This is likely to be at the booking visit or first contact with acute maternity services during this pregnancy, if this occurs prior to registering with an LMC.

This section contains the data elements related to 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** | |
| 2.5.1 | Previous miscarriage | 2.5.12 | Length of previous labour(s) |
| 2.5.2 | Previous miscarriage – date | 2.5.13 | Maternal complications in previous labours |
| 2.5.3 | Previous termination | 2.5.14 | Maternal complications in previous labours – ‘Other’ – detail |
| 2.5.4 | Previous termination – date | 2.5.15 | Mode of birth |
| 2.5.5 | Termination reason | 2.5.16 | Type of Caesarean section |
| 2.5.6 | Termination reason – ‘Other reason’ – detail | 2.5.17 | Indications for planned Caesarean section |
| 2.5.7 | Maternal antenatal complications in previous pregnancy | 2.5.18 | Indications for planned Caesarean section – ‘Other malpresentation’ – detail |
| 2.5.8 | Maternal complication – ‘Other complication’ – detail | 2.5.19 | Indications for unplanned Caesarean section |
| 2.5.9 | Onset of labour in previous pregnancy | 2.5.20 | Previous labour analgesia |
| 2.5.10 | Induction reason | 2.5.21 | Previous labour anaesthesia |
| 2.5.11 | Induction reason – ‘Other clinical reason’ – detail | 2.5.22 | Maternal complications immediately postpartum |

### Previous miscarriage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Miscarriages the woman has had (if known) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous outcomes reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72511000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72511000210104).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Ectopic pregnancy | 161763005 | | First trimester miscarriage | 91621000210106 | | Molar pregnancy | 16216821000119102 | | Second trimester miscarriage | 71561000210105 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | One code may be recorded for each previous miscarriage | | |
| **Verification rules** | Valid code only | | |

### Previous miscarriage – date

This element defines the date that the previous miscarriage occurred. The format is set out in the common **Date and time value domain** specification.

The data element is optional upon a response to section **2.5.1 Previous miscarriage**. The element is to be recorded for each event.

### Previous termination

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of termination the woman has had (if known) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | [Medical termination of pregnancy](https://browser.ihtsdotools.org/?perspective=full&conceptId1=285409006&edition=MAIN/2021-07-31&release=&languages=en) | 285409006 | | Surgical termination of pregnancy | 302375005 | |  |  | | | |
| **Obligation** | Mandatory on a termination having occurred | | |
| **Guide for use** | A code is to be recorded for each termination | | |
| **Verification rules** | Valid code only | | |

### Previous termination – date

This element defines the date that the previous termination occurred. The format is set out in the common **Date and time value domain** specification.

The data element is optional upon a response to section **2.5.3 Previous termination**. The element is to be recorded for each event.

### Termination reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason(s) a previous pregnancy was terminated | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Congenital anomaly of fetus | 72161000210106 | | Chromosomal anomaly  (SNOMED CT term: ‘History of fetus with chromosomal abnormality’) | 71871000210102 | | Unplanned pregnancy | 71881000210100 | | Otherreason | 417662000 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory on a response to section **2.5.3 Previous termination** | | |
| **Guide for use** | One response should be recorded for each instance identified in section **2.5.3 Previous termination** | | |
| **Verification rules** | Valid code only | | |

### Termination reason – ‘Other reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other reason’ for termination | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other reason’ for section **2.5.5 Termination reason** | | |
| **Guide for use** | One response is to be recorded for each identified ‘Other reason’ | | |
| **Verification rules** |  | | |

### Maternal antenatal complications in previous pregnancy

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced during any previous pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No previous complications | 443508001 | | Antenatal depression and/or anxiety | 71891000210103 | | Antepartum haemorrhage | 161804005 | | Eclampsia | 161806007 | | Gestational diabetes | 472971004 | | Epilepsy | 161480008 | | Hyperemesis | 71901000210102 | | Infection | 161413004 | | Obstetric cholestasis | 16216781000119107 | | Placental abruption | 789776003 | | Pre–eclampsia | 105651000119100 | | Preterm labour | 441493008 | | Preterm birth | 161765003 | | Small for gestational age fetus (SGA) | 726565008 | | Other complication occurring during pregnancy | 91461000210102 | |  |  | | | |
| **Obligation** | Mandatory on a previous pregnancy having occurred | | |
| **Guide for use** | ‘Other complication occurring during pregnancy’ is only to be selected when none of the preceding options in this category are clearly correct  A minimum of one code is to be selected for each previous pregnancy | | |
| **Verification rules** | Valid code only | | |

### Maternal complication – ‘Other complication’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other complication’ that occurred during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other complication occurring during pregnancy’ for section **2.5.7 Maternal antenatal complications in previous pregnancy** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Onset of labour in previous pregnancy

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How labour began for the previous pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72531000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72531000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Induction of labour | 725954003 | | Planned Caesarean section before labour | 725949007 | | Spontaneous labour | 726597008 | |  |  | | | |
| **Obligation** | Mandatory on a response greater than zero for section **2.4.6 Parity** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Induction reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason for the previous induction of labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72531000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72531000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Pre-labour rupture of membranes without spontaneous labour | 108951000119100 | | Prolonged pregnancy | 71911000210100 | | Other clinical reason | 417662000 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Induction of labour’ for section **2.5.9 Onset of labour in previous pregnancy** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Induction reason – ‘Other clinical reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other clinical reason’ for induction | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other clinical reason’ for section **2.5.10 Induction reason** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Length of previous labour(s)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Length of previous labour(s) | | |
| **Source standards** |  | | |
| **Data type** | Time | **Representational class** | Value |
| **Field size** | 5 | **Representational layout** | HH:MM |
| **Value domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory on a response of ‘Induction of labour’ or ‘Spontaneous labour ‘to section **2.5.9 Onset of labour in previous pregnancy** | | |
| **Guide for use** | This is a value provided by the woman | | |
| **Verification rules** | Valid value only | | |

### Maternal complications in previous labours

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced in previous labours | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No previous complications | 443508001 | | Third-degree perineal tear | 725941005 | | Fourth-degree perineal tear | 725942003 | | Hypertension | 161501007 | | Infection | 71921000210105 | | Intrapartum haemorrhage | 71931000210107 | | Obstructed labour | 71941000210104 | | Prolonged first stage of labour | 71951000210101 | | Prolonged ruptured membranes | 71971000210109 | | Prolonged second stage of labour | 71961000210103 | | Other labour finding | 1156096005 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | A minimum of one code is to be selected and recorded for each previous birth | | |
| **Verification rules** | Valid code only | | |

### Maternal complications in previous labours – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other labour finding’ reason for maternal complications in previous labours | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.5.13 Maternal complications in previous labours** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the previous baby or babies was or were born | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72521000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72521000210109).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Caesarean section | 161805006 | | Forceps | 161813007 | | Spontaneous vaginal birth | 275568006 | | Vacuum extraction | 726624001 | |  |  | | | |
| **Obligation** | Mandatory on a response greater than zero to section **2.4.6 Parity** | | |
| **Guide for use** | A minimum of one code is to be selected and recorded for each previous birth. This is to be reported in terms of spontaneity or assistance required | | |
| **Verification rules** | Valid code only | | |

### Type of Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of Caesarean section incision the woman had in any previous pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Classical Caesarean section | 71581000210102 | | Lower uterine segment Caesarean section (LUSCS) | 71591000210100 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Caesarean section’ to section **2.5.15 Mode of birth** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Indications for planned Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Clinical indication for performing a planned Caesarean section as an elective procedure when the woman was not in labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Breech presentation | 72031000210101 | | Congenital anomaly | 161572004 | | Chromosomal anomaly | 71871000210102 | | Medical or obstetric complication  (SNOMED CT term: ‘History of complication in pregnancy’) | 91461000210102 | | Maternal request | 720266003 | | Previous third-degree perineal tear | 725941005 | | Previous fourth-degree perineal tear | 725942003 | | Previous caesarean section | 161805006 | | Transverse lie | 72041000210109 | | Unstable lie | 72051000210107 | | Other malpresentation | 72001000210106 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Caesarean section’ to section **2.5.15 Mode of birth** | | |
| **Guide for use** | A minimum of one code is to be selected and recorded for each previous birth  This table incorporates a mix of SNOMED CT concepts from the Disorder and Situation hierarchies | | |
| **Verification rules** | Valid code only | | |

### Indications for planned Caesarean section – ‘Other malpresentation’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other malpresentation’ as an indication for planned Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other malpresentation’ for section **2.5.17 Indications for planned Caesarean section** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Indications for unplanned Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Clinical indication for performing an unplanned Caesarean section during labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Antepartum haemorrhage | 161804005 | | Failed induction of labour | 72061000210105 | | Failed instrumental/assisted delivery | 772006002 | | Fetal distress | 72071000210104 | | Fetal malposition | 72081000210102 | | Fetal malpresentation | 72001000210106 | | Intrapartum haemorrhage | 71931000210107 | | Obstructed labour | 71941000210104 | | Seizures | 72091000210100 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Caesarean section’ to section **2.5.15 Mode of birth** | | |
| **Guide for use** | Eight instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Previous labour analgesia

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of analgesia the woman may have had during previous labours | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No previous analgesia | 101571000210101 | | Non-pharmacological | 111491000210101 | | Pharmacological – non-opiate | 101591000210102 | | Pharmacological – opiate | 12275951000119104 | |  |  | | | |
| **Obligation** | Mandatory on a response greater than zero to section **2.4.6 Parity** | | |
| **Guide for use** | A minimum of one code is to be selected and recorded for each previous birth | | |
| **Verification rules** | Valid code only | | |

### Previous labour anaesthesia

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of anaesthesia the woman may have had during previous labours | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Combined spinal/epidural | 71601000210105 | | Epidural | 71611000210107 | | General anaesthetic | 71621000210102 | | Local anaesthetic | 71631000210100 | | Pudendal block | 71651000210106 | | Spinal | 71641000210108 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | One code may be selected and recorded for each previous birth | | |
| **Verification rules** | Valid code only | | |

### Maternal complications immediately postpartum

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced in the first two to four hours following previous births | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No previous complications | 72181000210103 | | Perineal haematoma | 72111000210109 | | Postpartum haemorrhage (greater than 1000 mls or treated) | 161809000 | | Retained placenta | 725948004 | | Other | 1156097001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## 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. This information should be collected at the first full contact the woman has with a maternity service provider. This is likely to be the booking visit or first contact with acute maternity services during this pregnancy if this occurs prior to registering with an LMC.

The section contains the data elements relevant 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** | |
| 2.6.1 | Outcome of previous baby or babies | 2.6.11 | Stillbirth cause |
| 2.6.2 | Outcome of previous baby or babies – date | 2.6.12 | Gestation at fetal demise |
| 2.6.3 | Antenatal fetal complications | 2.6.13 | Neonatal complications |
| 2.6.4 | Antenatal fetal complications – ‘Other’ – detail | 2.6.14 | Neonatal complications – ‘Other’ – detail |
| 2.6.5 | Intrapartum fetal complications | 2.6.15 | Neonatal care admissions |
| 2.6.6 | Intrapartum fetal complications – ‘Other’ – detail | 2.6.16 | Reason for admission to neonatal care |
| 2.6.7 | Mode of birth | 2.6.17 | Feeding history |
| 2.6.8 | Gestation of previous baby or babies | 2.6.18 | Duration of breastfeeding |
| 2.6.9 | Sex of previous baby or babies | 2.6.19 | Cause of death |
| 2.6.10 | Birth weight of previous baby or babies | 2.6.20 | Date of death – date |

### Outcome of previous baby or babies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Outcome for each baby in previous pregnancies | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous outcomes reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72511000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72511000210104).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Infant death | 739682007 | | Live born | 726001007 | | Neonatal death | 726626004 | | Stillborn | 161743003 | |  |  | | | |
| **Obligation** | Mandatory where a previous birth has occurred | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Outcome of previous baby or babies – date

This element defines the date of birth of previous baby or babies. The format is set out inthe common **Date and time value domain** specification.

The data element is optional upon a response to section **2.6.1 Outcome of previous baby or babies.** It is to be recorded for each baby.

### Antenatal fetal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications related to the fetus during the previous pregnancy or pregnancies | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 443508001 | | Chromosomal anomaly | 71871000210102 | | Congenital anomaly | 161572004 | | Fetal growth abnormality | 72121000210104 | | Fetal heart rate abnormality | 72131000210102 | | Oligohydramnios | 72141000210105 | | Polyhydramnios | 72151000210108 | | Other | 72171000210100 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal fetal complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ reason for antenatal fetal complications | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.6.3 Antenatal fetal complications** | | |
| **Guide for use** | One response is to be recorded for each identified ‘Other’ instance | | |
| **Verification rules** |  | | |

### Intrapartum fetal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications related to the fetus during previous labour(s) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 443508001 | | Fetal blood sample abnormality | 72701000210108 | | Fetal heart rate abnormality | 72131000210102 | | Meconium-stained liquor | 72191000210101 | | Other | 1156096005 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Intrapartum fetal complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ reason for intrapartum fetal complications | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.6.5 Intrapartum fetal complications** | | |
| **Guide for use** | One response is to be recorded for each identified ‘Other’ instance | | |
| **Verification rules** |  | | |

### Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the previous baby or babies was or were born | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72521000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72521000210109).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Caesarean section | 161805006 | | Forceps | 161813007 | | Spontaneous vaginal birth | 275568006 | | Vacuum extraction | 726624001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 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 | | |

### Gestation of previous baby or babies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Gestation of the previous baby or babies, in weeks and days | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NN.N |
| **Value domain** | Weeks and days | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 20 instances of this field may be recorded | | |
| **Verification rules** | Valid value only | | |

### Sex of previous baby or babies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Sex of previous baby or babies 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** | 1 | **Representational layout** | A |
| **Value domain** | M – Male  F – Female  I – Indeterminate | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 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 – see section **2.17.15 Baby National Health Index number**  Currently, the NHI does not record a value for sex. However, it does populate a gender field with a sex value. The Ministry is planning a change to rectify this situation  20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Birth weight of previous baby or babies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Birth weight of previous baby or babies | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NNNN |
| **Value domain** | Grams | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 20 instances of this field may be recorded | | |
| **Verification rules** | Integer greater than zero | | |

### Stillbirth cause

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Causes or factors that contributed to or led to the stillbirth of a previous baby or babies | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Stillborn’ for section **2.6.1 Outcome of previous baby or babies** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Gestation at fetal demise

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Gestation of previous baby or babies at demise, in weeks and days | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NN.N |
| **Value domain** | Weeks and days | | |
| **Obligation** | Mandatory on a response of Stillborn to section **2.6.1 Outcome of previous baby or babies** | | |
| **Guide for use** | This number is self-reported and may not be accurate, as the woman may not know the exact gestation  Record one instance of this field for each fetal demise | | |
| **Verification rules** | Valid value only | | |

### Neonatal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications with the previous baby or babies in the immediate postpartum period | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 72201000210104 | | Effects of maternal transmission of a substance | 72231000210109 | | Hypoglycaemia | 72221000210107 | | Large for gestational age | 72241000210101 | | Low birth weight | 37251000119108 | | Neonatal encephalopathy | 72211000210102 | | Respiratory distress syndrome (RDS) | 72251000210103 | | Small for gestational age (SGA) | 726565008 | | Transient tachypnoea | 72261000210100 | | Other | 161579008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Provided any value other than ‘None’ is selected, five instances of this field may be recorded  The values ‘Large for gestational age’ and ‘Small for gestational age’ cannot both be selected | | |
| **Verification rules** | Valid code only | | |

### Neonatal complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ reason for **Neonatal complications** | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.6.13 Neonatal complications** | | |
| **Guide for use** | A response is to be recorded for each identified ‘Other’ instance | | |
| **Verification rules** |  | | |

### Neonatal care admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Recording if previous baby or babies required admission to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No, not needed  (SNOMED CT term: ‘No history of neonatal care admission’) | 91471000210108 | | Yes, admitted to Neonatal Intensive Care Unit (NICU)  (SNOMED CT term: ‘History of admission to neonatal care unit’) | 91491000210107 | | Yes, admitted to Special Care Baby Unit (SCBU)  (SNOMED CT term: ‘History of admission to special care baby unit’) | 91501000210102 | | Yes, required specialist care but remained in the maternity unit  (SNOMED CT term: ‘History of previous baby under paediatric care while in maternity unit’) | 101671000210100 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Reason for admission to neonatal care

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason a previous baby or babies was admitted to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Asphyxia | 161581005 | | Cardiovascular disease | 72271000210106 | | Congenital anomaly | 161572004 | | Chromosomal anomaly | 71871000210102 | | Extremely preterm infant  (born before 27 weeks plus 6 days) | 72281000210108 | | Fetus or newborn affected by medicinal agents transmitted by placenta and/or breast milk | 72231000210109 | | Hypoglycaemia | 72221000210107 | | Hypothermia | 72291000210105 | | Infection | 161413004 | | Jaundice | 161536006 | | Late preterm infant (born between 32 weeks and 36 weeks plus 6 days) | 72301000210109 | | Very preterm infant (born between 28 weeks and 31 weeks plus 6 days) | 72311000210106 | | Respiratory distress syndrome (RDS) | 72251000210103 | | Seizures | 161583008 | | Weight loss | 72321000210101 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘No, not needed’ for section **2.6.15 Neonatal care admissions** | | |
| **Guide for use** | 10 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Feeding history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Feeding history of a previous baby or babies in the first six months of life | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Exclusively breastfed | 91711000210106 | | Fully breastfed | 101611000210109 | | Partially breastfed | 121491000210107 | | Artificially fed | 101611000210109 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘Stillborn’ to section **2.6.1 Outcome of previous baby or babies** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Duration of breastfeeding

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Number of months previous baby or babies was or were breastfed | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response other than ‘Stillborn’ to section **2.6.1 Outcome of previous baby or babies** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### Cause of death

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Cause of death of previous baby or babies or child(ren) | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Infant death’ or ‘Neonatal death’ for section **2.6.1 Outcome of previous baby or babies** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Date of death – date

This element defines the date of death of previous baby or babies. The format is set out in the common **Date and time value domain** specification.

The data element is optional upon a response to section **2.6.1 Outcome of previous baby or babies**. It is to be recorded for each baby.

## Woman’s comprehensive health history

This section covers information related to the woman’s health history. It records relevant current or past conditions to help recognise risk factors.

This information should be collected at the first full contact the woman has with a maternity service provider. This is likely to be at the booking visit or first contact with acute services during this pregnancy if this occurs prior to registering with an LMC.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.7.1 | Medical history | 2.7.3 | Gynaecological history |
| 2.7.2 | Surgical history | 2.7.4 | Mental health history |

### 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** | |
|  | Medical conditions |  | Medical conditions – ‘Other’ – detail |

#### Medical conditions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Medical conditions the woman has | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Autoimmune disorder | 72331000210104 | | Cardiac disorder | 266995000 | | Congenital abnormality | 161572004 | | Diabetes mellitus type 1 | 472970003 | | Diabetes mellitus type 2 | 472969004 | | Endocrine disorder | 266990005 | | Gastrointestinal disorder | 266997008 | | Haematological disorder | 266992002 | | Hypertension | 161501007 | | Infectious diseases | 161413004 | | Liver disorder | 161535005 | | Malignancy | 266987004 | | Mental health disorder | 72711000210105 | | Monogenic diabetes (MODY) | 472972006 | | Musculoskeletal disorder | 267004000 | | Neurological disorder | 32451000119107 | | Respiratory disorder | 161523006 | | Skin disorder | 161560005 | | Thrombosis and related disorder | 275546001 | | Other medical disorder | 312850006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Medical conditions – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other medical disorder’ reason for **Medical conditions** | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other medical disorder’ for **Medical conditions** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Surgical history

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
|  | Operations |  | Previous anaesthetic |
|  | Operations – date |  | Anaesthetic complications |
|  | Operations – ‘Other’ – detail |  | Anaesthetic complications detail |

#### Operations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of operations the woman has undergone | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No previous surgery  (SNOMED CT term: ‘No history of procedure’) | 416128008 | | Breast | 71661000210109 | | Cone biopsy | 108941000119102 | | Genital tract | 71671000210103 | | Large loop excision of transformation zone (LLETZ/LEEP) | 59251000119102 | | Uterine | 133581000119103 | | Other | 161615003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Operations – date

This element defines the date of each operation. The format is set out in the common **Date and time value domain** specification.

The data element is optional upon a response to the **Operations** section above. It is to be recorded for each operation

#### Operations – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ reason for **Operations** | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for **Operations** | | |
| **Guide for use** | A response should be recorded for each ‘Other’ instance identified | | |
| **Verification rules** |  | | |

#### Previous anaesthetic

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of anaesthetic previously administered to the woman, except during childbirth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | General anaesthetic | 71621000210102 | | Local anaesthetic | 71631000210100 | | Regional anaesthetic | 131501000210104 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Anaesthetic complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications when the woman was previously administered an anaesthetic | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response to **Previous anaesthetic** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

#### Anaesthetic complications detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of anaesthetic complications | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for **Anaesthetic complications** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Gynaecological history

This section covers gynaecological history information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
|  | Cervical smear status |  | Gynaecological history – diagnoses |
|  | Cervical smear results |  | Gynaecological history – procedures |
|  | Sexual health history – diagnoses |  |  |

#### Cervical smear status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | When the woman’s most recent cervical smear was taken (if known) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Within the last year  (SNOMED CT term: ‘History of cervical smear performed within last 12 months’) | 121501000210102 | | Within the last two years  (SNOMED CT term: ‘History of cervical smear performed within last two years’) | 91681000210107 | | Within the last three years  (SNOMED CT term: ‘History of cervical smear performed within last three years’) | 91691000210109 | | More than three years ago  (SNOMED CT term: ‘History of cervical smear performed for more than three years’) | 91701000210109 | | Never had a smear | 698753008 | | Unknown | 171163000 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | The default is ‘Unknown’ | | |
| **Verification rules** | Valid code only | | |

#### Cervical smear results

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Results from the woman’s most recent cervical smear | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72531000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72531000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Normal | 72341000210107 | | Abnormal (not specified) | 439956007 | | Adenocarcinoma in situ (ACIS) | 429484003 | | Cervical intraepithelial neoplasia  (CIN I) | 72361000210108 | | Cervical intraepithelial neoplasia  (CIN II) | 72371000210102 | | Cervical intraepithelial neoplasia  (CIN III) | 111501000210106 | | Invasive carcinoma | 72351000210105 | | Unknown | 281337006 | |  |  | | | |
| **Obligation** | Mandatory on a response to **Cervical smear status** of other than:   1. ‘Never had a smear’ or 2. ‘Unknown’ | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

#### Sexual health history – diagnoses

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Diagnosed sexually transmitted infections | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 704007002 | | Chlamydia | 472954000 | | Genital herpes simplex | 91531000210107 | | Genital warts | 91521000210105 | | Gonorrhoea | 72421000210108 | | Human immunodeficiency virus (HIV) | 101651000210108 | | Syphilis | 1087151000119108 | | Trichomonas vaginalis | 72441000210102 | | Other | 275881005 | | Unknown | 396782006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 16 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Gynaecological history – diagnoses

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Diagnosed gynaecological conditions | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 443508001 | | Bacterial vaginosis | 72381000210100 | | Bicornuate uterus | 72391000210103 | | Chlamydia | 472954000 | | Endometriosis | 72401000210100 | | Female genital mutilation (FGM) | 715477006 | | Fibroids | 72411000210103 | | Gonorrhoea | 72421000210108 | | Polycystic ovarian syndrome (PCOS) | 72431000210105 | | Syphilis | 1087151000119108 | | Trichomonas vaginalis | 72441000210102 | | Uterine anomalies | 72451000210104 | | Vaginismus | 72461000210101 | | Other gynaecological disorder | 271902005 | | Unknown | 396782006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 16 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Gynaecological history – procedures

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | History of gynaecological procedures | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | None | 416128008 | | Cone biopsy | 108941000119102 | | Hysterotomy | 275573000 | | Large loop excision of transformation zone (LLETZ/LEEP) | 59251000119102 | | Myomectomy | 275574006 | | Other uterine surgery | 133581000119103 | | Unknown | 787480003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 16 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### 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 experience issues again during pregnancy or in the year following birth.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
|  | Previous mental illness treatment |  | Serious mental illness treatment |
|  | Current mental illness treatment |  | Serious mental illness treatment – detail |

#### Previous mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | History of treatment for mental illness | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

#### Current mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Current treatment for mental illness, including treatment for addictions | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

#### Serious mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Use of pharmacological treatment or talking therapies for serious mental illness in the past | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

#### Serious mental illness treatment – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for **Serious mental illness treatment** section | | |
| **Guide for use** | A response is to be recorded for each instance identified | | |
| **Verification rules** |  | | |

## 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 should be collected at the first full contact the woman has with a maternity service provider. This is likely to be at the booking visit or first contact with acute services during this pregnancy if this occurs prior to registering with an LMC.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.8.1 | Allergies present | 2.8.4 | Allergies – substances – ‘Other’ – detail |
| 2.8.2 | Allergies – medicines | 2.8.5 | Adverse reactions |
| 2.8.3 | Allergies – substances |  |  |

### Allergies present

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Known allergies to medicines or other substances | | |
| **Source standards** | HISO 10042.2 Medicine Reconciliation Standard | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No known allergies | 716186003 | | Allergy to medicine | 416098002 | | Allergy to substance | 419199007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Allergies – medicines

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Specific medicines that the woman is known to be allergic to | | |
| **Source standards** | HISO 10042.2 Medicine Reconciliation Standard | | |
| **Data type** | Alphanumeric | **Representational class** | Value |
| **Field size** | 250 | **Representational layout** | X(250) |
| **Value domain** | Record the relevant medicine | | |
| **Obligation** | Mandatory on an ‘Allergy to medicine’ response to section **2.8.1 Allergies present** | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid value only | | |

### Allergies – substances

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Substances that the woman is known to be allergic to | | |
| **Source standards** | HISO 10042.2 Medicine Reconciliation Standard | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Dairy  (SNOMED CT term: ‘Cow’s milk’) | 3718001 | | Egg | 102263004 | | Latex | 111088007 | | Nut | 13577000 | | Seafood | 44027008 | | Other | 105590001 | |  |  | | | | |
| **Obligation** | Mandatory on a response of ‘Allergy to substance’ for section **2.8.1 Allergies present** | | |
| **Guide for use** | Record the substances the women is allergic to, other than medicines  Six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Allergies – substances – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ substance allergies | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.8.3 Allergies – substances** | | |
| **Guide for use** | A response is to be recorded for each identified ‘Other’ instance | | |
| **Verification rules** |  | | |

### Adverse reactions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Adverse drug reaction (ADR) to a medicine the woman may have experienced | | |
| **Source standards** | HISO 10042.2 Medicine Reconciliation Standard | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response other than ‘No known allergies’ to section **2.8.1 Allergies present** | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** |  | | |

## Alcohol and other drugs

This section records information about a woman’s consumption of alcohol and other drugs. This information should be collected at the first full contact the woman has with a maternity service provider and routinely thereafter. Women may not reveal their alcohol use the first time they are asked, and they may not stop drinking straight away; it is important to have this conversation more than once.

Primary health and allied health professionals asking about alcohol, tobacco, and other drugs as part of routine health care checks will help break down the stigma associated with its use.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.9.1 | Alcohol consumption | 2.9.5 | Referred to alcohol use services |
| 2.9.2 | Timing of alcohol cessation | 2.9.6 | History of drug use |
| 2.9.3 | Amount of alcohol consumed | 2.9.7 | Current drugs used |
| 2.9.4 | Brief alcohol cessation advice | 2.9.8 | Current drugs used – ‘Other’ – detail |

### Alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current alcohol consumption | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand alcohol consumption reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Does not drink alcohol | 105542008 | | Currently drinks alcohol | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Timing of alcohol cessation

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Definition** | | When the woman stopped drinking alcohol | | |
| **Source standards** | |  | | |
| **Data type** | SNOMED CT identifier | | **Representational class** | Code |
| **Field size** | 18 | | **Representational layout** | N(18) |
| **Value domain** | | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Pre-pregnancy | 91601000210103 | | First trimester of pregnancy | 101491000210103 | | Second trimester of pregnancy | 101501000210108 | | Third trimester of pregnancy | 101511000210105 | | Declined to answer | 426544006 | | Ongoing alcohol consumption | 427013000 | |  |  | | | |
| **Obligation** | | Mandatory on a response of ‘Currently drinks alcohol’ in section **2.9.1 Alcohol consumption** | | |
| **Guide for use** | |  | | |
| **Verification rules** | | Valid code only | | |

### Amount of alcohol consumed

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | 3 | **Representational layout** | NNN |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Currently drinks alcohol’ to section **2.9.1 Alcohol consumption** | | |
| **Guide for use** | An approximate number of units is acceptable | | |
| **Verification rules** | Valid value only | | |

### Brief alcohol cessation advice

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Brief advice offered to the woman regarding alcohol consumption | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Currently drinks alcohol’ to section **2.9.1 Alcohol consumption** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Referred to alcohol use services

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Offer of alcohol support services to the woman | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Currently drinks alcohol’ to section **2.9.1 Alcohol consumption** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### History of drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s history of illegal drugs use | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug use reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Current drug user | 417284009 | | Declined to answer | 426544006 | | Ex-drug user | 44870007 | | Has never misused drugs | 228368007 | | Misuse of prescription drugs | 191939002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This covers illegal drugs or misuse of drugs prescribed for the woman or others | | |
| **Verification rules** | Valid code only | | |

### Current drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Illegal drugs the woman is currently using | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other | 410942007 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Current drug user’ to section **2.9.6 History of drug use** | | |
| **Guide for use** | This covers illegal drugs or misuse of drugs prescribed for the woman or others | | |
| **Verification rules** | Valid code only | | |

### Current drugs used – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ drugs currently in use | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.9.7 Current drugs used** | | |
| **Guide for use** | A response is to be recorded for each identified ‘Other’ instance | | |
| **Verification rules** |  | | |

## Smoking and vaping status

This section records information about the tobacco smoking and/or vaping status of the woman. Smoking tobacco or vaping during pregnancy can have harmful effects on both the woman and baby. Pregnancy can provide motivation to stop. For these reasons it is important to collect information on the tobacco smoking or vaping rates of pregnant women and to offer them support and smoking/vaping cessation advice.

Information about the tobacco smoking or vaping status (for example, number of cigarettes smoked per day) and smoking cessation support received is collected at the booking visit, at the end of the antenatal period and in the postnatal period.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.10.1 | Smoking status | 2.10.5 | Number of cigarettes smoked per day |
| 2.10.2 | Vaping status | 2.10.6 | Brief smoking cessation advice |
| 2.10.3 | Change from smoking to vaping | 2.10.7 | Referral to smoke free services |
| 2.10.4 | Date quit smoking | 2.10.8 | Exposure to second-hand smoke |

### Smoking status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of tobacco | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand smoking status reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72741000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72741000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Currently smokes | 77176002 | | Never smoked | 266919005 | | Ex-smoker, greater than 12 months abstinent | 48031000119106 | | Ex-smoker, less than 12 months abstinent | 735128000 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Vaping status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of a vaping device | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand vaping status reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Ex-vaping for less than 1 year | 1137688001 | | Ex-vaping for more than 1 year | 1137692008 | | Trying to give up vaping | 1137691001 | | Never vaped | 113769000 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Change from smoking to vaping

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Change from smoking cigarettes to vaping during this pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of either ‘Currently vaping with nicotine’, ‘Currently vaping without nicotine’ or ‘Currently vaping’ to section **2.10.2 Vaping status** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Date quit smoking

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Date the woman stopped smoking tobacco | | |
| **Source standards** |  | | |
| **Data type** | Date | **Representational class** | Full or partial date |
| **Field size** | 8 | **Representational layout** | YYYY[MM[DD]] |
| **Value domain** | Valid date or valid partial date | | |
| **Obligation** |  | | |
| **Guide for use** | Mandatory on a response other than ‘Never smoked’ to section **2.10.1 Smoking status**  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 populated | | |
| **Verification rules** | A valid date that is less than or equal to the current date | | |

### Number of cigarettes smoked per day

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Number of tobacco cigarettes smoked per day | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 3 | **Representational layout** | NNN |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Currently smokes’ for section **2.10.1 Smoking status** | | |
| **Guide for use** | An approximate number is acceptable | | |
| **Verification rules** | A value greater than zero | | |

### Brief smoking cessation advice

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Brief advice offered regarding smoking cessation | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Currently smokes’ for section **2.10.1 Smoking status** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Referral to smoke free services

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral to smoke free services | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Currently smokes’ for section **2.10.1 Smoking status** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Exposure to second-hand smoke

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | If and where the woman has had regular exposure to second-hand tobacco smoke | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No known exposure to tobacco smoke | 711563001 | | Yes, at home | 228524006 | | Yes, at place of work | 228523000 | | Yes, in public places | 228525007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded where any code other than ‘No known exposure to tobacco smoke’ is selected | | |
| **Verification rules** | Valid code only | | |

## Family health

This section records the medical history of both the woman’s and father’s immediate family members. Current and past medical conditions and any risk factors for congenital abnormalities should be noted.

The information should be collected at the first full contact the woman has with a maternity service provider. This is likely to be at the booking visit or first contact with acute maternity services during this pregnancy if this occurs prior to registering with an LMC.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.11.1 | Maternal family history | 2.11.3 | Consanguinity |
| 2.11.2 | Paternal family history | 2.11.4 | Degree of relationship |

### Maternal family history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Relevant medical history of the woman’s close family | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity family history reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72661000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72661000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Allergies | 160469004 | | Asthma | 160377001 | | Chromosomal anomaly | 160425006 | | Congenital anomaly | 160417009 | | 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 condition | 281666001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 10 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Paternal family history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Relevant medical history of the baby’s father and his close family | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity family history reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72661000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72661000210103).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Allergies | 160469004 | | Chromosomal anomaly | 160425006 | | Congenital anomaly | 160417009 | | Intellectual disability | 763598005 | | Mental illness | 160324006 | | No relevant family history | 160266009 | | Not known | 407559004 | | Other condition | 281666001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Consanguinity

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Blood relationship of the baby’s parents to each other | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Yes | 1 | | No | 2 | | Not known | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Degree of relationship

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Degree of blood relationship between the baby’s parents | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | First cousin | 4577005 | | Second cousin | 13443008 | | Other | 125679009 | |  |  | | | |
| **Obligation** | Mandatory on a response of 'Yes’ to section **2.11.3 Consanguinity** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Tuberculosis risk assessment

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.12.1 | Lives with person with tuberculosis | 2.12.3 | Lived in country with tuberculosis |
| 2.12.2 | Lives in country with tuberculosis |  |  |

### Lives with person with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Presence in the household of a person with either current TB or a history of TB | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Unknown | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Lives in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The likelihood that during their first five years, that the infant will be living for three months or longer in a country with high rates of TB | | |
| **Source standards** | *Use of high burden country lists for TB by WHO in the post-2015 era*: https://www.who.int/[tb/publications/global\_report/high\_tb\_burdencountrylists2016-2020.pdf](https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf)  (page 3) | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Unknown | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information  Page 3 of the above report states that 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 code only | | |

### Lived in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Have one or both parents or household members or carers, within the last five years, lived in a country with high rates of TB | | |
| **Source standards** | *Use of high burden country lists for TB by WHO in the post-2015 era*:  <https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf> (page 3) | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Unknown | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information  Page 3 of the above report states that 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 code only | | |

## Current pregnancy

This section collates information about the woman’s current pregnancy, including screening tests, ultrasound scans, referrals for complications, and prescriptions. The information is collected throughout the pregnancy and should be summarised at the end of the pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.13.1 | Blood tests | 2.13.17 | Antenatal admissions |
| 2.13.2 | Antenatal screening | 2.13.18 | Antenatal admission – date and time |
| 2.13.3 | Antenatal vaccinations | 2.13.19 | Antenatal discharge – date and time |
| 2.13.4 | Family violence screening | 2.13.20 | Current alcohol consumption |
| 2.13.5 | Fetal anomaly screening | 2.13.21 | Drug use |
| 2.13.6 | Ultrasound scans | 2.13.22 | Current drugs used |
| 2.13.7 | Ultrasound scan total | 2.13.23 | Current smoking status |
| 2.13.8 | Chorionic villus sampling | 2.13.24 | Current vaping status |
| 2.13.9 | Amniocentesis | 2.13.25 | Antenatal prescriptions |
| 2.13.10 | Pregnancy complications | 2.13.26 | Antenatal prescriptions – ‘Other |
| 2.13.11 | Pregnancy complications – ‘Other’ – detail | 2.13.27 | Antenatal complementary therapies |
| 2.13.12 | Antenatal referrals | 2.13.28 | Antenatal complementary therapies – date |
| 2.13.13 | Antenatal referral – date | 2.13.29 | Antenatal visits – first trimester |
| 2.13.14 | Pregnancy loss prior to 20 weeks 0 days | 2.13.30 | Antenatal visits – second trimester |
| 2.13.15 | Pregnancy loss – date | 2.13.31 | Antenatal visits – third trimester |
| 2.13.16 | Antenatal referral code |  |  |

### Blood tests

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Blood tests during the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity screening and tests reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72641000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72641000210104).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Antenatal first blood tests (AN1) | 50961000210108 | | Antenatal subsequent blood tests (AN2) | 50951000210105 | | Oral glucose tolerance test (OGTT) | 113076002 | | Pre-eclampsia tests (PET) | 60881000210103 | | Other blood tests | 396550006 | | Declined blood tests | 116471000119100 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Screening tests during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity screening and tests reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72641000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72641000210104).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Red blood cell antibodies | 89754000 | | Gestational diabetes | 50491000210105 | | Group B streptococcus | 118001005 | | Hepatitis A (Hep A) | 252404004 | | Hepatitis B (Hep B) | 252405003 | | Hepatitis C (Hep C) | 413107006 | | Human immunodeficiency virus (HIV) | 390786002 | | Multi-drug resistant organisms (MDRO) | 14788002 | | Syphilis | 169698000 | | Other | 243787009 | | Declined screening tests | 31021000119100 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 10 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal vaccinations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Vaccinations during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Influenza | 73701000119109 | | Pertussis | 72011000210108 | | SARS COV-2 | 101631000210102 | | Other | 713404003 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Family violence screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Screening for family violence undertaken by the health professional | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Declined to answer | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Fetal anomaly screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Fetal anomaly screening tests during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Declined fetal anomaly screening | 111511000210108 | | Non-invasive prenatal screening (NIPS) | 121511000210100 | | First trimester combined screening | 111521000210103 | | Second trimester maternal serum screening | 111531000210101 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Ultrasound scans

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Ultrasound scans during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **Code** | | Dating | 169229007 | | Anatomy | 271442007 | | Growth | 241493005 | | Placental location | 164817009 | | Suspected malpresentation | 169228004 | | Other | 241491007 | | Declined ultrasound scans | 71771000210106 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Seven instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Ultrasound scan total

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Total number of ultrasound scans during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | 00–99 | | |
| **Obligation** | Mandatory on any response other than ‘Declined ultrasound scans’ to section **2.13.6 Ultrasound scans** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### Chorionic villus sampling

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Chorionic villus sampling during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Amniocentesis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Amniocentesis during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Pregnancy complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications experienced during the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity complication reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72601000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72601000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Antepartum haemorrhage | 34842007 | | Eclampsia | 198992004 | | Gestational diabetes | 11687002 | | Hypertensive disorders of pregnancy | 82771000119102 | | Infection | 40609001 | | Mental health problem | 413307004 | | Pre-eclampsia | 398254007 | | Placental conditions | 273983009 | | Preterm labour | 6383007 | | Seizure | 91175000 | | Other | 609496007 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Pregnancy complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ pregnancy complications | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.13.10 Pregnancy complications** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Antenatal referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral to specialist services during the pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Antenatal referral – date

This element defines the date that the antenatal referral was made. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a ‘1 – Yes’ response to section **2.13.12 Antenatal referrals**, where the woman chose to attend the specialist appointment.

### Pregnancy loss prior to 20 weeks 0 days

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Pregnancy loss prior to 20 weeks gestation | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on such a loss occurring | | |
| **Guide for use** | Record a code for each loss | | |
| **Verification rules** | Valid code only | | |

### Pregnancy loss – date

This element defines the date that the pregnancy loss occurred. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a ‘1 – Yes’ response to section **2.13.14 Pregnancy loss prior to 20 weeks 0 days**. A valid date should be recorded for each loss.

### Antenatal referral code

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Unique referral code | | |
| **Source standards** | *Guidelines for Consultation with Obstetric and Related Medical Services*: <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** | 18 | **Representational layout** | N(18) |
| **Value domain** | Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services* | | |
| **Obligation** | Mandatory on a ‘1 – Yes’ response to section **2.13.12 Antenatal referrals** | | |
| **Guide for use** | The Ministry is currently updating the list in Table 2 to provide SNOMED codes | | |
| **Verification rules** | Valid code only | | |

### Antenatal admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Admissions to hospital for antenatal care during the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Antenatal admission – date and time

This element defines the date and time of the antenatal admission. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a ‘1 – Yes’ response to section **2.13.17 Antenatal admissions**.

### Antenatal discharge – date and time

This element defines the date and time of the antenatal discharge. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory upon a ‘1 – Yes’ response to section **2.13.17 Antenatal admissions** and must be on or after the date and time recorded in section **2.13.18 Antenatal admission – date and time**.

### Current alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current alcohol consumption | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand alcohol consumption reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Does not drink alcohol | 105542008 | | Currently drinks alcohol | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.9.1 Alcohol consumption**, as this section records a value at the end of the pregnancy | | |
| **Verification rules** | Valid code only | | |

### Drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of illegal drugs | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug use reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Current drug user | 417284009 | | Declined to answer | 426544006 | | Does not misuse drugs | 228367002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.9.6 History of drug use**, as this section records use at the end of the pregnancy | | |
| **Verification rules** | Valid code only | | |

### Current drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Illegal drugs the woman is currently using | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other | 74964007 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Current drug user’ to section **2.13.21 Drug use** | | |
| **Guide for use** | This covers illegal drugs or misuse of drugs prescribed for the woman or others  Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Current smoking status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s use of tobacco in the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Currently smokes | 77176002 | | Current non-smoker | 160618006 | | Declined to answer | 426544006 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.10.1 Smoking status**, as section **2.13.23** records status at the end of the pregnancy | | |
| **Verification rules** | Valid code only | | |

### Current vaping status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s use of a vaping device in the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand vaping status reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Trying to give up vaping | 1137691001 | | Never vaped | 113769000 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal prescriptions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Prescriptions supplied to the woman by the LMC during the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity substances reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72651000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72651000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Analgesics | 373265006 | | Antacids | 372794006 | | Antibacterials | 419241000 | | Antifungals | 373219008 | | Minerals | 373460003 | | Non-steroidal anti-inflammatories (NSAIDs) | 372665008 | | Vitamins | 87708000 | | Other | 105590001 | | No prescriptions | 182849000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Eight instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal prescriptions – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ antenatal prescriptions | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.13.25 Antenatal prescriptions** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Antenatal complementary therapies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complementary therapies used by the woman during the current pregnancy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity complementary therapies reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72631000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Chiropractic | 182548004 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Massage | 387854002 | | Naturopathy | 439809005 | | Osteopathy | 182549007 | | Rongoā Māori | 789789009 | | Other | 225423004 | | | |
| **Obligation** | Optional | | |
| **Guide for use** | 10 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Antenatal complementary therapies – date

This element defines the date a complementary therapy was administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response to section **2.13.27 Antenatal complementary therapies**.

### Antenatal visits – first trimester

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

### Antenatal visits – second trimester

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

### Antenatal visits – third trimester

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

## Labour and birth

This section collates information about the details of the labour and birth relating to the woman.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.14.1 | Onset of labour | 2.14.23 | Labour and birth referral code |
| 2.14.2 | Gestation at onset of labour | 2.14.24 | Labour and birth referral – date and time |
| 2.14.3 | Labour established – date and time | 2.14.25 | Number of babies born |
| 2.14.4 | Actual place of birth | 2.14.26 | Type of birth |
| 2.14.5 | Actual place of birth – ‘Other’ – detail | 2.14.27 | Birth position |
| 2.14.6 | Actual place of birth – facility | 2.14.28 | Water birth |
| 2.14.7 | Maternity facility admission – date and time | 2.14.29 | Vaginal birth after Caesarean section |
| 2.14.8 | Labour augmented – first stage | 2.14.30 | Length of third stage of labour |
| 2.14.9 | Reason labour augmented – first stage | 2.14.31 | Analgesia in labour |
| 2.14.10 | Reason labour augmented – first stage – ‘Other’ – detail | 2.14.32 | Analgesia in labour – date and time (first administration) |
| 2.14.11 | Complications – first stage | 2.14.33 | Anaesthesia in labour |
| 2.14.12 | Cervix fully dilated – date and time | 2.14.34 | Anaesthesia in labour – date and time (first administration) |
| 2.14.13 | Length of active first stage of labour | 2.14.35 | Analgesia for the birth |
| 2.14.14 | Labour augmentation – second stage | 2.14.36 | Analgesia for the birth – date and time (first administration) |
| 2.14.15 | Reason labour augmented – second stage | 2.14.37 | Anaesthesia for the birth |
| 2.14.16 | Reason labour augmented – second stage – ‘Other’ – detail | 2.14.38 | Anaesthesia for the birth – date and time |
| 2.14.17 | Pushing commenced – date and time | 2.14.39 | Labour and birth prescriptions |
| 2.14.18 | Complications – second stage | 2.14.40 | Labour and birth prescriptions administered – date |
| 2.14.19 | Length of second stage of labour | 2.14.41 | Labour and birth prescriptions – ‘Other’ – detail |
| 2.14.20 | Rupture of membranes | 2.14.42 | Coping strategies |
| 2.14.21 | Meconium present | 2.14.43 | Coping strategies – ‘Other’ – detail |
| 2.14.22 | Labour and birth referrals | 2.14.44 | Induction of labour |

### Onset of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Manner by which the woman’s labour started | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Induced | 112070001 | | Planned caesarean section before labour | 200148001 | | Spontaneous | 84457005 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Gestation at onset of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Gestation at the onset of labour, in weeks and days | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NN.N |
| **Value domain** | Weeks and days | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record the number of completed weeks of this pregnancy, for example, a response of 38 weeks and 6 days would be recorded as 38:6 (WW:D) | | |
| **Verification rules** | A value greater than or equal to 20 | | |

### Labour established – date and time

This element defines the date and time that labour was established, as measured by duration, frequency, and strength of contractions. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a response of either ‘Induced’ or ‘Spontaneous’ for section **2.14.1 Onset of labour**.

### Actual place of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The actual place where the woman gave birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Home | 169813005 | | Primary birthing facility | 91541000210104 | | Secondary birthing facility | 91551000210101 | | Tertiary birthing facility | 91561000210103 | | In transit | 91571000210109 | | Other | 366344009 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Actual place of birth – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ actual place of birth | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.14.4 Actual place of birth** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Actual place of birth – facility

This element provides the actual place of birth facility detail. The information to be recorded is the ‘Provider facility identification number’ as specified in section **2.2 Health care** provider information.

The data element is mandatory upon any response other than ‘Home’ or ‘Other’ to section **2.14.4** **Actual place of birth**

### Maternity facility admission – date and time

This element defines the date and time the woman was admitted specifically for labour. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory if the response to section **2.14.4 Actual place of birth** is a primary, secondary, or tertiary facility.

### Labour augmented – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Augmentation of the first stage of labour with an artificial rupture of membranes (ARM) and/or oxytocin | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No augmentation | 91721000210101 | | Augmented with ARM | 408818004 | | Augmented with oxytocin | 816966004 | | Augmented with both ARM and oxytocin | 101621000210104 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Reason labour augmented – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason the woman’s labour was augmented during the first stage of labour | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Delay in first stage of labour | 1 | | Other | 2 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘No augmentation’ for section **2.14.8 Labour augmented – first stage** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Reason labour augmented – first stage – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ reason for augmentation of labour | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 250 | **Representational layout** | X(250) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.14.9 Reason labour augmented – first stage** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Complications – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of complications experienced during the first stage of labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72611000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72611000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Complications of an anaesthetic | 200046004 | | Cord prolapse | 270500004 | | Delay in first stage | 237320005 | | Fetal distress | 130955003 | | Infection | 32801000119106 | | Intrapartum haemorrhage | 38010008 | | Malposition | 698554000 | | Malpresentation | 698791008 | | Meconium liquor | 199595002 | | Other | 199745000 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Cervix fully dilated – date and time

This element defines the date and time the cervix was fully dilated. The format is set out in the common **Date and time value domain** specification. The data element is optional.

### Length of active first stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Calculated length of first stage of labour | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 5 | **Representational layout** | HH:MM |
| **Value domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory on a valid response to section **2.14.12 Cervix fully dilated – date and time** | | |
| **Guide for use** | 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 as requested by the LMC  The value for this field is created by:  subtracting the:  time labour commenced (a time value recorded in section **2.14.3 Labour established – date and time**)  from the:  recorded time for the end of first stage labour  (a value recorded in section **2.14.12 Cervix fully dilated – date and time**) | | |
| **Verification rules** | Valid value only | | |

### Labour augmentation – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Augmentation of the second stage of labour with ARM and/or oxytocin | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No augmentation | 91721000210101 | | Augmented with ARM | 408818004 | | Augmented with oxytocin | 816966004 | | Augmented with both ARM and oxytocin | 101621000210104 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Reason labour augmented – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason the woman’s labour was augmented during the second stage of labour | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Delay in second stage of labour | 1 | | Other | 2 | | | |
| **Obligation** | Mandatory on any other response than ‘No augmentation’ for section **2.14.14 Labour augmentation – second stage** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Reason labour augmented – second stage – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ reason labour augmented – second stage | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other – 2’ for section **2.14.15 Reason labour augmented – second stage** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Pushing commenced – date and time

This element defines the date and time active pushing commenced during the second stage. The format is set out in the common **Date and time value domain** specification. The data element is optional.

### Complications – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of complications experienced during the second stage of labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72611000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72611000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Complications of an anaesthetic | 200046004 | | Cord prolapse | 270500004 | | Delay in second stage | 249166003 | | Fetal distress | 130955003 | | Hypertensive disorder | 82771000119102 | | Infection | 32801000119106 | | Intrapartum haemorrhage | 38010008 | | Malposition | 698554000 | | Malpresentation | 698791008 | | Meconium liquor | 199595002 | | Other | 199745000 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | 11 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Length of second stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Calculated length of second stage of labour | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 5 | **Representational layout** | HH:MM |
| **Value domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory on a valid response to section **2.14.12 Cervix fully dilated – date and time** | | |
| **Guide for use** | 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 as requested by the LMC  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 section **2.14.12 Cervix fully dilated – date and time**  from the:  recorded time of the birth of the baby (a time value recorded in section **2.17.1 Birth – date and time**) | | |
| **Verification rules** | Valid value only | | |

### Rupture of membranes – date and time

This element defines the date and time the membranes ruptured. The format is set out in the common **Date and time value domain** specification. The data element is mandatory.

### Meconium present

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Presence of meconium in the amniotic fluid | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Yes | 1 | | No | 2 | | Amniotic fluid not present | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Labour and birth referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral to specialist services during the labour and birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Labour and birth referral code

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Unique referral code | | |
| **Source standards** | *Guidelines for Consultation with Obstetric and Related Medical Services*:  <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** | 18 | **Representational layout** | N(18) |
| **Value domain** | Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services* | | |
| **Obligation** | Mandatory on a ‘1 – Yes’ response to section **2.14.22 Labour and birth referrals** | | |
| **Guide for use** | The Ministry is currently updating the list in Table 2 to provide SNOMED codes | | |
| **Verification rules** | Valid code only | | |

### Labour and birth referral – date and time

This element defines the date and time the labour and birth referral took place. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a ‘1 – Yes’ response to section **2.14.22 Labour and birth referrals**.

### Number of babies born

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Number of babies born during this labour and birth, including stillbirths | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | A value greater than zero | | |

### Type of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72581000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72581000210105).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Caesarean section | 200146002 | | Forceps | 200130005 | | Spontaneous vaginal birth | 48782003 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Birth position

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Position the woman gave birth in | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Kneeling | 277773003 | | Lateral | 32185000 | | Lithotomy | 14205002 | | Semi-reclined | 272580008 | | Sitting (eg, birth stool) | 33586001 | | Squatting | 408797004 | | Standing | 10904000 | | Supine | 40199007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record one entry for each baby born | | |
| **Verification rules** | Valid code only | | |

### Water birth

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

### Vaginal birth after Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **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** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Length of third stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Calculated length of third stage of labour | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 5 | **Representational layout** | HH:MM |
| **Value domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | 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 as requested by the LMC  The value for this field is created by:  subtracting the:  recorded time of the birth of the baby (a value recorded in section **2.17.1 Birth – date and time**)  from the:  recorded time for the end of third stage of labour (a time value recorded in section **2.16.3 Placenta delivery – date and time**) | | |
| **Verification rules** | Valid value only | | |

### Analgesia in labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of analgesia used during labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No analgesia | 91631000210108 | | Pharmacological – non-opiate | 101581000210104 | | Pharmacological – opiate | 101661000210106 | | Non-pharmacological | 111481000210103 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Analgesia in labour – date and time (first administration)

If analgesia was administered during labour, this element defines the date and time the analgesia was first administered. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on any response other than ‘no analgesia’ to section **2.14.31** [**Analgesia in labour**](#_Analgesia_in_labour).

### Anaesthesia in labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of anaesthesia administered to the woman during labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Combined spinal/epidural | 231261002 | | Epidural | 18946005 | | General anaesthetic | 50697003 | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Spinal | 231249005 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Anaesthesia in labour – date and time (first administration)

If anaesthesia was administered during labour, this element defines the date and time the anaesthesia was first administered. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response to section **2.14.33 Anaesthesia in labour**.

### Analgesia for the birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of analgesia used by the woman for the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | No analgesia | 91631000210108 | | Non-pharmacological | 111481000210103 | | Pharmacological – non-opiate | 101581000210104 | | Pharmacological – opiate | 101661000210106 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded  This field records new analgesia administered for the birth; it captures those women who did not use analgesia for the labour but required it for the birth (eg, pudendal block for an assisted birth) | | |
| **Verification rules** | Valid code only | | |

### Analgesia for the birth – date and time (first administration)

If analgesia was administered for the birth, this element defines the date and time the analgesia was first administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response other than ‘No analgesia’ to section **2.14.35 Analgesia for the birth**.

### Anaesthesia for the birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of anaesthesia administered to the woman for the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Combined spinal/epidural | 231261002 | | Epidural | 18946005 | | General anaesthetic | 50697003 | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Spinal | 231249005 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Three instances of this field may be recorded  This field records new anaesthesia administered for the birth. It captures those women who did not require anaesthesia for the labour but required it for the birth (eg, spinal block for a Caesarean section) | | |
| **Verification rules** | Valid code only | | |

### Anaesthesia for the birth – date and time

If anaesthesia was administered for the birth, this element defines the date and time the anaesthesia was first administered. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response to section **2.14.37 Anaesthesia for the birth**.

### Labour and birth prescriptions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Prescriptions supplied to the woman during the labour and birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity substances reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72651000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72651000210101).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Analgesic | 373265006 | | Antacid | 372794006 | | Antibacterial | 419241000 | | Antiemetic | 372776000 | | Intravenous fluid | 118431008 | | No prescriptions  (SNOMED CT term: ‘No history of procedure’) | 416128008 | | Non-steroidal anti-inflammatory drug (NSAID) | 372665008 | | Uterotonic drug | 410937004 | | Other | 105590001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Labour and birth prescriptions administered – date

This element defines the date medication was administered during the labour and birth. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on any response to section **2.14.39 Labour and birth prescriptions** other than ‘No prescriptions’.

### Labour and birth prescriptions – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ labour and birth prescriptions | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.14.39 Labour and birth prescriptions** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Coping strategies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Types of coping strategies and complementary therapies used during labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity complementary therapies reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72631000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Aromatherapy | 394615007 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Hypnobirthing techniques | 19997007 | | Massage | 387854002 | | Naturopathy | 439809005 | | Positional techniques | 226048001 | | Rongoā Māori | 789789009 | | Support people | 816968003 | | TENS machine | 229559001 | | Water immersion | 229204004 | | Other | 225423004 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | 13 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Coping strategies – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ coping strategies | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.14.42 Coping strategies** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Induction of labour

This section collates information about the woman’s induction of labour, if she had one during this labour and birth. It should be left blank unless the woman has had an induction of labour.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
|  | Induction date and time |  | Induction reason |
|  | Induction method(s) |  |  |

#### Induction date and time

This element defines the date and time induction of labour was commenced. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘Induced’ for section **2.14.1 Onset of labour**. This field records the date and time of the first method (as listed in **Induction method(s)** below) used in the induction of labour process.

#### Induction method(s)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method(s) by which the labour was induced | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Artificial rupture of membranes (ARM) | 408816000 | | Cervical ripening balloon | 425861005 | | Mifepristone | 71721000210107 | | Misoprostol | 71731000210109 | | Oxytocin infusion | 177135005 | | Prostaglandin | 177136006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

#### Induction reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason for the induction of labour | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Abnormal dopplers | 312370006 | | Advanced maternal age | 416413003 | | Antepartum haemorrhage | 34842007 | | Blood group antibodies | 166167002 | | Congenital anomaly | 276654001 | | Diabetes | 10754881000119104 | | Eclampsia | 15938005 | | Fetal heart rate abnormality | 267257007 | | Gestational hypertension | 48194001 | | Hypertension | 106005003 | | In vitro fertilisation (IVF) | 10231000132102 | | Intrauterine fetal death | 14022007 | | Intrauterine growth restriction/small for gestational age (IUGR/SGA) | 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 | 169584000 | | Pre-eclampsia | 398254007 | | Prelabour rupture of membranes | 44223004 | | Preterm rupture of membranes | 312974005 | | Previous shoulder dystocia | 816150000 | | Prolonged pregnancy | 90968009 | | Reduced fetal movements | 276369006 | | Congenital anomaly of fetus | 609520005 | | Chromosomal anomaly of fetus | 267253006 | | Termination of pregnancy | 57797005 | | Unstable lie | 86356004 | | Other | 106007006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Caesarean section

This section collates information about the woman’s Caesarean section, if she had one during this birth event. It should be left blank unless the woman has had a Caesarean section.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.15.1 | Caesarean section type | 2.15.6 | Caesarean section primary indication – ‘Other fetal reason’ – detail |
| 2.15.2 | Caesarean grade | 2.15.7 | Caesarean section primary indication – ‘Other maternal reason’ – detail |
| 2.15.3 | Caesarean category | 2.15.8 | Complications during Caesarean section |
| 2.15.4 | Dilation before Caesarean section | 2.15.9 | Complications during Caesarean section – ‘Other’ – detail |
| 2.15.5 | Caesarean section primary indication |  |  |

### Caesarean section type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of uterine incision | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Classical caesarean section | 84195007 | | Lower uterine segment Caesarean section (LUSCS) | 788180009 | | Other | 11466000 | | | |
| **Obligation** | Mandatory on a response of ‘Caesarean section’ for section **2.14.26 Type of birth** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Caesarean grade

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Grade of urgency under which the Caesarean section was initiated | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Planned (elective) | 177141003 | | Unplanned (emergency) | 274130007 | |  |  | | | |
| **Obligation** | Mandatory on a valid response to section **2.15.1 Caesarean section type** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Caesarean category

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Category of the Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Category 1 Immediately life threatening to the woman or fetus | 91771000210102 | | Category 2  Woman or fetus compromised, not immediately life threatening | 101531000210103 | | Category 3 Decision for earlier delivery made by health service | 101541000210106 | | Category 4 Decision for rescheduled delivery made by health service and the woman | 101551000210109 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Unplanned (emergency)’ for section **2.15.2 Caesarean grade** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Dilation before Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Extent of cervical dilation as last measured prior to Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | Centimetres | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer | | |

### Caesarean section primary indication

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Primary indication for performing the Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Abnormal fetal blood sample | 71701000210104 | | Antepartum haemorrhage | 34842007 | | Augmentation causing uterine hyperstimulation | 34981006 | | Chorioamnionitis | 11612004 | | Chronic hypertension | 8762007 | | Cord presentation | 237305004 | | Cord prolapse | 270500004 | | Diabetes | 73211009 | | Failed induction of labour | 42571002 | | Failed instrumental delivery | 772006002 | | Fetal anomaly | 609520005 | | Fetal distress – intolerance of augmented labour | 816967008 | | Fetal distress – spontaneous labour | 288274003 | | Fetal heart rate abnormality | 312668007 | | Hypertensive disorder | 38341003 | | Inefficient uterine action – no oxytocin | 387699008 | | Inefficient uterine action – with oxytocin | 816969006 | | Large for gestational age | 199616008 | | Malposition | 289365005 | | Malpresentation | 15028002 | | Maternal age | 416413003 | | Maternal medical condition | 106007006 | | Maternal request | 408855004 | | Multiple pregnancy | 16356006 | | Obstructed labour | 199746004 | | Other fetal reason | 106009009 | | Other maternal reason | 106008001 | | Placenta praevia | 36813001 | | Placental abruption | 415105001 | | Pre-eclampsia | 398254007 | | Previous caesarean section | 200151008 | | Small for gestational age (SGA) | 267258002 | | Suboptimal augmentation | 91484005 | | Uterine rupture | 34430009 | | Unknown | 281337006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Caesarean section primary indication – ‘Other fetal reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other fetal reason’ for Caesarean information | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other fetal reason’ for section **2.15.5 Caesarean section primary indication** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Caesarean section primary indication – ‘Other maternal reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other maternal reason’ for Caesarean information | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other maternal reason’ for section **2.15.5 Caesarean section primary indication** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Complications during Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications that occurred during the Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from [the New Zealand maternity complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72601000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72601000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Adhesions | 197201009 | | Bladder injury | 77165001 | | Bowel injury | 125625000 | | Hypertension | 82771000119102 | | Intrapartum haemorrhage | 38010008 | | Thromboembolism | 371039008 | | Ureteric injury | 24850009 | | Uterine complications | 289618005 | | Other | 78408007 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Complications during Caesarean section – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ complications during Caesarean section | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ’Other’ for section **2.15.8 Complications during Caesarean section** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Post-birth

This section collates information about the woman during the third stage of labour and up to 24 hours postnatally.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.16.1 | Placenta mode of delivery | 2.16.8 | Non-perineal genital tract trauma type |
| 2.16.2 | Uterotonic drugs | 2.16.9 | Repair required |
| 2.16.3 | Placenta delivery – date and time | 2.16.10 | Placenta and membranes |
| 2.16.4 | Perineal status | 2.16.11 | Placenta appearance |
| 2.16.5 | Episiotomy type | 2.16.12 | Number of cord vessels |
| 2.16.6 | Episiotomy reason | 2.16.13 | Placenta kept by the woman |
| 2.16.7 | Episiotomy reason – ‘Other’ – detail | 2.16.14 | Total blood loss |

### Placenta mode of delivery

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Mode of delivery of the placenta | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Caesarean section | 50791000210101 | | Controlled cord traction with uterotonic | 302384005 | | Manual removal of retained placenta | 28233006 | | Physiological | 1141750000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Uterotonic drugs

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

### Placenta delivery – date and time

This element defines the date and time the placenta was delivered. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory. This field signifies the third stage of labour date and time.

### Perineal status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Status of the perineum after the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Perineum intact | 289854007 | | First-degree tear  – injury to perineal skin and vaginal wall only | 57759005 | | Second-degree tear  – injury to perineal skin, vaginal wall and superficial perineal muscles | 6234006 | | Third-degree tear (3a)  – injury to perineal skin, vaginal wall and perineal muscles and less than 50 percent of external anal sphincter (EAS) thickness torn | 449807005 | | Third-degree tear (3b)  – injury to perineal skin, vaginal wall and perineal muscles and more than 50 percent of EAS thickness torn | 449808000 | | Third-degree tear (3c)  – both external and internal anal sphincter (IAS) torn | 449809008 | | Fourth-degree tear  – anal sphincter complex (EAS and IAS) and anal epithelium torn | 399031001 | | Episiotomy incision | 860603002 | | Not known | 281337006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Episiotomy type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Episiotomy type | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Anterior | 71981000210106 | | J shaped | 71831000210104 | | Mediolateral | 71991000210108 | | Midline | 71821000210101 | | | |
| **Obligation** | Mandatory on a response of ‘Episiotomy incision’ for section **2.16.4 Perineal status** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Episiotomy reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Clinical indication for performing the episiotomy | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Abnormal fetal blood sample | 199597005 | | Delay in second stage | 249166003 | | Female genital mutilation (FGM) | 95041000119101 | | Fetal heart rate abnormality | 267257007 | | Forceps delivery | 200130005 | | Maternal distress | 87383005 | | Previous perineal damage | 15758941000119102 | | Rigid perineum | 289875004 | | Shoulder dystocia | 89700002 | | Vacuum extraction | 200138003 | | Other | 199745000 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Episiotomy incision’ for section **2.16.4 Perineal status** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Episiotomy reason – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other’ reason for episiotomy | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other’ for section **2.16.6 Episiotomy reason** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Non-perineal genital tract trauma type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of any non-perineal genital tract trauma | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Cervical laceration | 237090005 | | Labial graze or tear | 249221003 | | Vaginal laceration | 410062001 | |  |  | | | |
| **Obligation** | Mandatory if non-perineal genital tract trauma is present | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Repair required

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Perineal or genital tract trauma suturing or repair | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | 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 **2.16.4 Perineal status** | | |
| **Guide for use** | Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Placenta and membranes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the placenta complete | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Complete | 249170006 | | Incomplete | 268479002 | | Ragged membranes | 249182002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Placenta appearance

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the appearance of the placenta | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Normal | 289279004 | | Calcifications | 249174002 | | Fetus papyraceous | 90127001 | | Gritty | 249173008 | | Infarctions | 271403007 | | Oedematous | 56425003 | | Offensive | 289275005 | | Retroplacental clot | 249177009 | | Succenturiate lobe | 82664003 | | True knot in umbilical cord | 27696007 | | Velamentous insertion of cord | 77278008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Five instances of this field may be captured | | |
| **Verification rules** | Valid code only | | |

### Number of cord vessels

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Number of vessels identified in the umbilical cord | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | 2 or 3 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### Placenta kept by the woman

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

### Total blood loss

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated and/or measured total blood loss within two hours of the birth | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NNNN |
| **Value domain** | Millilitres | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | A value greater than zero | | |

## Newborn baby

This section collates information about the baby or babies 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** | |
| 2.17.1 | Birth – date and time | 2.17.19 | Neonatal resuscitation |
| 2.17.2 | Gestation at birth | 2.17.20 | Vitamin K |
| 2.17.3 | Birth outcome | 2.17.21 | Vitamin K administered – date and time |
| 2.17.4 | Mode of birth | 2.17.22 | Skin to skin |
| 2.17.5 | Presenting part of baby | 2.17.23 | Skin to skin start – date and time |
| 2.17.6 | Presenting part of baby – ‘Other’ – detail | 2.17.24 | Skin to skin end – date and time |
| 2.17.7 | Type of breech | 2.17.25 | Skin to skin – reason for end |
| 2.17.8 | Mode of breech birth | 2.17.26 | Skin to skin – reason for end – ‘Other reason’ – detail |
| 2.17.9 | Shoulder dystocia | 2.17.27 | Infant feeding method |
| 2.17.10 | Shoulder dystocia procedures | 2.17.28 | Breastfeeding start – date and time |
| 2.17.11 | Shoulder dystocia procedures – ‘Other manoeuvre’ – detail | 2.17.29 | Breastfeeding end – date and time |
| 2.17.12 | Cord blood sample | 2.17.30 | Newborn referral |
| 2.17.13 | Baby sex | 2.17.31 | Newborn referral – date |
| 2.17.14 | Birth weight | 2.17.32 | Reason for referral to specialist |
| 2.17.15 | Baby National Health Index number | 2.17.33 | Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) |
| 2.17.16 | Apgar 1 minute | 2.17.34 | Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time |
| 2.17.17 | Apgar 5 minutes | 2.17.35 | Discharge from Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time |
| 2.17.18 | Apgar 10 minutes |  |  |

### Birth – date and time

This element defines the date and time the baby was born. The format is set out in the common **Date and time value domain** specification. The data element is mandatory.

### Gestation at birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Gestation of the baby at birth | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NN:N |
| **Value domain** | Weeks and days | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | For example, a response of 38 weeks and 4 days would be recorded as 38:4 (WW:D) | | |
| **Verification rules** | Valid value only | | |

### Birth outcome

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Outcome of the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity outcomes reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72571000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72571000210108).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Live born | 281050002 | | Stillborn – antepartum | 44174001 | | Stillborn – indeterminate | 17766007 | | Stillborn – intrapartum | 1762004 | | Neonatal death | 276506001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the baby was born | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72581000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72581000210105).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Caesarean section | 200146002 | | Forceps | 200130005 | | Spontaneous vaginal birth | 48782003 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Presenting part of baby

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Presenting part of the baby at birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Breech | 6096002 | | Cephalic | 70028003 | | Compound | 124736009 | | Shoulder | 23954006 | | Other | 15028002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Presenting part of baby – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the type of ‘Other’ presenting part | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other’ for section **2.17.5 Presenting part of baby** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Type of breech

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of breech presentation | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Complete | 49168004 | | Extended (frank) | 18559007 | | Footling | 249097002 | | Kneeling | 249098007 | | Incomplete | 38049006 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Breech’ for section **2.17.5 Presenting part of baby** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Mode of breech birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Mode of the breech birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Assisted vaginal breech | 71711000210102 | | Caesarean section | 712654009 | | Spontaneous vaginal breech | 271373005 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Breech’ for section **2.17.5 Presenting part of baby** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Shoulder dystocia

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

### Shoulder dystocia procedures

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Procedures required to deliver the baby during the shoulder dystocia | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Delivery of posterior arm | 237012001 | | Internal manoeuvres (Rubin’s II/Wood’s screw/Reverse Wood’s screw) | 237011008 | | Maternal position change | 229824005 | | McRoberts’ position | 237009004 | | Suprapubic pressure (Rubin’s I) | 237010009 | | Other manoeuvre | 237008007 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section **2.17.9 Shoulder dystocia** | | |
| **Guide for use** | Six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Shoulder dystocia procedures – ‘Other manoeuvre’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the type of ‘Other manoeuvre’ | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other manoeuvre’ for section **2.17.10 Shoulder dystocia procedures** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Cord blood sample

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of the cord blood tests taken, if any | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity screening and tests reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72641000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72641000210104).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Blood group type and antibodies | 20099001 | | pH | 81065003 | | Lactate | 270982000 | | Laboratory test not necessary | 165330008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Baby sex

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Baby sex | | |
| **Source standards** | HISO 10046 Consumer Health Identity Standard, section 2.4 Gender  [https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard](file:///D:\Work\2019\Maternity\www.health.govt.nz\publication\hiso-10046-consumer-health-identity-standard) | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | A |
| **Value domain** | M – Male  F – Female  I – Indeterminate | | |
| **Obligation** | Mandatory  This value is to be obtained from the NHI system. This will require knowledge of the baby’s NHI number, as the number is the access key to the correct record – see section **2.17.15 Baby National Health Index number**  Currently, the NHI does not record a value for sex. However, it does populate a gender field with a sex value. The Ministry is planning a change to rectify this situation | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Birth weight

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Weight of the baby at birth (or the earliest weight recorded) | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | 4 | **Representational layout** | NNNN |
| **Value domain** | Grams | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer | | |

### Baby National Health Index number

The baby’s NHI number is to be obtained from the NHI system. The source of this information is described in section **2.1 Personal information**.

### Apgar 1 minute

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Apgar score the baby received at 1 minute of age | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity Apgar score reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Apgar score 0 at 1 minute | 169896003 | | Apgar score 1 at 1 minute | 169897007 | | Apgar score 2 at 1 minute | 169898002 | | Apgar score 3 at 1 minute | 169899005 | | Apgar score 4 at 1 minute | 169901001 | | Apgar score 5 at 1 minute | 169902008 | | Apgar score 6 at 1 minute | 169903003 | | Apgar score 7 at 1 minute | 169904009 | | Apgar score 8 at 1 minute | 169905005 | | Apgar score 9 at 1 minute | 169906006 | | Apgar score 10 at 1 minute | 169907002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **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 | | |

### Apgar 5 minutes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Apgar score the baby received at 5 minutes of age | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity Apgar score reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Apgar score 0 at 5 minutes | 169910009 | | Apgar score 1 at 5 minutes | 169911008 | | Apgar score 2 at 5 minutes | 169912001 | | Apgar score 3 at 5 minutes | 169913006 | | Apgar score 4 at 5 minutes | 169914000 | | Apgar score 5 at 5 minutes | 169915004 | | Apgar score 6 at 5 minutes | 169916003 | | Apgar score 7 at 5 minutes | 169917007 | | Apgar score 8 at 5 minutes | 169918002 | | Apgar score 9 at 5 minutes | 169919005 | | Apgar score 10 at 5 minutes | 169920004 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **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 | | |

### Apgar 10 minutes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Apgar score the baby received at 10 minutes of age | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity Apgar score reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Apgar score 0 at 10 minutes | 169923002 | | Apgar score 1 at 10 minutes | 169924008 | | Apgar score 2 at 10 minutes | 169925009 | | Apgar score 3 at 10 minutes | 169926005 | | Apgar score 4 at 10 minutes | 169927001 | | Apgar score 5 at 10 minutes | 169928006 | | Apgar score 6 at 10 minutes | 169929003 | | Apgar score 7 at 10 minutes | 169930008 | | Apgar score 8 at 10 minutes | 169931007 | | Apgar score 9 at 10 minutes | 169932000 | | Apgar score 10 at 10 minutes | 169933005 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **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 | | |

### Neonatal resuscitation

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Requirement for neonatal resuscitation, including the outcome | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity outcomes reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72571000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72571000210108).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Not performed | 71761000210100 | | Successful | 71741000210101 | | Unsuccessful | 71751000210103 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Vitamin K

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Prophylactic Vitamin K administration, including the route of administration | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Intramuscular | 736388004 | | Oral | 698350008 | | Declined | 15651391000119108 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Vitamin K administered – date and time

This element defines the date and time Vitamin K was administered. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘Intramuscular’ or ‘Oral’ for section **2.17.20 Vitamin K**.

### Skin to skin

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the baby receive skin-to-skin contact between baby and mother at the birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Skin to skin start – date and time

This element defines the start date and time of skin-to-skin contact. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘1 – Yes’ to section **2.17.22 Skin to skin**.

### Skin to skin end – date and time

This element defines the end date and time of skin-to-skin contact. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘1 – Yes’ to section **2.17.22 Skin to skin** and must be greater than the value recorded in section **2.17.23 Skin to skin start – date and time**.

### Skin to skin – reason for end

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason why initial skin-to-skin contact was ended | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | One hour or more skin-to-skin contact had been achieved | 1 | | Maternal request | 2 | | Health professional decision | 3 | | Medical reason | 4 | | Other reason | 5 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section **2.17.22 Skin to skin** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Skin to skin – reason for end – ‘Other reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of the ‘Other reason’ that the skin-to-skin time ended | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other reason – 5’ for section **2.17.25 Skin to skin – reason for end** | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

### Infant feeding method

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method by which the baby was first fed after the birth | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | |  |  | | --- | --- | |  |  | | **Agreed term** | **Code** | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | 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’) | 2 | | 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’) | 3 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 4 | | Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 5 | | Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’) | 6 | | Parenteral nutrition | 7 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Breastfeeding start – date and time

This element defines the date and time that breastfeeding was initiated after birth. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on any response other than ‘Infant formula’ (option 6) or ‘Parenteral nutrition’ (option 7) to section **2.17.27 Infant feeding method**.

### Breastfeeding end – date and time

This element defines the date and time the initial breastfeed ended after the birth. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a valid response to section **2.17.28 Breastfeeding start – date and time**. The element must be a date and time greater than the value specified in section **2.17.28 Breastfeeding start – date and time**.

### Newborn referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral of the baby to a specialist in the immediate post-birth period | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Newborn referral – date

This element defines the referral date. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a ‘1 – Yes’ response to section **2.17.30 Newborn referral**, where the woman chose to attend the specialist appointment.

### Reason for referral to specialist

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason for a referral to a specialist in the immediate post-birth period | | |
| **Source standards** | *Guidelines for Consultation with Obstetric and Related Medical Services*:  https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///D:\Work\2019\Maternity\www.health.govt.nz\publication\guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines)  See Table 2: Conditions and referral categories | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services* | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section **2.17.30 Newborn referral** | | |
| **Guide for use** | The Ministry is currently updating the list in Table 2 to provide SNOMED codes  10 instances for this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Admission to Neonatal Intensive Care Unit (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** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Yes, but kept in paediatric care on a postnatal ward | 3 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time

This element defines the date and time the baby was admitted to a NICU or SCBU. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response other than ‘No – 1’ to section **2.17.33 Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)**.

### Discharge from Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time

This element defines the date and time the baby was discharged from a NICU or SCBU. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response other than ‘No – 1’ to section **2.17.33 Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)**.

The date must be greater than or equal to that recorded in section **2.17.34 Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time**.

## Postnatal baby

This section collates the postnatal information about the baby or babies resulting from the birth. The information is collected throughout the six weeks following the birth and should be summarised at the end of the postnatal period. There is one set of coded entries per baby born.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.18.1 | Maternity facility discharge – date and time | 2.18.14 | Infant feeding at discharge from LMC |
| 2.18.2 | Infant feeding on discharge from facility | 2.18.15 | Neonatal referral |
| 2.18.3 | Baby safe sleep information | 2.18.16 | Neonatal referral code |
| 2.18.4 | Baby sleep environment | 2.18.17 | Neonatal referral – date |
| 2.18.5 | Red eye reflex screening – right eye | 2.18.18 | Neonatal admission |
| 2.18.6 | Red eye reflex screening (right eye) – date | 2.18.19 | Neonatal admission – date and time |
| 2.18.7 | Red eye reflex screening – left eye | 2.18.20 | Well Child provider referral |
| 2.18.8 | Red eye reflex screening (left eye) – date | 2.18.21 | Well Child provider |
| 2.18.9 | Metabolic screening | 2.18.22 | Well Child provider referral – date |
| 2.18.10 | Newborn hearing screening | 2.18.23 | General practice referral |
| 2.18.11 | Infant feeding | 2.18.24 | General practice referral – date |
| 2.18.12 | Infant feeding at 48 hours | 2.18.25 | Neonatal death |
| 2.18.13 | Infant feeding at two weeks |  |  |

### Maternity facility discharge – date and time

This element defines the date and time the baby was discharged from a maternity facility, if admitted to a facility. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on the baby’s admission to a maternity facility.

### 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** | 2 | **Representational layout** | NN |
| **Value domain** | |  |  | | --- | --- | |  | | | **Agreed term** | **Code** | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | 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’) | 2 | | 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’) | 3 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 4 | | Donor breast milk, fed via syringe, cup, spoon, 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’) | 8 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Baby safe sleep information

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Provision of safe sleep information to the parents | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Baby sleep environment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Assessment of the baby’s sleep environment for safety | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Red eye reflex screening – right eye

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Result of the baby’s red eye reflex screening test – right eye | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Normal | 43408002 | | Abnormal | 247079003 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Red eye reflex screening (right eye) – date

This element defines the date the red eye reflex screening (right eye) was undertaken. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on any response other than ‘Not completed’ to section **2.18.5 Red eye reflex screening – right eye**.

### Red eye reflex screening – left eye

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Result of the baby’s red eye reflex screening test – left eye | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Normal | 43408002 | | Abnormal | 247079003 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Red eye reflex screening (left eye) – date

This element defines the date the red eye reflex screening (left eye) was undertaken. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on any response other than ‘Not completed’ to section **2.18.7 Red eye reflex screening – left eye**

### Metabolic screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Result of the baby’s newborn metabolic screening test (also known as the heel prick or Guthrie test) | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Normal | 17621005 | | Abnormal | 263654008 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Newborn hearing screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Result of the baby’s newborn hearing screening | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Pass | 91651000210102 | | Pass surveillance required | 91661000210104 | | Referral needed | 91671000210105 | | Screening declined | 11911000175100 | | Did not attend/lost contact | 281399006 | | Unsuitable for screening – medical | 702371008 | | Missed (older than three months) (SNOMED CT term: ‘Procedure not done’) | 101521000210100 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Infant feeding

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the baby ever fed at the mother’s breast | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Infant feeding at 48 hours

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method by which the baby was being fed at 48 hours of age | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | |  |  | | --- | --- | |  | | | **Agreed term** | **Code** | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | 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’) | 2 | | 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’) | 3 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 4 | | Donor breast milk, fed via syringe, cup, spoon, 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 fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘partially breastfed’) | 7 | | Infant formula, fed via bottle (‘artificially fed’) Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’) | 8 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Infant feeding at two weeks

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method by which the baby was being fed at two weeks of age | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 2 | **Representational layout** | NN |
| **Value domain** | |  |  | | --- | --- | |  | | | **Agreed term** | **Code** | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | Expressed breast milk from the mother’s breast, fed via bottle or nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 2 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 3 | | Donor breast milk, fed via bottle or nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 4 | | 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’) | 5 | | Mixed feeding, where the infant has taken a mixture of breast milk and infant formula, fed via bottle, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘partially breastfed’) | 6 | | Infant formula, fed via bottle (‘artificially fed’) | 7 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Infant feeding at discharge from LMC

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | 2 | **Representational layout** | NN |
| **Value domain** | |  |  | | --- | --- | |  | | | **Agreed term** | **Code** | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | Expressed breast milk from the mother’s breast, fed via supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 2 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 3 | | Donor breast milk, fed via bottle or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 4 | | 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’) | 5 | | Mixed feeding, where the infant has taken a mixture of breast milk and infant formula, fed via bottle or supplemental nursing system (SNS) tube (‘partially breastfed’) | 6 | | Infant formula, fed via bottle (‘artificially fed’) | 7 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Neonatal referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral of the baby to a specialist during the six weeks following the birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Neonatal referral code

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Unique referral code | | |
| **Source standards** | *Guidelines for Consultation with Obstetric and Related Medical Services*:  https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///D:\Work\2019\Maternity\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** | 4 | **Representational layout** | N(4) |
| **Value domain** | Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services* | | |
| **Obligation** | Mandatory on a ‘1 – Yes’ response to section **2.18.15 Neonatal referral** | | |
| **Guide for use** | The Ministry is currently updating the list in Table 2 to provide SNOMED codes | | |
| **Verification rules** | Valid code only | | |

### Neonatal referral – date

This element defines the referral date. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response of ‘1 – Yes’ to section **2.18.15 Neonatal referral**.

### Neonatal admission

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Neonatal admissions to a facility at any time in the six weeks following the birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Neonatal admission – date and time

This element defines the date and time of a neonatal admission. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response of ‘1 – Yes’ to section **2.18.18 Neonatal admission**.

### Well Child provider referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral of the baby to a Well Child provider | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Yes | 1 | | No | 2 | | Declined | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Well Child provider

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Well Child provider referred to | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | General practice | 788007007 | | Māori provider | 54421000210104 | | Pasifika provider | 91581000210106 | | Plunket | 91591000210108 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Yes – 1’ for section **2.18.20 Well Child provider referral** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Well Child provider referral – date

This element defines the date a notification was sent to a Well Child provider. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory on a response of ‘Yes – 1’ for section **2.18.20 Well Child provider referral.**

### General practice referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral of the baby to general practice | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **Code** | | Yes | 1 | | No | 2 | | Declined | 3 | |  |  | | | |
| **Obligation** | Mandatory if ‘General practice’ was not selected in section **2.18.21 Well Child provider.** | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### General practice referral – date

This element defines the date and time a notification was sent to general practice. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘Yes – 1’ to section **2.18.23 General practice referral.**

### Neonatal death

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Death of the baby during the 28 days after the birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Postnatal woman

This section collates postnatal information about the woman. The information is collected throughout the six weeks following the birth and should be summarised at the end of the postnatal period.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.19.1 | Maternity facility discharge – date and time | 2.19.12 | Family violence screening |
| 2.19.2 | Postnatal complications | 2.19.13 | Current alcohol consumption |
| 2.19.3 | Postnatal referrals | 2.19.14 | Current smoking status |
| 2.19.4 | Postnatal referral – date | 2.19.15 | Current vaping status |
| 2.19.5 | Postnatal admissions | 2.19.16 | Current drug use |
| 2.19.6 | Postnatal admission – date and time | 2.19.17 | Drugs used |
| 2.19.7 | Postnatal discharge – date and time | 2.19.18 | Drugs used – ‘Other’ – detail |
| 2.19.8 | Contraception | 2.19.19 | Postnatal visits |
| 2.19.9 | Postnatal prescriptions | 2.19.20 | General practice notification |
| 2.19.10 | Postnatal complementary therapies | 2.19.21 | Maternal death |
| 2.19.11 | Postnatal complementary therapies – date |  |  |

### Maternity facility discharge – date and time

This element defines 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.

The format is set out in the common **Date and time value domain** specification. The data element is mandatory on admission to a maternity facility.

### Postnatal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced during the six weeks after the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity complication reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72601000210102).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Breast infection | 198108005 | | Breastfeeding issues | 289084000 | | Hypertensive disorder | 40521000119100 | | Other | 198609003 | | Other infection | 40733004 | | Postnatal depression | 58703003 | | Postnatal distress | 300894000 | | Postpartum hysterectomy | 860602007 | | Postpartum psychosis | 18260003 | | Secondary postpartum haemorrhage | 23171006 | | Thromboembolism | 371039008 | | Urinary tract infection | 68566005 | | Uterine infection | 301775005 | | Wound infection | 76844004 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Postnatal referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Referral to specialist services during the six weeks after the birth | | |
| **Source standards** | *Guidelines for Consultation with Obstetric and Related Medical Services*:  https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///D:\Work\2019\Maternity\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** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The list of codes in Table 2 from the above source can guide the Yes/No response  The Ministry is currently updating the list in Table 2 to provide SNOMED codes | | |
| **Verification rules** | Valid code only | | |

### Postnatal referral – date

This element defines the date the woman was referred in the postnatal period. The format is set out in the common **Date and time value domain** specification.

The data element is Mandatory upon a ‘1 – Yes’ response to section **2.19.3 Postnatal referrals**, where the woman chose to attend the specialist appointment.

### Postnatal admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Postnatal admissions to a facility in the six weeks after the birth | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Postnatal admission – date and time

This element defines the date and time the woman was postnatally admitted to a facility. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘1 – Yes’ to section **2.19.5 Postnatal admissions**.

### Postnatal discharge – date and time

This element defines the date and time the woman was discharged from a postnatal facility. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory on a response of ‘1 – Yes’ to section **2.19.5 Postnatal admissions.** The date must be greater than or equal to that recorded in section **2.19.6 Postnatal admission – date and time**.

### Contraception

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of contraception supplied to the woman in the six weeks after the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Barrier contraceptive | 225370004 | | Contraceptive implant | 860691008 | | Declined contraception | 406149000 | | Injectable contraceptive | 268464009 | | Intrauterine contraceptive device (IUCD) | 312081001 | | Oral contraceptive | 5935008 | | Other method | 13197004 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Postnatal prescriptions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | 2 | **Representational layout** | NN |
| **Value domain** | 00–99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Postnatal complementary therapies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complementary therapies used by the woman in the six weeks after the birth | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity complementary therapies reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72631000210107).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Chiropractic | 182548004 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Lactation support | 408883002 | | Massage | 387854002 | | Naturopathy | 439809005 | | Rongoā Māori | 789789009 | | Osteopathy | 182549007 | | Other | 225423004 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | 10 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Postnatal complementary therapies – date

This element defines the date a complementary therapy was administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response to section **2.19.10 Postnatal complementary therapies**.

### Family violence screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the woman was screened postnatally for family violence | | |
| **Source standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | 1 | **Representational layout** | N |
| **Value domain** | |  |  | | --- | --- | |  | | | **Agreed term** | **Code** | | No | 1 | | Yes | 2 | | Declined | 3 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Current alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current alcohol consumption | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand alcohol consumption reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Does not drink alcohol | 105542008 | | Current drinker | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.13.20 Current alcohol consumption**, as this section records status at the end of the postnatal period | | |
| **Verification rules** | Valid code only | | |

### Current smoking status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of tobacco | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Current smoker | 77176002 | | Current non-smoker | 160618006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.13.23 Current smoking** **status**, as this section records status at the end of the postnatal period  Three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Current vaping status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of a vaping device | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand vaping status reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Trying to give up vaping | 1137691001 | | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Three instances of this field may be recorded  The information collected for this section is distinct from that collected for section **2.13.24 Current vaping status**, as this section records status at the end of the postnatal period | | |
| **Verification rules** | Valid code only | | |

### Current drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s current use of illegal drugs | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug use reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Does not misuse drugs | 228367002 | | Current drug user | 417284009 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.9.6 History of drug use**, as this section records status at the end of the postnatal period | | |
| **Verification rules** | Valid code only | | |

### Drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Illegal drugs the woman is currently using | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | **Representational class** | Code |
| **Field size** | 18 | **Representational layout** | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand non-medicinal drug reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108).   |  |  | | --- | --- | | **Agreed term** | **SCTID** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Drug or medicament | 410942007 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other | 74964007 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Current drug user’ to section **2.19.16 Current drug use** | | |
| **Guide for use** | The information collected for this section is distinct from that collected for section **2.9.7 Current drugs used**, as this section records status at the end of the postnatal period | | |
| **Verification rules** | Valid code only | | |

### Drugs used – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of ‘Other’ drugs currently in use | | |
| **Source standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | 1000 | **Representational layout** | X(1000) |
| **Value domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section **2.19.17 Drugs used** | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance of use identified in section **2.19.17 Drugs used.** | | |
| **Verification rules** |  | | |

### Postnatal visits

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | 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** | 2 | **Representational layout** | NN |
| **Value domain** | 00–99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### General practice notification

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Notification of the birth event sent to the woman’s general practice | | |
| **Source standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | 1 | **Representational layout** | N(1,0) |
| **Value domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### 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** | 1 | **Representational layout** | N(1,0) |
| **Value 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  ‘Maternal death’ does not include accidental or incidental causes of death of a pregnant woman | | |
| **Verification rules** | Valid code only | | |

1. See <https://standards.iso.org/ittf/PubliclyAvailableStandards/index.html> [↑](#footnote-ref-2)