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PAEREWA PĀRONGO HAUORA

Te Whatu Ora
Health New Zealand

Maternity Care Summary Standard

HISO 10050:2023

Released 2023

Te Kāwanatanga o Aotearoa
New Zealand Government

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Te Whatu Ora
Health New Zealand

This document is available at **tewhatuora.govt.nz**

Contents

1 Introduction

1.1 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 pregnant people, 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 seamless care provision.

1.2 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 person and includes administrative and clinical information about their 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. Te Whatu Ora - Health New Zealand 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Care Summary Standard supersedes HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which is now withdrawn.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.

1.3 New Zealand legislation

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

- **Health Act 1956**
- **Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996**
- **Health Information Privacy Code 2020**
- **Health Practitioners Competence Assurance Act 2003**
- **New Zealand Public Health and Disability Act 2000**
- **Pae Ora (Healthy Futures) Act 2022**
- **Privacy Act 2020**
- **Public Records Act 2005**
- **Retention of Health Information Regulations 1996**.
- **Abortion Legislation Act 2020**

1.4 Supporting Te Pae Tata | Interim New Zealand Health Plan 2022

Te Pae Tata | interim New Zealand Health Plan 2022 (Te Pae Tata) sets out the first two years of action for Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Maori Health Authority as healthcare is transformed in Aotearoa New Zealand. Te Pae Tata outlines the first steps to build the foundations of a sustainable affordable and unified health system that better serves all of Aotearoa's people and communities.

One of Te Pae Tata's six priority actions is to place Whānau at the heart of the system to improve equity and outcomes with a specific focus on Kahu Taurima | Maternity and early years. The Maternity Care Summary Standard will support the goals of the Kahu Taurima Programme of having integrated services by enabling maternity and Well Child service providers to collect, share and report robust standardised data for the people in their care.

Another of Te Pae Tata's priorities is to develop greater use of digital services to provide more care in homes and communities. High quality and consistent maternity information that can be shared between community and hospital providers will support the seamless provision of care and improve health outcomes.

1.5 Related specifications

Te Whatu Ora-Health New Zealand used or referenced the following documents to develop this standard:

- **HISO 10046:2022 Consumer Health Identity Standard**
- **HISO 10005:2008 Health Practitioner Index (HPI) Data Set**
- **HISO 10006:2008 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. A copy of the revised draft standard can be requested from standards@health.govt.nz.

- **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** 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.

1.6 Acknowledgement of gender diversity

Te Whatu Ora – Health New Zealand acknowledge that not all people who become pregnant identify as women or female. Gender neutral terms are included alongside gendered terms where possible in this standard in an effort to ensure greater inclusion and representation. There are clinical maternity related coding terms that use female gendered language in this standard and we have limited ability to change these in the short term. Te Whatu Ora – Health New Zealand will continue work to ensure our standards are more inclusive for the people they are relevant to.

Health professionals and those involved in the care of pregnant people should ensure they know the pronouns and name each person uses so that these are used correctly and documented in their records.

1.7 Data element template

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

Data element format

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**. Where there are many member concepts, a reference set		

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

	is published in the **SNOMED NZ Edition**, available from the **SNOMED Member Licensing and Distribution Service**. 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		

2 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/person's individual data, those involved in health care provision (people, organisations, facilities) and the woman/person's medicines.

2.1 Personal information

Personal information related to the woman/person 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.**

The following data elements relate to the woman/person (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
Gender
Ethnicity
Address information
Language
Contact information

2.2 Health care provider information

This section specifies the health care provider information that is related to this 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**
- **HISO 10006:2008 Health Practitioner Index (HPI) Code Set**.

An update of these standards (HISO 10045 Health Provider Identity Standard) is currently underway and has been referred to in this document. A copy of the revised draft standard can be requested from standards@health.govt.nz.

The following data elements relate to the woman/person 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

2.3 Medicines information

This section covers medicine information directly related to the woman/person and baby or babies.

Specific medication information about a woman/person 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**
- use the NZePS application programming interface (API)
- be available on request to Standards@health.govt.nz
- use the **New Zealand Universal List of Medicines (NZULM) and New Zealand Formulary (NZF)**
- conform to **HISO 10030.1:2008 Electronic Pharmaceutical Business Process Standard**
- conform to **HISO 10042 Medication Charting and Medicine Reconciliation Standards**
- conform to New Zealand prescribing guidelines in the Medicines Regulations 1984

2.4 Booking information

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

2.4.1 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** (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		

2.4.2 Method of assisted reproduction

Definition	Method of assisted reproduction if conception occurred via 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** (72591000210107) **Agreed term** / **SCTID** Hormonal stimulation / 71841000210107 Intrauterine insemination (IUI) / 71851000210105 In vitro fertilisation (IVF) / 10231000132102 Other / 71861000210108		
Obligation	Mandatory if assisted reproduction occurred		
Guide for use	Three instances of this field may be recorded		

Verification rules	Valid code only

2.4.3 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 **Method of assisted reproduction**.		
Guide for use			
Verification rules			

2.4.4 Gravida

Definition	Total number of times the woman/person 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, someone who has had one prior pregnancy and is currently pregnant is designated Gravida 2 (G2) This value may be derived from previous pregnancy records or be provided by the woman/person If the number is self-reported it may not be accurate, as the woman/person may not know or wish to disclose the full number		
Verification rules	Valid value only		

2.4.5 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 value may be derived from previous pregnancy records or be provided by the woman/person If the number is self-reported it may not be accurate, as the woman/person may not wish to disclose the full number		
Verification rules	A value less than or equal to the value reported in **Gravida** is required		

2.4.6 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/person recalling the date, and may not be accurate		
Verification rules	A valid date that is less than or equal to the current date		

2.4.7 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 **Last menstrual period**.		
Guide for use			
Verification rules	A valid future date		

2.4.8 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		

2.4.9 Agreed estimated due date

Definition	Estimated due date as agreed by the woman/person 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

2.4.10 Height

Definition	Measured height		
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		

2.4.11 Weight

Definition	Pre-pregnancy weight		
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 during this pregnancy Record weight to one decimal place		
Verification rules	A value greater than zero		

2.4.12 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 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		

2.4.13 Lead Maternity Carer (LMC) 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 if the woman/person is registered with an LMC during the pregnancy, labour and birth, or postnatal period		

Guide for use	
Verification rules	Valid code only

2.4.14 Planned place of birth

Definition	Place or facility where the woman/person plans to give 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** (72591000210107)		

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

2.4.15 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 **Planned place of birth.**		

Guide for use	
Verification rules	

2.4.16 Planned place of birth – facility

This element provides the planned place of birth facility detail. The information to be recorded must be the facility identifier. See section **2.2 Health care provider information.**

The data element is mandatory upon any response other than 'Home' or 'Other' to section **2.4.14 Planned place of birth.**

2.5 Previous pregnancies

This section covers information about the woman/person's obstetric history. Information is collected at the first full contact the woman/person 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.

2.5.1 Previous miscarriage

<table>
<tr><td>Definition</td><td colspan="3">Miscarriages (if known)</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous outcomes reference set</u> (72511000210104)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Ectopic pregnancy</td><td>161763005</td></tr>
<tr><td>First trimester miscarriage</td><td>91621000210106</td></tr>
<tr><td>Molar pregnancy</td><td>16216821000119102</td></tr>
<tr><td>Second trimester miscarriage</td><td>71561000210105</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
</table>

Obligation	Optional
Guide for use	One code may be recorded for each previous miscarriage
Verification rules	Valid code only

2.5.2 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.

2.5.3 Previous termination

<table>
<tr><td>Definition</td><td colspan="3">Terminations (if known)</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td><u>Medical termination of pregnancy</u></td><td>412758008</td></tr><tr><td>Surgical termination of pregnancy</td><td>71571000210104</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a termination having occurred</td></tr>
<tr><td>Guide for use</td><td colspan="3">A code is to be recorded for each termination</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.4 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.

2.5.5 Termination reason

<table>
<tr><td>Definition</td><td colspan="3">Reason(s) a previous pregnancy was terminated</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Congenital anomaly of fetus</td><td>72161000210106</td></tr>
<tr><td>Chromosomal anomaly

(SNOMED CT term: ‘History of fetus with chromosomal abnormality’)</td><td>71871000210102</td></tr>
<tr><td>Unplanned pregnancy</td><td>71881000210100</td></tr>
<tr><td>Other medical or social reason</td><td>417662000</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response to Previous termination</td></tr>
<tr><td>Guide for use</td><td colspan="3">One response should be recorded for each instance identified in section 2.5.3 Previous termination.</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.6 Termination reason – other 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 **Termination reason**.		
Guide for use			
Verification rules			

2.5.7 Maternal antenatal complications in previous pregnancy

Definition	Complications during any 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 complications reference set** (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

	<table><tr><td>Infection</td><td>161413004</td></tr><tr><td>Obstetric cholestasis</td><td>16216781000119107</td></tr><tr><td>Placental abruption</td><td>789776003</td></tr><tr><td>Pre–eclampsia</td><td>105651000119100</td></tr><tr><td>Preterm labour</td><td>441493008</td></tr><tr><td>Preterm birth</td><td>161765003</td></tr><tr><td>Small for gestational age fetus (SGA)</td><td>726565008</td></tr><tr><td>Other complication occurring during pregnancy</td><td>91461000210102</td></tr><tr><td></td><td></td></tr></table>
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

2.5.8 Maternal complication – other detail

Definition	Detail of the ‘Other complication’ that occurred during a previous 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 **Maternal antenatal complications in previous pregnancy**.		
Guide for use			
Verification rules			

2.5.9 Onset of labour in previous pregnancies

Definition	Onset of labour 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 findings reference set** (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 **2.4.5 Parity.**
Guide for use	
Verification rules	Valid code only

2.5.10 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** (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 **Onset of labour in previous pregnancies**.
Guide for use	
Verification rules	Valid code only

2.5.11 Induction reason – other 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 **Induction reason.**		
Guide for use			
Verification rules			

2.5.12 Length of previous labours

Definition	Length of previous labours		
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 **Onset of labour in previous pregnancies**.		
Guide for use	This value is provided by previous pregnancy records (if held) or by the woman/person		
Verification rules	Valid value only		

2.5.13 Maternal complications in previous labours

<table>
<tr><td>Definition</td><td colspan="3">Complications in previous labours</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous complications reference set</u> (72541000210103)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No previous complications</td><td>443508001</td></tr>
<tr><td>Third-degree perineal tear</td><td>725941005</td></tr>
<tr><td>Fourth-degree perineal tear</td><td>725942003</td></tr>
<tr><td>Hypertension</td><td>161501007</td></tr>
<tr><td>Infection</td><td>71921000210105</td></tr>
<tr><td>Intrapartum haemorrhage</td><td>71931000210107</td></tr>
<tr><td>Obstructed labour</td><td>71941000210104</td></tr>
<tr><td>Prolonged first stage of labour</td><td>71951000210101</td></tr>
<tr><td>Prolonged ruptured membranes</td><td>71971000210109</td></tr>
<tr><td>Prolonged second stage of labour</td><td>71961000210103</td></tr>
<tr><td>Other labour finding</td><td>1156096005</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">A minimum of one code is to be selected and recorded for each previous birth</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.14 Maternal complications in previous labours – other labour finding 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 labour finding' for **Maternal complications in previous labours**.		
Guide for use			
Verification rules			

2.5.15 Mode of birth

Definition	Previous baby or babies mode 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 previous mode of delivery reference set** (72521000210109)		

Agreed term	SCTID
Caesarean section	161805006
Forceps	161813007
Spontaneous vaginal birth (cephalic)	263411000210106
Spontaneous vaginal birth (breech)	263401000210109
Vacuum extraction	726624001

Obligation	Mandatory on a response greater than zero to section **2.4.5 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

2.5.16 Type of Caesarean section

Definition	Type of Caesarean section incision 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** (72501000210101)		

Agreed term	SCTID
Classical Caesarean section	71581000210102
Lower uterine segment Caesarean section (LUSCS)	71591000210100
Unknown (SNOMED CT term: 'No known procedures')	787480003

Obligation	Mandatory on a response of 'Caesarean section' to **Mode of birth**.
Guide for use	
Verification rules	Valid code only

2.5.17 Indications for planned Caesarean section

Definition	Clinical indication for performing a planned Caesarean section as an elective procedure prior to labour commencing

<table>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Breech presentation</td><td>72031000210101</td></tr>
<tr><td>Congenital anomaly</td><td>161572004</td></tr>
<tr><td>Chromosomal anomaly</td><td>71871000210102</td></tr>
<tr><td>Medical or obstetric complication

(SNOMED CT term: ‘History of complication in pregnancy’)</td><td>91461000210102</td></tr>
<tr><td>Maternal request</td><td>720266003</td></tr>
<tr><td>Previous third-degree perineal tear</td><td>725941005</td></tr>
<tr><td>Previous fourth-degree perineal tear</td><td>725942003</td></tr>
<tr><td>Previous caesarean section</td><td>161805006</td></tr>
<tr><td>Transverse lie</td><td>72041000210109</td></tr>
<tr><td>Unstable lie</td><td>72051000210107</td></tr>
<tr><td>Other malpresentation</td><td>72001000210106</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Caesarean section’ to Mode of birth.</td></tr>
<tr><td>Guide for use</td><td colspan="3">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</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.18 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 **Indications for planned Caesarean section**.		
Guide for use			
Verification rules			

2.5.19 Indications for unplanned Caesarean section

Definition	Clinical indication for performing an unplanned Caesarean section during labour, either latent or established		
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** (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 Seizure: 72091000210100
Obligation	Mandatory on a response of ‘Caesarean section’ to **Mode of birth.**
Guide for use	Eight instances of this field may be recorded
Verification rules	Valid code only

2.5.20 Previous labour analgesia

Definition	Type of analgesia used 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 **2.4.5 Parity.**		
Guide for use	A minimum of one code is to be selected and recorded for each previous birth		
Verification rules	Valid code only		

2.5.21 Previous labour anaesthesia

Definition	Type of anaesthesia administered during previous labours
Source standards	

<table>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>No previous anaesthesia

(SNOMED CT term: ‘No history of procedure’)</td><td>416128008</td></tr><tr><td>Combined spinal/epidural</td><td>71601000210105</td></tr><tr><td>Epidural</td><td>71611000210107</td></tr><tr><td>General anaesthetic</td><td>71621000210102</td></tr><tr><td>Local anaesthetic</td><td>71631000210100</td></tr><tr><td>Pudendal block</td><td>71651000210106</td></tr><tr><td>Spinal</td><td>71641000210108</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">One code may be selected and recorded for each previous birth</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.22 Maternal complications immediately postpartum

<table>
<tr><td>Definition</td><td colspan="3">Complications in the first two to four hours following previous births</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous complications reference set</u> (72541000210103)</td></tr>
</table>

	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>No previous complications</td><td>72181000210103</td></tr><tr><td>Perineal haematoma</td><td>72111000210109</td></tr><tr><td>Postpartum haemorrhage (greater than 1000 mls or treated)</td><td>161809000</td></tr><tr><td>Retained placenta</td><td>725948004</td></tr><tr><td>Other</td><td>1156097001</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.6 Previous babies

This section covers information related to babies from previous pregnancies. It should be left blank unless the woman/person has previously given birth at 20 weeks gestation or later. This information should be collected at the first full contact the woman/person 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.

2.6.1 Outcome of previous 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** (72511000210104)		

	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Infant death</td><td>739682007</td></tr><tr><td>Live born</td><td>726001007</td></tr><tr><td>Neonatal death</td><td>726626004</td></tr><tr><td>Stillborn</td><td>161743003</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory where a previous birth has occurred
Guide for use	
Verification rules	Valid code only

2.6.2 Date of birth – previous babies

This element defines the date of birth of previous 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 babies.** It is to be recorded for each baby.

2.6.3 Antenatal fetal complications

Definition	Complications related to the fetus during 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 complications reference set** (72541000210103) <table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>None</td><td>443508001</td></tr><tr><td>Chromosomal anomaly</td><td>71871000210102</td></tr><tr><td>Congenital anomaly</td><td>161572004</td></tr><tr><td>Fetal growth abnormality</td><td>72121000210104</td></tr></table>		

	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

2.6.4 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 **Antenatal fetal complications**.		
Guide for use	One response is to be recorded for each identified 'Other' instance		
Verification rules			

2.6.5 Intrapartum fetal complications

Definition	Complications related to the fetus 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 complications reference set** (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

2.6.6 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 **Intrapartum fetal complications.**		
Guide for use	One response is to be recorded for each identified 'Other' instance		
Verification rules			

2.6.7 Mode of birth

Definition	How previous babies were born
Source standards	

<table>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous mode of delivery reference set</u> (72521000210109)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Caesarean section</td><td>394699000</td></tr><tr><td>Forceps</td><td>395681004</td></tr><tr><td>Spontaneous vaginal birth (cephalic)</td><td>395683001</td></tr><tr><td>Spontaneous vaginal birth (breech)</td><td>407613009</td></tr><tr><td>Vacuum extraction</td><td>407614003</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Three instances of this field may be recorded

This is to be reported in terms of spontaneity or assistance required</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.6.8 Gestation of previous babies

Definition	Gestational age of previous 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	This value is provided by previous pregnancy records (if held) or by the woman/person		

	If the value is self-reported it may not be accurate, as the woman/person may not know the exact gestation 20 instances of this field may be recorded
Verification rules	Valid value only

2.6.9 Gender of previous babies

Definition	Gender of previous 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 O – Another gender U – Unspecified or unknown		
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 **2.21.15 Baby National Health Index number**		
Verification rules	Valid code only		

2.6.10 Birth weight of previous babies

Definition	Birth weight of previous 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

2.6.11 Stillbirth cause

Definition	Causes of, or factors that contributed to, the stillbirth of a previous baby		
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 **Outcome of previous babies**.		
Guide for use			

2.6.12 Gestation at fetal demise

Definition	Gestational age of a previous baby at demise		
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 **Outcome of previous babies**.		
Guide for use	This value is provided by previous pregnancy records (if held) or by the woman/person If the value is self-reported it may not be accurate, as the woman/person may not know the exact gestation Record one instance of this field for each fetal demise		
Verification rules	Valid value only		

2.6.13 Neonatal complications

<table>
<tr><td>Definition</td><td colspan="3">Complications with the previous babies in the immediate postpartum period</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous complications reference set</u> (72541000210103)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>None</td><td>72201000210104</td></tr>
<tr><td>Fetal disorder caused by substance transmitted via placenta</td><td>285161000210104</td></tr>
<tr><td>Neonatal disorder caused by substance transmitted via breast milk</td><td>294671000210101</td></tr>
<tr><td>Hypoglycaemia</td><td>72221000210107</td></tr>
<tr><td>Large for gestational age</td><td>72241000210101</td></tr>
<tr><td>Low birth weight</td><td>37251000119108</td></tr>
<tr><td>Neonatal encephalopathy</td><td>72211000210102</td></tr>
<tr><td>Respiratory distress syndrome (RDS)</td><td>72251000210103</td></tr>
<tr><td>Small for gestational age (SGA)</td><td>726565008</td></tr>
<tr><td>Transient tachypnoea</td><td>72261000210100</td></tr>
<tr><td>Other</td><td>161579008</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">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</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.6.14 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 **Neonatal complications.**		
Guide for use	A response is to be recorded for each identified 'Other' instance		
Verification rules			

2.6.15 Neonatal care admissions

Definition	Indicates whether a previous baby 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	

2.6.16 Reason for admission to neonatal care

Definition	Reason a previous baby 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** (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
Fetal disorder caused by medicinal agent transmitted via placenta	284801000210106
Neonatal disorder caused by medicinal agent transmitted via breast milk	284811000210108

	<table><tr><td>Hypoglycaemia</td><td>72221000210107</td></tr><tr><td>Hypothermia</td><td>72291000210105</td></tr><tr><td>Infection</td><td>161413004</td></tr><tr><td>Jaundice</td><td>161536006</td></tr><tr><td>Late preterm infant (born between 32 weeks and 36 weeks plus 6 days)</td><td>72301000210109</td></tr><tr><td>Very preterm infant (born between 28 weeks and 31 weeks plus 6 days)</td><td>72311000210106</td></tr><tr><td>Respiratory distress syndrome (RDS)</td><td>72251000210103</td></tr><tr><td>Seizures</td><td>161583008</td></tr><tr><td>Weight loss</td><td>72321000210101</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory on a response other than ‘No, not needed’ for **Neonatal care admissions**.
Guide for use	10 instances of this field may be recorded
Verification rules	Valid code only

2.6.17 Feeding history

Definition	Feeding history of previous 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	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Exclusively breastfed</td><td>91711000210106</td></tr><tr><td>Fully breastfed</td><td>101611000210109</td></tr><tr><td>Partially breastfed</td><td>121491000210107</td></tr></table>		

	Artificially fed	101611000210109
Obligation	Mandatory on a response other than ‘Stillborn’ to **Outcome of previous babies**.	
Guide for use		
Verification rules	Valid code only	

2.6.18 Duration of breastfeeding

Definition	Number of months previous babies 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 **Outcome of previous babies**.		
Guide for use			
Verification rules	Valid value only		

2.6.19 Cause of death

Definition	Cause of death of a previous baby or child		
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 **Outcome of previous babies**.		
Guide for use			
Verification rules			

2.6.20 Date of death – previous babies

This element defines the date of death of a previous baby. 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 babies**. It is to be recorded for each baby.

2.7 Medical history

This section covers information related to the woman/person's medical 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/person 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.

2.7.1 Medical conditions

<table>
<tr><td>Definition</td><td colspan="3">Medical conditions</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No relevant medical history</td><td>443508001</td></tr>
<tr><td>Autoimmune disorder</td><td>72331000210104</td></tr>
<tr><td>Cardiac disorder</td><td>266995000</td></tr>
<tr><td>Congenital abnormality</td><td>161572004</td></tr>
<tr><td>Diabetes mellitus type 1</td><td>472970003</td></tr>
<tr><td>Diabetes mellitus type 2</td><td>472969004</td></tr>
<tr><td>Endocrine disorder</td><td>266990005</td></tr>
<tr><td>Gastrointestinal disorder</td><td>266997008</td></tr>
</table>
</td></tr>
</table>

	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

2.7.2 Medical conditions – other disorder 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			

2.8 Surgical history

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

2.8.1 Operations

<table>
<tr><td>Definition</td><td colspan="3">Type of previous operations</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No previous surgery

(SNOMED CT Term: 'No history of procedure')</td><td>416128008</td></tr>
<tr><td>Breast</td><td>71661000210109</td></tr>
<tr><td>Cone biopsy</td><td>108941000119102</td></tr>
<tr><td>Genital tract</td><td>71671000210103</td></tr>
<tr><td>Large loop excision of transformation zone (LLETZ/LEEP)</td><td>59251000119102</td></tr>
<tr><td>Uterine</td><td>133581000119103</td></tr>
<tr><td>Other</td><td>161615003</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Four instances of this field may be recorded</td></tr>
</table>

Verification rules	Valid code only

2.8.2 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 **2.8.1 Operations** section above. It is to be recorded for each operation.

2.8.3 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			

2.8.4 Previous anaesthetic

Definition	Types of anaesthetic previously administered, 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** (72501000210101)		

Agreed term	**SCTID**
General anaesthetic	71621000210102

	<table><tr><td>Local anaesthetic</td><td>71631000210100</td></tr><tr><td>Regional anaesthetic</td><td>131501000210104</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory on a response other than ‘No previous surgery’ for **Operations** within this section.
Guide for use	Three instances of this field may be recorded
Verification rules	Valid code only

2.8.5 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	2 – Unknown 1 – Yes 0 – No		
Obligation	Mandatory on a response to **Previous anaesthetic.**		
Guide for use			
Verification rules	Valid code only		

2.8.6 Anaesthetic complications – detail

Definition	Detail of anaesthetic complications, where a complication occurred during administration, or as a result of an anaesthetic		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text
Field size	1000	**Representational layout**	X(1000)
Value domain			

Obligation	Mandatory if there is a response of '1 – Yes' for **Anaesthetic complications.**
Guide for use	
Verification rules	

2.9 Gynaecological history

This section covers gynaecological history information. It records relevant current or past conditions to help recognise risk factors.

This information should be collected at the first full contact the woman/person 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.

2.9.1 Cervical smear status

Definition	Most recent cervical smear date (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	

2.9.2 Cervical smear results

Definition	Results from the 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** (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** other than:: a) 'Never had a smear' or b) 'Unknown'
Guide for use	
Verification rules	Valid code only

2.9.3 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** (72551000210100)

Agreed term	SCTID
None	704007002
Bacterial vaginosis	72381000210100
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

2.9.4 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** (72551000210100)		
Obligation	Mandatory		
Guide for use	16 instances of this field may be recorded		
Verification rules	Valid code only		

Agreed term	SCTID
None	443508001
Bacterial vaginosis	72381000210100
Bicornuate uterus	72391000210103
Endometriosis	72401000210100
Female genital mutilation (FGM)	715477006
Fibroids	72411000210103
Polycystic ovarian syndrome (PCOS)	72431000210105
Uterine anomalies	72451000210104
Vaginismus	72461000210101
Other gynaecological disorder	271902005
Unknown	396782006

2.9.5 Gynaecological history – procedures

<table>
<tr><td>Definition</td><td colspan="3">History of gynaecological procedures</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>None</td><td>416128008</td></tr>
<tr><td>Cone biopsy</td><td>108941000119102</td></tr>
<tr><td>Hysterotomy</td><td>275573000</td></tr>
<tr><td>Large loop excision of transformation zone (LLETZ/LEEP)</td><td>59251000119102</td></tr>
<tr><td>Myomectomy</td><td>275574006</td></tr>
<tr><td>Other uterine surgery</td><td>133581000119103</td></tr>
<tr><td>Unknown</td><td>787480003</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">16 instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.10 Mental health history

This section covers information related to the woman/person's mental health history. If the woman/person has had previous mental health issues, they are more likely to experience issues again during pregnancy or in the year following birth. It records relevant current or past conditions to help recognise risk factors.

This information should be collected at the first full contact the woman/person 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.

2.10.1 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		

2.10.2 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		

2.10.3 Serious mental illness treatment

Definition	Detail of pharmacological treatment or talking therapies for serious mental illness in the past		
Source standards			
Data type	Alphanumeric	**Representational class**	Free text

Field size	1000	**Representational layout**	X(1000)
Value domain			
Obligation	Mandatory if there is a history of treatment for serious mental illness noted		
Guide for use			
Verification rules	Valid code only		

2.11 Allergies and adverse reactions

This section records any allergies and adverse reactions the woman/person 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/person 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.

2.11.1 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** (72591000210107)		

Agreed term	**SCTID**
No known allergies	716186003
Allergy to medicine	416098002
Allergy to substance (SNOMED CT term: Allergic disposition)	609328004

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.11.2 Allergies – medicines

Definition	Known allergies to specific medicines		
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 **Allergies present**		
Guide for use	Nine instances of this field may be recorded		
Verification rules	Valid value only		

2.11.3 Allergies – substances

Definition	Known allergies to specific 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** (72591000210107)		

Agreed term	**SCTID**
Dairy (SNOMED CT term: 'Cow's milk')	3718001
Egg	102263004
Latex	111088007
Nut	13577000

	<table><tr><td>Seafood</td><td>44027008</td></tr><tr><td>Other</td><td>105590001</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory on a response of ‘Allergy to substance’ for **Allergies present**
Guide for use	Record the substances the women/person is allergic to, other than medicines Six instances of this field may be recorded
Verification rules	Valid code only

2.11.4 Allergies – other substance 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 Allergies – substances		
Guide for use	A response is to be recorded for each identified ‘Other’ instance		

2.11.5 Adverse reactions

Definition	Known adverse drug reactions (ADR) to a medicine		
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 **Allergies present**		
Guide for use	Nine instances of this field may be recorded		

2.12 Alcohol and other drugs

This section records information about a woman/person's consumption of alcohol and other drugs. This information should be collected at the first full contact the woman/person has with a maternity service provider and routinely thereafter. Women/people 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.

Information about the alcohol and other drug use is collected at the booking visit, at the end of the antenatal period and the postnatal period. 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.

2.12.1 Alcohol consumption

<table>
<tr><td>Definition</td><td colspan="3">Current alcohol consumption</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand alcohol consumption reference set</u> (72671000210109)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Does not drink alcohol</td><td>105542008</td></tr><tr><td>Currently drinks alcohol</td><td>219006</td></tr><tr><td>Declined to answer</td><td>426544006</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.12.2 Timing of alcohol cessation

Definition	When the woman/person 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 **Alcohol consumption**		
Guide for use			
Verification rules	Valid code only		

2.12.3 Amount of alcohol consumed

Definition	Units of alcohol consumed 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 **Alcohol consumption**		
Guide for use	An approximate number of units is acceptable		
Verification rules	Valid value only		

2.12.4 Brief alcohol cessation advice

Definition	Brief advice offered 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 **Alcohol consumption**		
Guide for use			
Verification rules	Valid code only		

2.12.5 Referred to alcohol use services

Definition	Offer of referral to alcohol support 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 drinks alcohol’ to **Alcohol consumption**		
Guide for use			
Verification rules	Valid code only		

2.12.6 History of drug use

Definition	History of illegal drug 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** (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/person or others
Verification rules	Valid code only

2.12.7 Current drugs used

Definition	Currently used 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 reference set** (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 **History of drug use.**
Guide for use	This covers illegal drugs or misuse of drugs prescribed for the woman/person or others
Verification rules	Valid code only

2.12.8 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 **Current drugs used**		
Guide for use	A response is to be recorded for each identified 'Other' instance		

2.13 Smoking and vaping status

This section records information about the tobacco smoking and/or vaping status of the woman/person. Smoking tobacco or vaping during pregnancy can have harmful effects on both the woman/person 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/people 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 the postnatal period.

2.13.1 Smoking status

<table>
<tr><td>Definition</td><td colspan="3">Current use of tobacco</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand smoking status reference set</u> (72741000210106)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Currently smokes tobacco</td><td>77176002</td></tr>
<tr><td>Never smoked</td><td>266919005</td></tr>
<tr><td>Ex-smoker, greater than 12 months abstinent</td><td>48031000119106</td></tr>
<tr><td>Ex-smoker, less than 12 months abstinent</td><td>735128000</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Three instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.13.2 Vaping status

Definition	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** (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

2.13.3 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 **Vaping status**
Guide for use	
Verification rules	Valid code only

2.13.4 Date quit smoking

Definition	Date the woman/person 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 **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		

2.13.5 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 **Smoking status**		
Guide for use	An approximate number is acceptable		

Verification rules	A value greater than zero

2.13.6 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 **Smoking status**		
Guide for use			
Verification rules	Valid code only		

2.13.7 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 **Smoking status**		
Guide for use			
Verification rules	Valid code only		

2.13.8 Exposure to second-hand smoke

Definition	If and where the woman/person has had regular exposure to second-hand tobacco smoke

<table>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>No known exposure to tobacco smoke</td><td>711563001</td></tr><tr><td>Yes, at home</td><td>228524006</td></tr><tr><td>Yes, at place of work</td><td>228523000</td></tr><tr><td>Yes, in public places</td><td>228525007</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Three instances of this field may be recorded where any code other than ‘No known exposure to tobacco smoke’ is selected</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.14 Family health

This section records the medical history of immediate family members of both the woman/person and the baby’s biological father. 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/person 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.

2.14.1 Maternal family history

Definition	Relevant medical history of the woman/person’s close family		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code

<table>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity family history reference set</u> (72661000210103)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Allergies</td><td>160469004</td></tr><tr><td>Asthma</td><td>160377001</td></tr><tr><td>Chromosomal anomaly</td><td>160425006</td></tr><tr><td>Congenital anomaly</td><td>160417009</td></tr><tr><td>Diabetes mellitus</td><td>160303001</td></tr><tr><td>Hypertensive disorders of pregnancy</td><td>160401003</td></tr><tr><td>Intellectual disability</td><td>763598005</td></tr><tr><td>Malignant hyperthermia</td><td>401052005</td></tr><tr><td>Mental illness</td><td>160324006</td></tr><tr><td>Multiple pregnancy</td><td>266906006</td></tr><tr><td>Not known</td><td>407559004</td></tr><tr><td>No relevant family history</td><td>160266009</td></tr><tr><td>Other condition</td><td>281666001</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">10 instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.14.2 Maternal family history – other detail

Definition	Detail of ‘Other condition’ maternal family history		
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 **Maternal family history**
Guide for use	A response is to be recorded for each identified 'Other condition' instance of maternal family history
Verification rules	

2.14.3 Paternal family history

Definition	Relevant medical history of the baby's biological father and their 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** (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

2.14.4 Paternal family history – other detail

Definition	Detail of the 'Other condition' paternal family history

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 **Paternal family history**		
Guide for use	A response is to be recorded for each identified 'Other condition' paternal family history		
Verification rules			

2.14.5 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		

2.14.6 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 **Consanguinity**
Guide for use	
Verification rules	Valid code only

2.15 Tuberculosis risk assessment

Manatū Hauora - Ministry of Health 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.

2.15.1 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		

2.15.2 Lives in country with tuberculosis

<table>
<tr><td>Definition</td><td colspan="3">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</td></tr>
<tr><td>Source standards</td><td colspan="3">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)</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>1</td><td>Representational layout</td><td>N</td></tr>
<tr><td>Value domain</td><td colspan="3"><table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>No</td><td>1</td></tr><tr><td>Yes</td><td>2</td></tr><tr><td>Unknown</td><td>3</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">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</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.15.3 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

<table>
<tr><td>Source standards</td><td colspan="3">Use of high burden country lists for TB by WHO in the post-2015 era: <u>https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf</u> (page 3)</td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>1</td><td>Representational layout</td><td>N</td></tr>
<tr><td>Value domain</td><td colspan="3"><table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>No</td><td>1</td></tr><tr><td>Yes</td><td>2</td></tr><tr><td>Unknown</td><td>3</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">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</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.16 Current pregnancy

This section collates information about the 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.

2.16.1 Blood tests

<table>
<tr><td>Definition</td><td colspan="3">Blood tests during the current pregnancy</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity screening and tests reference set</u> (72641000210104)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Antenatal first blood tests (AN1)</td><td>50961000210108</td></tr>
<tr><td>Antenatal subsequent blood tests (AN2)</td><td>50951000210105</td></tr>
<tr><td>Oral glucose tolerance test (OGTT)</td><td>113076002</td></tr>
<tr><td>Pre-eclampsia tests (PET)</td><td>60881000210103</td></tr>
<tr><td>Other blood test</td><td>396550006</td></tr>
<tr><td>Declined blood tests</td><td>116471000119100</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Five instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.16.2 Blood test – other test detail

Definition	Detail of ‘Other blood test’ taken		
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 blood tests’ for **Blood tests**		

Guide for use	A response is to be recorded for each instance of ‘Other’
Verification rules	

2.16.3 Antenatal screening

Definition	Screening 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** (72641000210104)		

Agreed term	SCTID
Red blood cell antibodies	89754000
Gestational diabetes	1268646002
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

2.16.4 Antenatal screening – other detail

Definition	Detail of 'Other' antenatal screening undertaken		
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 **Antenatal screening**		
Guide for use	A response is to be recorded for each instance of 'Other'		
Verification rules			

2.16.5 Antenatal vaccinations

Definition	Vaccinations 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 findings reference set** (72591000210107)		
Obligation	Optional		
Guide for use	Three instances of this field may be recorded		
Verification rules	Valid code only		

Agreed term	SCTID
Influenza	73701000119109
Pertussis	72011000210108
SARS COV-2	101631000210102
Other	713404003

2.16.6 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, not screened / 1 Yes, screened / 2 Declined to answer / 3 Unable to ask / 4		
Obligation	Mandatory		
Guide for use			
Verification rules	Multiple responses can be recorded		

2.16.7 Fetal anomaly screening

Definition	Fetal anomaly screening tests during 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** Declined fetal anomaly screening / 111511000210108 Non-invasive prenatal screening (NIPS) / 121511000210100 First trimester combined screening / 111521000210103		

	Second trimester maternal serum screening: 111531000210101 Unknown: 406011002
Obligation	Mandatory
Guide for use	Three instances of this field may be recorded
Verification rules	Valid code only

2.16.8 Ultrasound scans

Definition	Ultrasound scans during the current 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** (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

2.16.9 Ultrasound scan total

Definition	Total number of ultrasound scans during the current 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' in **Ultrasound scans**		
Guide for use			
Verification rules	Valid value only		

2.16.10 Chorionic villus sampling

Definition	Chorionic villus sampling 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		

2.16.11 Amniocentesis

Definition	Amniocentesis 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

2.16.12 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 complications reference set** (726010002101 02)

Agreed term	SCTID
No complications (SNOMED CT term: 'Normal pregnancy')	72892002
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	Mandatory	
Guide for use	Nine instances of this field may be recorded	
Verification rules	Valid code only	

2.16.13 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 **Pregnancy complications**		
Guide for use			
Verification rules			

2.16.14 Antenatal referral – date

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

2.16.15 Antenatal referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-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 if a referral was made to a specialist service during the antenatal period **Antenatal referral date**.		
Guide for use			
Verification rules	Valid code only		

2.16.16 Pregnancy loss – date

This element defines the date a pregnancy loss occurred. The format is set out in the common **Date and time value domain** specification. The data element is mandatory if there was a pregnancy loss prior to 20 weeks and 0 days. A valid date should be recorded for each loss.

2.16.17 Antenatal admission – date and time

This element defines the antenatal admission date and time if admission occurred during the current pregnancy. The format is set out in the common **Date and time value domain** specification.

The Facility ID of the facility the women/person is admitted to must be recorded. Refer to the updated health provider identify standard for further details. See section **2.2 Health care provider information.**

2.16.18 Antenatal discharge – date and time

This element defines the antenatal discharge date and time if antenatal admission was recorded at section **Antenatal admission – date and time**. The format is set out in the common **Date and time value domain** specification.

The data element is mandatory upon a response to **Antenatal admission – date and time.** The value must be on or after the date and time recorded in **Antenatal admission – date and time**.

2.16.19 Current alcohol consumption

Definition	Current alcohol consumption		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code

<table>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand alcohol consumption reference set</u> (72671000210109)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Does not drink alcohol</td><td>105542008</td></tr><tr><td>Currently drinks alcohol</td><td>219006</td></tr><tr><td>Declined to answer</td><td>426544006</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">The information collected for this section is distinct from that collected for section 2.12.1 Alcohol consumption, as this section records a value at the end of the pregnancy</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.16.20 Current drug use

<table>
<tr><td>Definition</td><td colspan="3">Current use of illegal drugs</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand non-medicinal drug use reference set</u> (72681000210106)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Current drug user</td><td>417284009</td></tr><tr><td>Declined to answer</td><td>426544006</td></tr><tr><td>Does not misuse drugs</td><td>228367002</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
</table>

Guide for use	The information collected for this section is distinct from that collected for section 2.12.6 History of drug use, as this section records a value at the end of the pregnancy
Verification rules	Valid code only

2.16.21 Current drugs used

Definition	Currently used 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 reference set** (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 **2.16.20 Current drug use**
Guide for use	This covers illegal drugs or misuse of drugs prescribed for the woman/person or others The information collected for this section is distinct from that collected for section 2.12.7 Current drugs used, as this section records a value at the end of the pregnancy Nine instances of this field may be recorded
Verification rules	Valid code only

2.16.22 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 **2.16.21 Current drugs used**.		
Guide for use			
Verification rules			

2.16.23 Current smoking status

Definition	Current tobacco smoking status		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	**Agreed term**	**SCTID**	

	Currently smokes tobacco: 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 2.13.1 Smoking status, as section **2.16.23** records status at the end of the pregnancy
Verification rules	Valid code only

2.16.24 Current vaping status

Definition	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** (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	The information collected for this section is distinct from that collected for section 2.13.2 Vaping status, as section **2.16.24** records status at the end of the pregnancy Three instances of this field may be recorded
Verification rules	Valid code only

2.16.25 Antenatal prescriptions

Definition	Prescriptions supplied 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** (72651000210101)		

Agreed term	SCTID
Analgesics	373265006
Antacids	372794006
Antibacterials	419241000
Antifungals	373219008
Minerals	373460003
Non-steroidal anti-inflammatories (NSAIDs)	372665008
Vitamins	87708000
Other	410942007
No prescriptions	182849000

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

2.16.26 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 Antenatal prescriptions
Guide for use	
Verification rules	

2.16.27 Antenatal complementary therapies

Definition	Use of complementary therapies 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** (72631000210107)

Agreed term	**SCTID**
None (SNOMED CT Term ‘Procedure not indicated’)	428119001
Acupressure	231107005
Acupuncture	231081007
Aromatherapy	394615007
Chiropractic	182548004
Herbal medicine	414392008
Homeopathy	182968001
Massage	387854002
Naturopathy	439809005
Osteopathy	182549007
Reflexology	394614006

	Rongoā Māori	789789009
	Other	225423004
Obligation	Mandatory	
Guide for use	10 instances of this field may be recorded	
Verification rules	Valid code only	

2.16.28 Antenatal visits – first trimester

Definition	Number of antenatal visits received 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		

2.16.29 Antenatal visits – second trimester

Definition	Number of antenatal visits received 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		

2.16.30 Antenatal visits – third trimester

Definition	Number of antenatal visits received 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		

2.17 Labour and birth

This section collates information about the details of the labour and birth relating to the woman/person. Labour and birth details pertaining to the baby or babies are collated in section **2.21 Newborn baby**.

2.17.1 Onset of labour

Definition	Manner by which the 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** (72591000210107)		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

Agreed term	SCTID
Induced	112070001
Planned caesarean section before labour	200148001
Spontaneous	84457005

2.17.2 Gestation at onset of labour

Definition	Gestational age of the baby at the onset of labour		
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	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: EDD date (a value recorded in section **2.4.9 Agreed estimated due date** from the: recorded date for the onset of labour (a value recorded in section **2.17.1 Onset of labour**)		
Verification rules	A value greater than or equal to 20		

2.17.3 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 **Onset of labour**.

2.17.4 Actual place of birth

Definition	The actual place where the woman/person gave birth
Source standards	

<table>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3"><table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Home</td><td>169813005</td></tr>
<tr><td>Primary birthing facility</td><td>91541000210104</td></tr>
<tr><td>Secondary birthing facility</td><td>91551000210101</td></tr>
<tr><td>Tertiary birthing facility</td><td>91561000210103</td></tr>
<tr><td>In transit</td><td>91571000210109</td></tr>
<tr><td>Other</td><td>366344009</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.5 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 **Actual place of birth**		
Guide for use			
Verification rules			

2.17.6 Actual place of birth – facility

This element provides the actual place of birth facility detail. The Facility ID of the facility the women/person gave birth. Refer to the updated health provider identify standard for further details. See section **2.2 Health care provider information.** The data element is mandatory upon any response other than ‘Home’ or ‘Other’ to **Actual place of birth**.

2.17.7 Maternity facility admission – date and time

This element defines the date and time the woman/person was admitted specifically for labour or birth. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory if the response to **Actual place of birth** is a primary, secondary, or tertiary facility.

2.17.8 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		

2.17.9 Reason labour augmented – first stage

Definition	Reason the 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 **Labour augmented – first stage**
Guide for use	
Verification rules	Valid code only

2.17.10 Reason labour augmented in 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 **Reason labour augmented – first stage**		
Guide for use			
Verification rules			

2.17.11 Complications – first stage

Definition	Complications 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** (726110002101 00) **Agreed term** / **SCTID**		

	No complications SNOMED CT Term ‘Normal first stage of labour’	289214004
	Complications of an anaesthetic	200046004
	Cord prolapse	270500004
	Delay in first stage	237320005
	Fetal distress	130955003
	Hypertensive disorder	82771000119102
	Infection	32801000119106
	Intrapartum haemorrhage	38010008
	Malposition	1263633009
	Malpresentation	1259921009
	Meconium liquor	199595002
	Pre-eclampsia	398254007
	Other (SNOMED CT Term ‘First stage of labour problem’)	289215003
Obligation	Mandatory	
Guide for use	Nine instances of this field may be recorded	
Verification rules	Valid code only	

2.17.12 Complications in first stage – other detail

Definition	Detail of ‘Other first stage of labour problem’		
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 **Complications – first stage**
Guide for use	
Verification rules	

2.17.13 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.

2.17.14 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 **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 established (a time value recorded in **Labour established – date and time**) section from the: recorded time for the end of first stage labour (a value recorded in **Cervix fully dilated – date and time**)		
Verification rules	Valid value only		

2.17.15 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

2.17.16 Reason labour augmented – second stage

Definition	Reason the 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 **Labour augmentation – second stage**
Guide for use	

Verification rules	Valid code only

2.17.17 Reason labour augmented in 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 **Reason labour augmented – second stage**		
Guide for use			
Verification rules			

2.17.18 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.

2.17.19 Complications – second stage

Definition	Complications 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** (72611000210100)		

Agreed term	**SCTID**
No complications	289223001

	(SNOMED CT Term ‘Normal second stage of labour’)	
	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	1263633009
	Malpresentation	1259921009
	Meconium liquor	199595002
	Other (SNOMED CT Term ‘Second stage of labour problem’)	289222006
Obligation	Mandatory	
Guide for use	11 instances of this field may be recorded	
Verification rules	Valid code only	

2.17.20 Complications in second stage – other detail

Definition	Detail of ‘Other first stage of labour problem’		
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 **Complications – second stage**		
Guide for use			

2.17.21 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 **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 **Cervix fully dilated – date and time**) from the: recorded time of the birth of the baby (a time value recorded in section **2.21.1 Birth – date and time**)		
Verification rules	Valid value only		

2.17.22 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.

2.17.23 Amniotic fluid

Definition	Description of the amniotic fluid
Source standards	

<table>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)
<table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Amniotic fluid not present</td><td>284831000210101</td></tr>
<tr><td>Bloodstained liquor</td><td>249134008</td></tr>
<tr><td>Malodorous liquor</td><td>284821000210103</td></tr>
<tr><td>Particulate matter</td><td>284841000210109</td></tr>
<tr><td>Thin (insignificant) meconium</td><td>408792005</td></tr>
<tr><td>Thick (significant) meconium</td><td>289294000</td></tr>
<tr><td>Not known

(SNOMED CT term: No clinical detail given)</td><td>281337006</td></tr>
<tr><td>Other</td><td>366334007</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">4 instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.24 Labour and birth referral – date

This element defines the date a labour and birth referral was made. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory if a referral was made.

2.17.25 Labour and birth referral code

Definition	Unique referral code

Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-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 if a referral was made to a specialist service during the labour and birth		
Guide for use			
Verification rules	Valid code only		

2.17.26 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		

2.17.27 Type of birth

Definition	Type of birth		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code

<table>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity mode of delivery reference set</u> (72581000210105)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Caesarean section</td><td>200144004</td></tr><tr><td>Forceps</td><td>200130005</td></tr><tr><td>Spontaneous vaginal birth (cephalic)</td><td>309469004</td></tr><tr><td>Spontaneous vaginal birth (breech)</td><td>271373005</td></tr><tr><td>Vacuum extraction</td><td>267278005</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Four instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.28 Birth position

<table>
<tr><td>Definition</td><td colspan="3">Position the woman/person gave birth in</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Kneeling</td><td>277773003</td></tr><tr><td>Lateral</td><td>32185000</td></tr><tr><td>Lithotomy</td><td>14205002</td></tr><tr><td>Semi-reclined</td><td>272580008</td></tr><tr><td>Sitting (eg, birth stool)</td><td>33586001</td></tr><tr><td>Squatting</td><td>408797004</td></tr></table></td></tr>
</table>

	Standing: 10904000 Supine: 40199007
Obligation	Mandatory
Guide for use	Record one entry for each baby born
Verification rules	Valid code only

2.17.29 Water birth

Definition	Indicates whether 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		

2.17.30 Vaginal birth after Caesarean section

Definition	Identifies whether the birth was a vaginal birth after a previous 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** (72591000210107) **Agreed term** — **SCTID**		

	Yes (SNOMED CT Term: ‘Vaginal delivery following previous caesarean section’)	237313003
	Not known (SNOMED CT Term: ‘No clinical detail given)	281337006
	Not applicable	385432009
Obligation	Mandatory	
Guide for use	Record one entry for each baby born	
Verification rules	Valid code only	

2.17.31 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 **2.21.1 Birth – date and time**) from the: recorded time for the end of third stage of labour (a time value recorded in section **2.20.3 Placenta delivery – date and time**)		

Verification rules	Valid value only

2.17.32 Analgesia in labour

Definition	Types of analgesia used during the first, second or third stage of 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
Codeine	387494007
Diamorphine	387341002
Gas (nitrous oxide)	111132001
Fentanyl	373492002
Paracetamol	387517004
Pethidine	387298007
Morphine	373529000
Remifentanil	386839004
Non-pharmacological	111481000210103

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

2.17.33 Analgesia in labour – date and time

If analgesia was administered during the first, second or third stage of labour, this element defines the date and time each instance of analgesia was 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 **Analgesia in labour**.

2.17.34 Anaesthesia in labour

<table>
<tr><td>Definition</td><td colspan="3">Types of anaesthesia administered during the first, second or third stage of labour</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity procedures reference set</u> (72561000210102)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No anaesthesia</td><td>263421000210101</td></tr>
<tr><td>Combined spinal/epidural (CSE)</td><td>231261002</td></tr>
<tr><td>Dural puncture epidural</td><td>1285642008</td></tr>
<tr><td>Epidural</td><td>18946005</td></tr>
<tr><td>Epidural top-up for procedure</td><td>231260001</td></tr>
<tr><td>General anaesthetic</td><td>50697003</td></tr>
<tr><td>Local anaesthetic</td><td>408803000</td></tr>
<tr><td>Injection of anaesthetic agent into pudendal nerve</td><td>68248001</td></tr>
<tr><td>Sedation</td><td>72641008</td></tr>
<tr><td>Spinal</td><td>231249005</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Five instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.35 Anaesthesia in labour – date and time

If anaesthesia was administered during the first, second or third stage of labour, this element defines the date and time each instance of anaesthesia 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 **Analgesia in labour.**

2.17.36 Labour and birth prescriptions

<table>
<tr><td>Definition</td><td colspan="3">Prescriptions supplied during the labour and birth</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity substances reference set</u> (72651000210101)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No prescriptions

(SNOMED CT Term: ‘No drug therapy prescribed’)</td><td>182849000</td></tr>
<tr><td>Analgesic</td><td>373265006</td></tr>
<tr><td>Antacid</td><td>372794006</td></tr>
<tr><td>Antibacterial</td><td>419241000</td></tr>
<tr><td>Antiemetic</td><td>372776000</td></tr>
<tr><td>Intravenous fluid</td><td>118431008</td></tr>
<tr><td>Non-steroidal anti-inflammatory drug (NSAID)</td><td>372665008</td></tr>
<tr><td>Uterotonic drug</td><td>410937004</td></tr>
<tr><td>Other</td><td>410942007</td></tr>
<tr><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Nine instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.37 Labour and birth prescriptions administered – date

- This element defines the date and time any 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 **Labour and birth prescriptions** other than 'No prescriptions'.

2.17.38 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 **Labour and birth prescriptions**		
Guide for use			
Verification rules			

2.17.39 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** (72631000210107)		

Agreed term	SCTID
None (SNOMED CT Term 'Procedure not indicated')	428119001
Acupressure	231107005
Acupuncture	231081007

	Aromatherapy	394615007
	Heat packs	398074008
	Herbal medicine	414392008
	Homeopathy	182968001
	Hypnobirthing techniques	19997007
	Massage	387854002
	Naturopathy	439809005
	Positional techniques	226048001
	Reflexology	394614006
	Rongoā Māori	789789009
	Sterile water injection	144711000146107
	Support people	816968003
	TENS machine	229559001
	Water immersion	229204004
	Other	225423004

Obligation	Mandatory
Guide for use	13 instances of this field may be recorded
Verification rules	Valid code only

2.17.40 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 **Coping strategies**		
Guide for use			

2.18 Induction of labour

This section collates information about the woman/persons induction of labour, if they had one during this labour and birth. It should be left blank unless there was an induction of labour.

2.18.1 Induction date and time

This element defines the date and time an 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 **2.17.1 Onset of labour**. This field records the date and time of the first method (as listed in **2.18.2 Induction method(s)** below) used in the induction of labour process.

2.18.2 Induction method(s)

<table>
<tr><td>Definition</td><td colspan="3">Method(s) by which the labour was induced</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity procedures reference set</u> (72561000210102)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Artificial rupture of membranes (ARM)</td><td>408816000</td></tr>
<tr><td>Cervical ripening balloon</td><td>425861005</td></tr>
<tr><td>Mifepristone</td><td>71721000210107</td></tr>
<tr><td>Misoprostol</td><td>71731000210109</td></tr>
<tr><td>Oxytocin infusion</td><td>177135005</td></tr>
<tr><td>Prostaglandin</td><td>177136006</td></tr>
<tr><td>Other method</td><td>236958009</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory if Induction date and time is completed</td></tr>
<tr><td>Guide for use</td><td colspan="3">Four instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.18.3 Induction method – other detail

Definition	Detail of 'Other' induction method		
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 method' in **Induction method(s)**		
Guide for use			

2.18.4 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** (72591000210107)		

Agreed term	SCTID
Abnormal dopplers	312370006
Advanced maternal age	416413003
Antepartum haemorrhage	34842007
Blood group antibodies	166167002
Chromosomal anomaly of fetus	267253006
Congenital anomaly of fetus	609520005
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 anomaly complicating pregnancy	721153000
Maternal medical condition	281667005
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
Termination of pregnancy	57797005
Unstable lie	86356004
Other	173300003

Obligation	Mandatory if **Induction date and time** is entered
Guide for use	Five instances of this field may be recorded
Verification rules	Valid code only

2.18.5 Induction reason – other detail

Definition	Detail of ‘Other’ induction reason		
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’ in **Induction reason**		
Guide for use			
Verification rules			

2.19 Caesarean section

This section collates information about the woman/persons Caesarean section, if they had one during this birth event. It should be left blank unless there was a Caesarean section.

2.19.1 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** (72561000210102)		

Agreed term	SCTID
Classical caesarean section	84195007

	Lower uterine segment Caesarean section (LUSCS)	788180009
	Other	11466000
	Not known (SNOMED CT Term: 'No clinical detail given')	281337006
Obligation	Mandatory on a response of 'Caesarean section' for section **2.17.27 Type of birth**	
Guide for use		
Verification rules	Valid code only	

2.19.2 Caesarean section type – other detail

Definition	Detail of 'Other' Caesarean section type		
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' in **Caesarean section type**		
Guide for use			
Verification rules			

2.19.3 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 **Caesarean section type**
Guide for use	
Verification rules	Valid code only

2.19.4 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

The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)

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 **Caesarean grade**

Guide for use	
Verification rules	Valid code only

2.19.5 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		

2.19.6 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 disorders reference set** (72611000210100)		

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	281667005
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 on a response of ‘Caesarean section’ for section **2.17.27 Type of birth**	
Guide for use		
Verification rules	Valid code only	

2.19.7 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 **2.19.6 Caesarean section primary indication**		
Guide for use			
Verification rules			

2.19.8 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 **Caesarean section primary indication**
Guide for use	
Verification rules	

2.19.9 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** (72601000210102)		

Agreed term	SCTID
None	263391000210106
Adhesions	197201009
Bladder injury	77165001
Bowel injury	125625000
Hypertension	82771000119102
Intrapartum haemorrhage	38010008
Thromboembolism	371039008
Ureteric injury	24850009
Uterine complications	289618005
Other	78408007

Obligation	Mandatory on a response of ‘Caesarean section’ for section **2.17.27 Type of birth**
Guide for use	Nine instances of this field may be recorded
Verification rules	Valid code only

2.19.10 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 **Complications during Caesarean section**		
Guide for use			

2.20 Post-birth

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

2.20.1 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** (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

2.20.2 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		

2.20.3 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.

2.20.4 Perineal status

Definition	Status of the perineum after the birth		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code

<table>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Perineum intact</td><td>289854007</td></tr>
<tr><td>First-degree tear

– injury to perineal skin and vaginal wall only</td><td>57759005</td></tr>
<tr><td>Second-degree tear

– injury to perineal skin, vaginal wall and superficial perineal muscles</td><td>6234006</td></tr>
<tr><td>Third-degree tear (3a)

– injury to perineal skin, vaginal wall and perineal muscles and less than 50 percent of external anal sphincter (EAS) thickness torn</td><td>449807005</td></tr>
<tr><td>Third-degree tear (3b)

– injury to perineal skin, vaginal wall and perineal muscles and more than 50 percent of EAS thickness torn</td><td>449808000</td></tr>
<tr><td>Third-degree tear (3c)

– both external and internal anal sphincter (IAS) torn</td><td>449809008</td></tr>
<tr><td>Fourth-degree tear

– anal sphincter complex (EAS and IAS) and anal epithelium torn</td><td>399031001</td></tr>
<tr><td>Episiotomy incision</td><td>860603002</td></tr>
<tr><td>Not known</td><td>281337006</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
</table>

Guide for use	Four instances of this field may be recorded
Verification rules	Valid code only

2.20.5 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** (72591000210107) **Agreed term** / **SCTID** Anterior / 71981000210106 J shaped / 71831000210104 Mediolateral / 71991000210108 Midline / 71821000210101		
Obligation	Mandatory on a response of ‘Episiotomy incision’ for **Perineal status**		
Guide for use			
Verification rules	Valid code only		

2.20.6 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** (72591000210107)		

	<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Abnormal fetal blood sample</td><td>199597005</td></tr><tr><td>Delay in second stage</td><td>249166003</td></tr><tr><td>Female genital mutilation (FGM)</td><td>95041000119101</td></tr><tr><td>Fetal heart rate abnormality</td><td>267257007</td></tr><tr><td>Forceps delivery</td><td>200130005</td></tr><tr><td>Maternal distress</td><td>87383005</td></tr><tr><td>Previous perineal damage</td><td>15758941000119102</td></tr><tr><td>Rigid perineum</td><td>289875004</td></tr><tr><td>Shoulder dystocia</td><td>89700002</td></tr><tr><td>Vacuum extraction</td><td>200138003</td></tr><tr><td>Other</td><td>199745000</td></tr><tr><td></td><td></td></tr></table>
Obligation	Mandatory on a response of ‘Episiotomy incision’ for **Perineal status**
Guide for use	
Verification rules	Valid code only

2.20.7 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 **Episiotomy reason**		
Guide for use			
Verification rules			

2.20.8 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** (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

2.20.9 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** (72561000210102)		

Agreed term	SCTID
Repair not required	418014008
Repair declined	105480006

	(SNOMED CT: Procedure declined by patient) | 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 **Perineal section**
Guide for use	Three instances of this field may be recorded
Verification rules	Valid code only

2.20.10 Placenta and membranes

Definition	Indicates whether the placenta was 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** (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		

2.20.11 Placenta appearance

Definition	Description of the appearance of the placenta

<table>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Normal</td><td>289279004</td></tr><tr><td>Calcifications</td><td>249174002</td></tr><tr><td>Fetus papyraceous</td><td>90127001</td></tr><tr><td>Gritty</td><td>249173008</td></tr><tr><td>Infarctions</td><td>268585006</td></tr><tr><td>Oedematous</td><td>56425003</td></tr><tr><td>Offensive</td><td>289275005</td></tr><tr><td>Retroplacental clot</td><td>249177009</td></tr><tr><td>Succenturiate lobe</td><td>82664003</td></tr><tr><td>True knot in umbilical cord</td><td>27696007</td></tr><tr><td>Velamentous insertion of cord</td><td>77278008</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Five instances of this field may be captured</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.20.12 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	**Agreed term** / **Code** One vessel / 1 Two vessels / 2 Three vessels / 3 Other / 8 Unknown / 9
Obligation	Mandatory
Guide for use	
Verification rules	Valid value only

2.20.13 Placenta kept by the woman/person

Definition	Was the placenta kept by the woman/person		
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		

2.20.14 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

2.21 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.

2.21.1 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.

2.21.2 Gestation at birth

Definition	Gestational age 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	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: Agreed EDD (a value recorded in section **2.4.9 Agreed estimated due date** from the:		

	recorded date for the date and time of birth (a value recorded in section **2.21.1 Birth – date and time**)
Verification rules	Valid value only

2.21.3 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** (72571000210108) **Agreed term** / **SCTID** Live born / 281050002 Stillborn – antepartum / 44174001 Stillborn – indeterminate / 17766007 Stillborn – intrapartum / 1762004		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

2.21.4 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** (72581000210105) **Agreed term** / **SCTID**		

	Caesarean section: 200144004 Forceps: 200130005 Spontaneous vaginal birth (cephalic): 309469004 Spontaneous vaginal birth (breech): 271373005 Vacuum extraction: 267278005
Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.5 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** (72591000210107)		

Agreed term	SCTID
Breech	6096002
Cephalic	70028003
Compound	124736009
Shoulder	23954006
Other	15028002

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.6 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 **Presenting part of baby**		
Guide for use			
Verification rules			

2.21.7 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** (72591000210107)		
Obligation	Mandatory on a response of 'Breech' for **Presenting part of baby**		
Guide for use			
Verification rules	Valid code only		

Agreed term	**SCTID**
Complete	49168004
Extended (frank)	18559007
Footling	249097002
Kneeling	249098007
Incomplete	38049006

2.21.8 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** (72591000210107)		

Agreed term	SCTID
Assisted vaginal breech	71711000210102
Caesarean section	712654009
Spontaneous vaginal breech	271373005

Obligation	Mandatory on a response of 'Breech' for Presenting part of baby
Guide for use	
Verification rules	Valid code only

2.21.9 Shoulder dystocia

Definition	Indicates whether there was a shoulder dystocia during the birth		
Source standards			
Data type	Numeric	**Representational class**	N/A
Field size	1	**Representational layout**	N
Value domain			

Agreed term	Code
Yes	1
No	2
Unknown	3

Obligation	Mandatory

Guide for use	
Verification rules	Valid code only

2.21.10 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** (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 **Shoulder dystocia**
Guide for use	Six instances of this field may be recorded
Verification rules	Valid code only

2.21.11 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 **Shoulder dystocia procedures**		
Guide for use			

2.21.12 Cord blood sample

Definition	A record of cord blood tests taken		
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** (72641000210104)

Agreed term	SCTID
Laboratory test not necessary	165330008
Arterial pH	27051004
Arterial base excess	263441000210107
Arterial lactate	394960005
Blood group and rhesus factor	165745004
Coombs (antibodies)	165771000
Cord blood taken – put on hold	6708002
Electrophoresis	814007
Serum bilirubin	166610007
Venous pH	9456006
Venous base excess	263451000210105
Venous lactate	263431000210104

	Other: 15220000 Unknown: 69466000
Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.13 Baby sex

Definition	Baby sex		
Source standards			
Data type	Alphabetic	**Representational class**	Code
Field size	1	**Representational layout**	A
Value domain	M – Male F – Female O – Another term		
Obligation	Mandatory		
Guide for use	A review of the categories for capturing sex related details is currently underway by Te Whatu Ora-Health New Zealand		
Verification rules	Valid code only		

2.21.14 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

2.21.15 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.**

2.21.16 Apgar 1 minute

<table>
<tr><td>Definition</td><td colspan="3">Apgar score received at 1 minute of age</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity Apgar score reference set</u> (72621000210105)

<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Apgar score 0 at 1 minute</td><td>169896003</td></tr>
<tr><td>Apgar score 1 at 1 minute</td><td>169897007</td></tr>
<tr><td>Apgar score 2 at 1 minute</td><td>169898002</td></tr>
<tr><td>Apgar score 3 at 1 minute</td><td>169899005</td></tr>
<tr><td>Apgar score 4 at 1 minute</td><td>169901001</td></tr>
<tr><td>Apgar score 5 at 1 minute</td><td>169902008</td></tr>
<tr><td>Apgar score 6 at 1 minute</td><td>169903003</td></tr>
<tr><td>Apgar score 7 at 1 minute</td><td>169904009</td></tr>
<tr><td>Apgar score 8 at 1 minute</td><td>169905005</td></tr>
<tr><td>Apgar score 9 at 1 minute</td><td>169906006</td></tr>
<tr><td>Apgar score 10 at 1 minute</td><td>169907002</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes</td></tr>
</table>

Verification rules	Valid code only

2.21.17 Apgar 5 minutes

Definition	Apgar score 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** (72621000210105)		
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		

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

2.21.18 Apgar 10 minutes

<table>
<tr><td>Definition</td><td colspan="3">Apgar score received at 10 minutes of age</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity Apgar score reference set</u> (72621000210105)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Apgar score 0 at 10 minutes</td><td>169923002</td></tr>
<tr><td>Apgar score 1 at 10 minutes</td><td>169924008</td></tr>
<tr><td>Apgar score 2 at 10 minutes</td><td>169925009</td></tr>
<tr><td>Apgar score 3 at 10 minutes</td><td>169926005</td></tr>
<tr><td>Apgar score 4 at 10 minutes</td><td>169927001</td></tr>
<tr><td>Apgar score 5 at 10 minutes</td><td>169928006</td></tr>
<tr><td>Apgar score 6 at 10 minutes</td><td>169929003</td></tr>
<tr><td>Apgar score 7 at 10 minutes</td><td>169930008</td></tr>
<tr><td>Apgar score 8 at 10 minutes</td><td>169931007</td></tr>
<tr><td>Apgar score 9 at 10 minutes</td><td>169932000</td></tr>
<tr><td>Apgar score 10 at 10 minutes</td><td>169933005</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.21.19 Neonatal resuscitation

Definition	Requirement for neonatal resuscitation, including the outcome

<table>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity outcomes reference set</u> (72571000210108)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Not performed</td><td>71761000210100</td></tr><tr><td>Successful</td><td>71741000210101</td></tr><tr><td>Unsuccessful</td><td>71751000210103</td></tr><tr><td>Unknown

(SNOMED CT Term ‘Procedure status unknown’)</td><td>399714002</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.21.20 Vitamin K

<table>
<tr><td>Definition</td><td colspan="3">Prophylactic Vitamin K administration, including the route of administration</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity procedures reference set</u> (72561000210102)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Intramuscular</td><td>736388004</td></tr><tr><td>Oral</td><td>698350008</td></tr></table></td></tr>
</table>

	Declined: 15651391000119108
Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.21 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 **Vitaman K**.

2.21.22 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 upon skin to skin contact occurring within the early postnatal period.

2.21.23 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 to **Skin to skin start – date and time** and must be greater than the value recorded in **Skin to skin start – date and time**.

2.21.24 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 for **Skin to skin end – date and time**
Guide for use	
Verification rules	Valid code only

2.21.25 Skin to skin – reason for end – other 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 **Skin to skin – reason for end**		
Guide for use			
Verification rules			

2.21.26 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**: Exclusively breastfed at the mother's breast ('exclusively breastfed') — **Code**: 1 **Agreed term**: Expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or — **Code**: 3		

	supplemental nursing system (SNS) tube (‘exclusively breastfed’)	
	Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	4
	Breastfeeding at someone else’s breast (‘exclusively breastfed’)	5
	Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	8
	Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’)	14
	Parenteral nutrition	16
Obligation	Mandatory	
Guide for use	Up to two instances of this field may be recorded	
Verification rules	Valid code only	

2.21.27 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 **Infant feeding method**.

2.21.28 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 **Breastfeeding start - date and time**. The element must be a date and time greater than the value specified in **Breastfeeding start - date and time.**

2.21.29 Newborn referral – date

This element defines the date a referral was made. The format is set out in the common **Date and time value domain** specification. The data element is mandatory if a referral was made.

2.21.30 Newborn referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: **https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-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 if a referral was made to a specialist service during the immediate post-birth period		
Guide for use			
Verification rules	Valid code only		

2.21.31 Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)

Definition	Indicates whether a baby requires admission to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)		
Source standards			
Data type	Numeric	**Representational class**	Code
Field size	1	**Representational layout**	N
Value domain	**Agreed term**	**Code**	

	No, not needed (SNOMED CT term: Inpatient management not required)	707851002
	Yes, admission to Neonatal Intensive Care Unit (NICU)	830077005
	Yes, admission to Special Care Baby Unit (SCBU)	305388001
	Yes, requires specialist care but remains in the maternity unit	284861000210105
Obligation	Mandatory	
Guide for use		
Verification rules	Valid code only	

2.21.32 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 after the 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 'No, not needed' to **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU).**

2.21.33 Facility of Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) admission

This element records the facility of NICU or SCBU admission in the immediate postnatal period. 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 a response to **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time.**

2.21.34 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, not needed' to **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 **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time.**

2.22 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. Postnatal details pertaining to the woman/person are collated in section **2.23 Postnatal woman/person**.

2.22.1 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.

2.22.2 Infant feeding on discharge from facility

<table>
<tr><td>Definition</td><td colspan="3">Infant feeding method on discharge from maternity facility</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>2</td><td>Representational layout</td><td>NN</td></tr>
<tr><td>Value domain</td><td colspan="3"><table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Exclusively breastfed at the mother's breast ('exclusively breastfed')</td><td>1</td></tr>
<tr><td>Expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG)</td><td>3</td></tr>
</table></td></tr>
</table>

	feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	
	Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	4
	Breastfeeding at someone else’s breast (‘exclusively breastfed’)	5
	Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	8
	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’)	9
	Mixed feeding, where the infant has taken a mixture of breast milk and infant formula (‘partially breastfed’)	12
	Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’)	14
	Infant formula, fed via bottle (‘artificially fed’)	15
Obligation	Mandatory	
Guide for use	Two instances of this field may be recorded	
Verification rules	Valid code only	

2.22.3 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

2.22.4 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		

2.22.5 Red eye reflex screening – right eye

Definition	Result of 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	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		
	Agreed term	SCTID	
	Normal	43408002	
	Abnormal	247079003	
	Screening declined	31021000119100	

	Not completed	394908001
Obligation	Mandatory	
Guide for use		
Verification rules	Valid code only	

2.22.6 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 **Red eyed reflex screening – right eye**.

2.22.7 Red eye reflex screening – left eye

Definition	Result of the 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		

2.22.8 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 **Red eye reflex screening – left eye.**

2.22.9 Metabolic screening

Definition	Result of the 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		

2.22.10 Newborn hearing screening

Definition	Result of the newborn hearing screening test		
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 / 410543007 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	

2.22.11 Infant feeding

Definition	Indicates whether the baby has ever fed at the mother's breast (breastfeeding initiation)		
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		

2.22.12 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
	Expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG)		3

	feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	
	Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	4
	Breastfeeding at someone else’s breast (‘exclusively breastfed’)	5
	Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)	8
	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’)	9
	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’)	13
	Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’)	**14**
	Infant formula, fed via bottle (‘artificially fed’)	**15**
	Parenteral nutrition	**16**
Obligation	Mandatory	
Guide for use	Two instances of this field may be recorded	
Verification rules	Valid code only	

2.22.13 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')	5
Donor breast milk, fed via bottle or nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')	6
Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed')	9
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')	11
Infant formula, fed via bottle ('artificially fed')	15

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

2.22.14 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	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Exclusively breastfed at the mother's breast ('exclusively breastfed')</td><td>1</td></tr><tr><td>Expressed breast milk from the mother's breast, fed via supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>17</td></tr><tr><td>Breastfeeding at someone else's breast ('exclusively breastfed')</td><td>5</td></tr><tr><td>Donor breast milk, fed via bottle or supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>7</td></tr><tr><td>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')</td><td>9</td></tr><tr><td>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')</td><td>10</td></tr><tr><td>Infant formula, fed via bottle ('artificially fed')</td><td>15</td></tr></table>
Obligation	Mandatory
Guide for use	Two instances of this field may be recorded
Verification rules	Valid code only

2.22.15 Neonatal referral – date

This element defines the date a neonatal or paediatric referral was made for the baby during the postnatal period. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory if a referral was made.

2.22.16 Neonatal referral code

Definition	Unique referral code
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*:

	https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-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 if a referral to neonatal or paediatric specialist services was made for the baby during the postnatal period		
Guide for use			
Verification rules	Valid code only		

2.22.17 Neonatal admission – date and time

This element defines the date and time of a neonatal or paediatric admission if this has occurred at any time in the first six weeks following the birth. The format is set out in the common **Date and time value domain** specification. The data element is mandatory.

2.22.18 Facility of neonatal admission

This element records the facility of neonatal or paediatric admission. 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 if a value is recorded in **Neonatal admission – date and time.**

2.22.19 Postnatal visits

Definition	Number of postnatal visits provided by the LMC to the baby 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	This value is distinct from that provided in **2.23.20 Postnatal visits**, as this field records visits provided to a baby where they are not with their birth mother, but in the care of another person
Verification rules	Valid value only

2.22.20 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		

2.22.21 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 Well Child service / 192031000210100		

Obligation	Mandatory on a response of ‘Yes – 1’ for **Well Child provider referral**
Guide for use	
Verification rules	Valid code only

2.22.22 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 **Well Child Provider referral**.

2.22.23 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		
Guide for use			
Verification rules	Valid code only		

2.22.24 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 **General practice referral**.

2.22.25 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		

2.23 Postnatal woman/person

This section collates postnatal information about the woman/person. The information is collected throughout the six weeks following the birth and should be summarised at the end of the postnatal period. Postnatal details pertaining to the baby or babies are collated in section **2.22 Postnatal baby.**

2.23.1 Maternity facility discharge – date and time

This element defines the date and time the woman/person was discharged from a maternity facility, if they were 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.

2.23.2 Postnatal referral – date

This element defines the date a postnatal referral was made. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory if a referral was made.

2.23.3 Postnatal referral code

Definition	Unique referral code

Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-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 if a referral was made to a specialist service during the postnatal period		
Guide for use			
Verification rules	Valid code only		

2.23.4 Postnatal complications

Definition	Complications 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 complications reference set** (72601000210102)		

Agreed term	SCTID
No complications (SNOMED CT Term: Postnatal examination normal)	169784003
Anaemia	271737000
Bladder dysfunction	236632007
Breast infection (Mastitis)	198108005
Breastfeeding issues	289084000

Hypertensive disorder	40521000119100
Other infection	40733004
Peripartum cardiomyopathy	62377009
Postnatal depression	58703003
Postnatal distress	300894000
Postpartum hysterectomy	860602007
Postpartum psychosis	18260003
Secondary postpartum haemorrhage	23171006
Sepsis	91302008
Thromboembolism	371039008
Urinary retention	267064002
Urinary tract infection	68566005
Uterine infection (Endometritis)	301775005
Venous thromboembolism (VTE)	429098002
Wound dehiscence	225553008
Wound infection	76844004
Other	198609003

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

2.23.5 Postnatal complications – other detail

Definition	Detail of the ‘Other’ postnatal complications		
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 **Postnatal complications**
Guide for use	
Verification rules	

2.23.6 Postnatal admission – date and time

This element defines the date and time the woman/person was postnatally admitted (after having been previously discharged) to a facility if this occurs. The format is set out in the common **Date and time value domain** specification. The data element is mandatory.

2.23.7 Facility of postnatal admission

This element provides the actual facility when there has been a postnatal admission. 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 to **Postnatal admission – date and time**.

2.23.8 Postnatal discharge – date and time

This element defines the date and time the woman/person 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 to **Postnatal admission – date and time** The date must be greater than or equal to that recorded in **Postnatal admission – date and time.**

2.23.9 Contraception

<table>
<tr><td>Definition</td><td colspan="3">Type of contraception supplied in the six weeks after the birth</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity findings reference set</u> (72591000210107)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Barrier contraceptive</td><td>225370004</td></tr></table></td></tr>
</table>

	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

2.23.10 Contraception – other detail

Definition	Detail of the ‘Other’ contraception method		
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 **Contraception.**		
Guide for use			
Verification rules			

2.23.11 Postnatal prescriptions

Definition	Number of prescriptions supplied 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

2.23.12 Postnatal complementary therapies

Definition	Complementary therapies used 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** (72631000210107)		

Agreed term	SCTID
Acupressure	231107005
Acupuncture	231081007
Aromatherapy	394615007
Chiropractic	182548004
Herbal medicine	414392008
Homeopathy	182968001
Lactation support	408883002
Massage	387854002
Naturopathy	439809005
Reflexology	394614006
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

2.23.13 Family violence screening

Definition	A record of whether the woman/person 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, not screened / 1 Yes, screened / 2 Declined to answer / 3 Unable to ask / 4		
Obligation	Mandatory		
Guide for use			
Verification rules	Multiple responses can be recorded		

2.23.14 Current alcohol consumption

Definition	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** (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 2.16.19 Current alcohol consumption, as this section records status at the end of the postnatal period
Verification rules	Valid code only

2.23.15 Current drug use

Definition	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** (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 2.12.6 History of drug use, as this section records status at the end of the postnatal period
Verification rules	Valid code only

2.23.16 Current drugs used

Definition	Currently used illegal drugs
Source standards	

<table>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand non-medicinal drug reference set</u> (72691000210108)

<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Amphetamines</td><td>703842006</td></tr><tr><td>Aromatic solvent</td><td>117499009</td></tr><tr><td>Benzodiazepine sedative</td><td>372616003</td></tr><tr><td>Cannabis</td><td>398705004</td></tr><tr><td>Cocaine</td><td>387085005</td></tr><tr><td>Codeine phosphate</td><td>261000</td></tr><tr><td>Crack cocaine</td><td>229003004</td></tr><tr><td>Gas (nitrous oxide)</td><td>111132001</td></tr><tr><td>Hallucinogenic agent</td><td>373469002</td></tr><tr><td>Heroin</td><td>387341002</td></tr><tr><td>Methadone</td><td>387286002</td></tr><tr><td>Methamphetamine</td><td>387499002</td></tr><tr><td>Morphine</td><td>373529000</td></tr><tr><td>Synthetic cannabinoid</td><td>788540007</td></tr><tr><td>Other

(SNOMED CT Term: ‘Drug or medicament’)</td><td>410942007</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Current drug user’ to section 2.23.15 Current drug use</td></tr>
<tr><td>Guide for use</td><td colspan="3">This covers illegal drugs or misuse of drugs prescribed for the woman/person or others</td></tr>
</table>

	The information collected for this section is distinct from that collected for section 2.12.7 Current drugs used, as this section records status at the end of the postnatal period
Verification rules	Valid code only

2.23.17 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 **2.23.16 Current drugs used**		
Guide for use	One response should be recorded for each 'Other' instance of use identified in **Current drugs used**.		

2.23.18 Current smoking status

Definition	Current tobacco smoking status		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain			
Obligation	Mandatory		
Guide for use	The information collected for this section is distinct from that collected for section 2.16.23 Current smoking status, as this section records status at the end of the postnatal period		

Agreed term	SCTID
Current smoker	77176002
Current non-smoker	160618006
Declined to answer	426544006

	Three instances of this field may be recorded
Verification rules	Valid code only

2.23.19 Current vaping status

Definition	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** (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 2.16.24 Current vaping status, as this section records status at the end of the postnatal period		
Verification rules	Valid code only		

2.23.20 Postnatal visits

Definition	Number of postnatal visits provided by 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	This value is distinct from that provided in section 2.22.19 Postnatal visits, as this field records visits provided to a woman/person who either has their baby with them, or whose baby is in the care of another person
Verification rules	Valid value only

2.23.21 General practice notification

Definition	Notification of the birth event sent to 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		

2.23.22 Maternal death

Definition	Indicates whether there was a maternal death 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/person 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/person
Verification rules	Valid code only