

JANUARY 2020

TASMANIAN PERINATAL DATA COLLECTION

Guidelines for the completion of the
Perinatal Data Collection Form
Version 7.0

Effective 1 January 2020

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I OPERATION

I.1 Background

The Tasmanian Perinatal Data Collection Form is a mandatory requirement for data collection under the *Obstetric and Paediatric Mortality and Morbidity Act 1994* (previously known as *Perinatal Registry Act 1994*).

For the purpose of section 16 (2) of the Act, the following particulars are required to be recorded:

(2) An attendant must provide the required information in relation to a birth, maternal death or perinatal death to the Council within 7 days after that birth or death.

Required information means the information required by the Council of Obstetric & Paediatric Mortality & Morbidity (the Council) as specified in a form provided or approved by the Council.

For the data submission timeline for data collection, please see section I.6.

The data is used for two purposes:

- To compile a complete record of the outcomes in Tasmania of, and circumstances surrounding, any pregnancy maintained beyond 20 weeks. The items of data collected are either identical to or compatible with those collected throughout Australia as part of the Perinatal National Minimum Data Set. Consequently, the epidemiology of Tasmanian infant and maternal mortality and morbidity can be researched in a number of ways, and understood in relation to Australia as a whole.
- This data collection is the basis for research, which is used to improve understanding, training and education of both the general public and relevant health professionals, which will contribute to the long-term improved health of the Tasmanian community.

This guidelines document provides you with the definitions of terms used on the Perinatal Data Collection Form, and the purpose to which the data gathered will be put.

The majority of data items collected and the definitions used are the same as those in the National Minimum Data Set for perinatal data collections, which has been developed by the Australian Institute of Health and Welfare (AIHW) in consultation with State and Territory health authorities and the Australian Bureau of Statistics. The most recent update of definitions included in this manual are contained in Version 15 of the National Health Data Dictionary (NHDD). The collection of this data will be useful in compiling national studies of the epidemiology of perinatal morbidity and mortality and the circumstances surrounding these events. It will also help Tasmanian clinicians, educators and policy makers to understand Tasmanian epidemiology in comparison with other States.

I.2 Scope

The Tasmanian Perinatal Data Collection collects information on demographic, medical and obstetric information on the mother, and information on the labour, birth and condition of the infant relating to **every birth in Tasmania of at least 20 gestation weeks and/or weighing at least 400 grams at birth.**

Fetus compressus (compressed enough to be noticed) or fetus papyraceous (flattened remarkably through loss of fluid and most of the soft tissue) is within the scope of reporting.

1.3 Responsibility for completion of the Perinatal Data Collection Form

The Tasmanian Perinatal Data Collection Form is required to be completed by all private hospitals and birth centres where the birth occurs, or by private midwifery and medical practitioners who deliver babies outside hospitals.

Please use the electronic perinatal database system (i.e. ObstetrixTas) for all births reported in public and public contracted maternity hospitals.

If the mother and/or baby are transferred from the hospital of confinement, the form should be **completed by the hospital of birth**. In cases where the mother is transferred to another hospital for surgical birth and transferred back to the hospital of confinement immediately after the operation, the form should be **completed by the hospital of confinement**.

*If the mother and/or baby are admitted to hospital after the birth has occurred, a form should be **completed by the hospital where the mother is first admitted**.*

NOTE: A multiple birth requires a separate Perinatal Data Collection Form to be completed for each baby with the same identifying maternal demographic information. Please ensure that the second twin's Perinatal Data Collection Form is also transferred.

1.4 Aim of the perinatal data collection

The aims of the Collection are to:

- monitor patterns of obstetric and neonatal practice in Tasmania
- undertake epidemiological studies on the health of mothers and babies to assist with the planning of Tasmania maternity health services
- provide de-identified data to the AIHW National Perinatal Epidemiology and Statistics Unit or researchers (upon application) for obstetric and neonatal health research purpose.

1.5 Confidentiality of data

All birth records collected are treated as strictly confidential and information provided to the Council is privileged by legislation.

1.6 Data submission timeline

According to the *Act*, 7 days would deem to be a reasonable time for submitting data in all cases.

1.7 Data quality

It is important for each birth setting to have arrangements to ensure procedures for quality assurance of the data. The Department will undertake reviews periodically and an extensive set of rules will apply to the data. This trigger edits for records containing invalid or inappropriate data or data requiring confirmation.

The hospital, birth centre, private midwifery and medical practitioners must take the appropriate action to provide corrections or further information in a timely and effective manner.

1.8 Publication

The Council releases an annual report presenting summary obstetric and perinatal statistics based on the data collected on the form. This report is available on:

http://www.health.tas.gov.au/about_the_department/partnerships/registration_boards/copmm.

The AIHW National Perinatal Epidemiology and Statistics Unit also publish Australia's Mothers and Babies report annually which compiles Australia-wide figures. This report is available on:

<https://www.aihw.gov.au/reports-statistics/population-groups/mothers-babies/overview>.

1.9 Contacts

Question concerning the information outlined in this document and other queries relating to completion of the Perinatal Data Collection Form may be directed to:

Health Information – Monitoring, Reporting and Analysis Unit
Planning Purchasing and Performance Group
Department of Health
GPO Box 125
Hobart TAS 7001
Phone : (03) 6166 1012
Email : ppp.perinataldata@health.tas.gov.au

1.10 General instructions

- Please print clearly using a ballpoint pen and all writing and figures must be legible (paper submission only).
- Use ticks on the form to indicate the appropriate options.
- **ANSWER ALL QUESTIONS.** If a particular item of information is not available or unknown, please fill all numeric fields with '9' or record 'Unknown' in a text field.
- If any data items are not complete, the hospital of birth will be asked to supply the missing information.
- In the case of multiple births, a separate form should be completed for each baby. For example, in the case of twins, two forms are to be completed, identifying each twin as Twin 1 and Twin 2 in the Birth order question of the Baby's Details section.
- Where boxes are present, place a tick or write the appropriate number(s) in the relevant box(es).
- Where there are more boxes provided than necessary, please 'right adjust' your response.

e.g. Weight – 58 kgs

0	5	8
---	---	---

Admission date – 1 May 2013

0	1	0	5	2	0	1	3
---	---	---	---	---	---	---	---

2 DEFINITIONS

It is important that the following definitions are understood and applied when completing all sections of the Perinatal Data Collection Form.

Antenatal care visit

(METeOR identifier: [461257](#))

An intentional encounter between a pregnant woman and a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour.

An antenatal care visit may occur in the following clinical settings:

- antenatal outpatients clinic
- specialist outpatient clinic
- general practitioner surgery
- obstetrician private room
- community health centre
- rural and remote health clinic
- independent midwife practice setting including home of pregnant female

Birthweight

(METeOR identifier: [696102](#))

The first weight of a live born or stillborn baby obtained after birth. The World Health Organisation further defines the following categories:

- extremely low birthweight: less than 1 000 grams (up to and including 999 grams)
- very low birthweight: less than 1 500 grams (up to and including 1 499 grams)
- low birthweight: less than 2 500 grams (up to and including 2 499 grams).

Gestational age

(METeOR identifier: [695332](#))

It is the best clinical estimate of the duration of pregnancy at a specific point in time, based on the first day of the last menstrual period (LMP), ultrasound or physical examination of the baby. When gestational age is calculated using the first day of the LMP, the first day is counted as day zero and not day one. Therefore, a 25 week, 5 day fetus is considered a 25 week fetus (25+0, 25+1, 25+2, 25+3, 25+4, 25+5, 25+6).

Live birth

(METeOR identifier: [327248](#))

Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered as liveborn (World Health Organisation definition).

Neonatal death

(METeOR identifier: [327250](#))

The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

This definition applies regardless of the birthweight or gestational age and also for resuscitated stillbirths. Example obtained from the Perinatal Society of Australia & New Zealand¹ is provided here:

Example 1: Resuscitated stillbirth

Where an infant is stillborn and, following active resuscitation, a heartbeat is detected, the birth is required to be registered as a livebirth. If the infant subsequently dies up to 28 days of age registration as a neonatal death is necessary.

Stillbirth

(METeOR identifier: [482008](#))

Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight.

The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.

Examples are provided here of circumstances which may require clarification.

¹ Flenady V, Oats J, Gardener G, Masson Vicki, McCowan Lesley, Kent A, Tudehope David, Middleton P, Donnelly N, Boyle F, Horey D, Ellwood D, Gordon A, Sinclair L, Humphrey M, Zuccollo J, Dahlstrom J, Mahomed K, Henry S, Khong Y for the PSANZ Care around the time of stillbirth and neonatal death guidelines group. Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death. Version 3, NHMRC Centre of Research Excellence in Stillbirth. Brisbane, Australia, March 2018.
<https://sanda.psanz.com.au/clinical-practice/clinical-guidelines/>

Example 1: Fetus papyraceous and fetus compressus

Fetus papyraceous and fetus compressus are products of conception recognisable as a deceased fetus. These fetal deaths are likely to have occurred before 20 weeks gestation but should be included as stillbirths in perinatal collections if they are recognisable as a fetus and have been expelled or extracted with other products of conception at 20 or more weeks gestational age.

Example 2: Multiple pregnancy²

2A: In the case of a twin pregnancy with a fetal death of Twin 1 at 19 weeks and spontaneous onset of labour and delivery at 23 weeks gestation where Twin 2 is live born weighing 550g and Twin 1 weighs 200g, Twin 1 is registered as a stillbirth and Twin 2 as a livebirth.

2B: In the case of a twin pregnancy with a fetal death and spontaneous delivery of Twin 1 at 19 weeks weighing 200g and subsequent fetal death and delivery of Twin 2 at 21 weeks weighing 300g, Twin 1 is not required to be registered, however Twin 2 must be registered as a stillbirth.

² Flenady V, Oats J, Gardener G, Masson Vicki, McCowan Lesley, Kent A, Tudehope David, Middleton P, Donnelly N, Boyle F, Horey D, Ellwood D, Gordon A, Sinclair L, Humphrey M, Zuccollo J, Dahlstrom J, Mahomed K, Henry S, Khong Y for the PSANZ Care around the time of stillbirth and neonatal death guidelines group. Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death. Version 3, NHMRC Centre of Research Excellence in Stillbirth. Brisbane, Australia, March 2018.
<https://sanda.psanz.com.au/clinical-practice/clinical-guidelines/>

3 SUMMARY OF CHANGES TO THE TASMANIAN PERINATAL DATA COLLECTION GUIDELINES

3.1 Amendments to definition

Old	New
Birthweight (327212)	Birthweight (696102)

3.2 Addition of data elements

Section	Data element	What has changed?
Vaccinations	Vaccinations	Addition of Pertussis and Influenza questions
Maternity Model of Care	Maternity Model of Care	Addition of Maternity Model of Care at the start of care and time of birth

3.3 Amendments to data elements

Section	Data element	What has changed?
Baby's details	Actual place of birth	Addition of Born before arrival
Baby's details	Gestational age at birth	Addition of the gestational day numeral box

3.4 Amendments to the COPMM Maternal Death Reporting Form

The COPMM Maternal Death Reporting form is a separated form. If maternal death is identified, the COPMM Maternal Death Reporting Form must be completed and sent to the Health Information Unit, Department of Health.

4 TASMANIAN PERINATAL DATA COLLECTION FORM

4.1 Mother's details

4.1.1 Hospital code

This refers to the establishment or hospital in which the birth occurred.

Code	Establishment / hospital
1111	Calvary Health Care
1113	Hobart Private Hospital
4182	Home Births (South)
4280	Launceston Birth Centre
4281	Home Births (North)
4384	Home Births (North West)

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.2 URN

This is the number allocated by the hospital to each patient. Please 'right adjust' your response if there are more boxes provided than are necessary.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.3 Surname

The legal surname of the mother.

4.1.4 First name

The full first name of the mother.

4.1.5 Date of birth (mother)

The date of birth of the mother using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

The default date of birth, when the date is not known, is 01011900. If a date is partially known, insert the known parts of the date and use the default values for any unknown parts. (e.g. a mother knows she was born in 1973, but does not know the month or day. The date of birth would therefore be recorded as 01011973).

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.6 Country of birth

The name of the mother's country of birth, as stated by the patient.

If not appropriate, record: "Not stated or Unknown".

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.7 Suburb

The suburb/town where the mother usually resides (not postal address). The Australia Post listing of postcodes and suburbs is available from <http://www.auspost.com.au>.

NOTE: Changes in suburb may occur after these details are initially collected at a 'book-in' or antenatal visit. In these cases it will be necessary to amend the information on the form.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.8 Postcode

The usual residential postcode where the mother usually resides (not postal address). The Australia Post listing of postcodes and suburbs is available from <http://www.auspost.com.au>.

The following postcodes have been allocated for patients from overseas; or no fixed address; or where no further information available:

Code	Description
8888	No fixed address
8899	Non-Australian resident
9999	Not stated/Unknown

NOTE: Changes in postcode may occur after these details are initially collected at a 'book-in' or antenatal visit. In these cases it will be necessary to amend the information on the form.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.9 Indigenous status (mother)

Indigenous Status is a measure of whether a person (mother) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community with which she is associated.

Code:

Tick one of the boxes

- 1 Aboriginal
- 2 Torres Strait Islander
- 3 Aboriginal and Torres Strait Islander
- 4 Neither

Guide for use:

The mother's Indigenous status should be asked directly of the mother, regardless of the information separately recorded in the hospital database.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors. Every mother **must** be asked the following question:

'Are you of Aboriginal or Torres Strait Islander origin?'

If the patient answers 'Yes' to being of Aboriginal or Torres Strait Islander origin, then ask further questions to record correctly the person's indigenous status.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.1.10 Marital status

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

Code:

Tick one of the boxes

- 1 Never married
- 2 Widowed
- 3 Divorced
- 4 Separated
- 5 Married (including de facto)

Guide for use:

This item collects information on social marital status. The recommended question module is:

Do you usually live with a partner in a registered or de facto marriage?

- Yes, in a registered marriage
- Yes, in a de facto marriage
- No, never married
- No, separated
- No, divorced
- No, widowed

4.2 Previous pregnancies

NOTE: This section refers to all previous pregnancies and therefore excludes the current pregnancy. A pregnancy resulting in multiple births should be counted as one pregnancy.

Enter **the number of previous pregnancies (not number of babies born)** resulting in each of:

4.2.1 Livebirths

The number of previous pregnancies resulting in livebirths (i.e. liveborn infants of at least 20 weeks gestation, or weighing at least 400 grams at birth).

Guide for use:

A pregnancy resulting in multiple births should be counted as one pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

4.2.2 Stillbirths

The number of previous pregnancies resulting in stillbirths (i.e. a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight. The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles).

Guide for use:

A pregnancy resulting in multiple births should be counted as one pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

4.2.3 Ectopic pregnancy

Ectopic pregnancy is defined as any pregnancy occurring outside the uterus terminating at less than 20 weeks.

4.2.4 Miscarriage

Spontaneous loss of confirmed pregnancy before 20 weeks gestation or less than 400 grams birthweight if gestational age is unknown. Confirmation of pregnancy can be either by positive pregnancy test or ultrasound scan.

4.2.5 Terminated pregnancy

A terminated pregnancy is defined as a live pregnancy that is artificially terminated prior to 20 weeks gestational age.

Guide for use:

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

4.2.6 Parity

The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth, **excluding this current pregnancy**.

This data element excludes:

- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation
- ectopic pregnancies.

4.2.7 Number of neonatal deaths

The total number of neonatal deaths as a result from the previous pregnancies.

Guide for use:

Neonatal death is defined as the death of an infant in period following livebirth, up until 28 days of age.

Have any of the previously reported liveborn infants died prior to reaching 28 days of age?

4.2.8 Number of previous caesarean sections

The total number of previous pregnancies where the method of delivery was caesarean section.

Guide for use:

This item should be completed if there has been a previous birth. In the case of no previous birth, the item should be left blank.

Birth of twins via caesarean section counts as one caesarean section.

4.2.9 Mode of last delivery

The mode of the last delivery. Select Not applicable (N/A) if this is the first delivery.

Code:

Tick one of the boxes

- 1 Vaginal
- 2 Caesarean section
- 3 N/A

Guide for use:

This field only relates to the last birth, not necessarily the last pregnancy.

- If the mother has had two previous pregnancies and the last pregnancy resulted in a terminated pregnancy, record the delivery mode of the first pregnancy.
- If a previous multiple pregnancy resulted in two or more different delivery methods (e.g. vaginal and caesarean section), tick caesarean section.

4.3 This pregnancy

4.3.1 Estimated date of confinement

Enter the day, month and year of the best estimated date of confinement (EDC) for this pregnancy using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

4.3.2 EDC determined by

The most accurate option through which the estimated date of confinement has been determined.

Code:

Tick one of the boxes

- 1 Known conception
- 2 Known date LMP
- 3 Ultrasound < 12 weeks
- 4 Ultrasound > 12 weeks

4.3.3 Is this pregnancy the result of assisted reproductive technology?

Whether Artificial Reproductive Technology (ART) was used to achieve this pregnancy.

Code:

Tick one of the boxes

- 1 No
- 2 Yes

4.3.4 Intended place of birth

Indicate the place in which the mother plans to give birth.

- **Hospital** – includes all registered hospitals as well as designated hospital beds in multi-purpose centres.
- **Birth centre** – an approved facility, separate to a hospital, for the provision of birthing services and staffed by a qualified midwife. There is an approved birth centre in Launceston.
- **Home/other** – the mother **intends** to give birth in their own home, or in the home of another person, or in any other location not listed above.

Code:

Tick one of the boxes

- 1 Hospital
- 2 Birth centre
- 3 Home/other

4.3.5 Intending to breastfeed

Whether the mother intends to breastfeed the baby.

Code:

Tick one of the boxes

- 1 No
- 2 Yes
- 3 Unsure

4.3.6 Plurality

The number of babies resulting from this pregnancy.

Code:

Tick one of the boxes and enter the total number of babies resulting from this pregnancy in the boxes provided if this is a multiple pregnancy.

- 1 Single
- 2 Multiple

Guide for use:

Plurality of a pregnancy is determined by the number of fetuses that remain in utero at 20 weeks gestation. If gestational age is unknown, only live born fetuses (of any birth weight) and stillborn fetuses weighing 400 grams or more are taken into account in determining plurality.

Fetuses aborted before 20 completed weeks are excluded. Fetuses compressed in the placenta (fetus papyraceous) at 20 or more weeks and expelled at time of delivery are included.

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

4.3.7 Gestation at first antenatal visit

The number of completed weeks of the current pregnancy's estimated duration on the day of the first visit for antenatal care.

The valid range of completed weeks for pregnancy duration at the first visit for antenatal care is 03 – 46. Please 'right adjust' your response if there are more boxes provided than are necessary.

Guide for use:

The day of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues. It does not include a first contact after the onset of labour.

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

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

4.3.8 Total number of antenatal visits

The total number of antenatal care visits attended by a pregnant female for the current pregnancy.

Guide for use:

In rural and remote locations where a midwife or doctor is not employed, registered Aboriginal health workers and registered nurses may perform this role within the scope of their training and skill licence.

Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record.

Antenatal visit does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues. It does not include a first contact after the onset of labour.

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

4.3.9 Height

The mother's height in total centimetres. This item can either be measured or self-reported and will be used in conjunction with self-reported weight for Body Mass Index (BMI) assessment.

The valid range of height is 100 – 250. Please 'right adjust' your response if there are more boxes provided than are necessary.

4.3.10 Weight

The mother's weight (body mass) in total kilograms around the time of conception. This item is self-reported and will be used in conjunction with height for Body Mass Index (BMI) assessment.

The valid range of weight is 20 – 300. Please 'right adjust' your response if there are more boxes provided than are necessary.

4.4 Antenatal testing

Indicate those, if any, of the listed procedures that were performed.

More than one box may be ticked. If no procedures were performed tick 'None'.

Code:

Tick one or more of the boxes.

- 1 None
- 2 1st trimester Downs screening
- 3 2nd trimester Downs screening
- 4 Amniocentesis
- 5 Chorionic villus sampling
- 6 Screening for gestational diabetes
- 7 GBS screen
- 8 Level 2 ultrasound
- 9 Non-invasive prenatal testing

4.5 Antenatal screening

4.5.1 Mental health condition

Indicate whether mental health condition has been screened.

Code:

Tick one of the boxes

- 1 Yes
- 2 Not offered
- 3 Declined

4.5.2 Domestic violence

Indicate whether domestic violence has been screened.

Code:

Tick one of the boxes

- 1 Yes
- 2 Not offered
- 3 Declined

4.6 Pre pregnancy conditions

Indicate those, if any, of the listed conditions, diseases or illnesses the mother has prior to pregnancy (pre-existing) or arising during the current pregnancy, which are not directly attributable to the pregnancy but may significantly affect care during pregnancy and/or pregnancy outcome.

- **Pre-existing Type 1 diabetes** – Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.
- **Pre-existing Type 2 diabetes** – Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.
- **Other type of diabetes mellitus** – This categorisation includes less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes. Impaired glucose regulation is not to be included here.
- **Insulin** – this includes fast or rapid-acting, short-acting, intermediate-acting, mixed or long-acting insulin.
- **Oral hypoglycaemic** – This includes the options of sulphonylurea, biguanide (e.g. metformin), alpha-glucosidase inhibitor, thiazolidinedione, meglitinide, combination (e.g. biguanide & sulphonylurea), or other.
- **Diet and exercise** – This includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.
- **Chronic hypertension** – This may include essential or secondary hypertension. Essential hypertension is defined by a blood pressure > 140 mmHg systolic and/or > 90mm diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause. It may also be diagnosed in women presenting early in pregnancy taking antihypertensive medications where no secondary cause for hypertension has been determined.

Important secondary causes of chronic hypertension in pregnancy include:

- Chronic kidney disease, e.g. glomerulonephritis, reflux nephropathy, and adult polycystic kidney disease.
- Renal artery stenosis
- Systemic disease with renal involvement, e.g. diabetes mellitus, systemic lupus erythematosus.
- Endocrine disorders, e.g. pheochromocytoma, Cushing syndrome and primary hyperaldosteronism.
- Coarctation of the aorta.

In the absence of any of the above conditions it is likely that a woman with high blood pressure in the first half of pregnancy has essential hypertension.

More than one box may be ticked. If the mother has no current medical conditions, tick 'None'. Where 'Other' is ticked, please provide further detail.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Cardiovascular
- 3 Thyroid
- 4 Diabetes mellitus
 - 4.1 Pre-existing Type 1 diabetes
 - 4.2 Pre-existing Type 2 diabetes
 - 4.3 Other type of diabetes mellitus
- Treatment:
 - 4.4 Insulin
 - 4.5 Oral hypoglycaemic
 - 4.6 Diet and exercise
- 5 Mental health
- 6 Renal disease
- 7 Epilepsy
- 8 Chronic hypertension
- 9 Other

Guide for use:

Diabetes mellitus

Note that where there is a Gestational diabetes mellitus (GDM) and a current history of Pre-existing Type 2 diabetes then record Pre-existing Type 2 diabetes.

While most women will know what type of diabetes they have, where their type of diabetes is unknown the clinician should leave it blank.

Indicate if the mother suffered from any of the listed conditions. If more than one option is appropriate, tick ALL appropriate options.

4.7 Smoking / alcohol / drug

4.7.1 Did the mother smoke at all during the first half (< 20 weeks) of pregnancy?

Whether the mother smoked cigarette at any time during the first 20 weeks of the pregnancy.

Tick the box that corresponds to the mother's smoking status.

Code:

Tick one of the boxes

- 1 No
- 2 Yes

Guide to use:

If 'yes' to this question, record the average number of cigarettes smoked per day in the boxes provided.

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

4.7.2 Did the mother smoke at all during the second half (\geq 20 weeks) of pregnancy?

Whether the mother smoked cigarette at any time after the first 20 weeks of the pregnancy until birth.

Tick the box that corresponds to the mother's smoking status.

Code:

Tick one of the boxes

- 1 No
- 2 Yes

Guide to use:

If 'yes' to this question, record the average number of cigarettes smoked per day in the boxes provided.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.7.3 Did the mother consume alcohol at all during the first half (< 20 weeks) of pregnancy?

Whether the mother consumed alcohol at any time during the first 20 weeks of the pregnancy.

Tick the box that corresponds to the mother's drinking status.

Code:

Tick one of the boxes

- 1 Never
- 2 Monthly or less
- 3 2-3 times a week
- 4 2-4 times a month
- 5 ≥ 4 times a week

Guide to use:

If not 'never' to this question, record the number of standard drinks consumed on a typical day in the boxes provided.

4.7.4 Did the mother consume alcohol at all during the second half (≥ 20 weeks) of pregnancy?

Whether the mother consumed alcohol at any time after the first 20 weeks of the pregnancy.

Tick the box that corresponds to the mother's drinking status.

Code:

Tick one of the boxes

- 1 Never
- 2 Monthly or less
- 3 2-3 times a week
- 4 2-4 times a month
- 5 ≥ 4 times a week

Guide to use:

If not 'never' to this question, record the number of standard drinks consumed on a typical day in the boxes provided.

4.7.5 Did the mother smoke marijuana during the pregnancy?

Whether the mother smoke marijuana at any time of the pregnancy.

Tick the box that corresponds to the mother's smoking marijuana status.

Code:

Tick one of the boxes

- 1 No
- 2 Yes
- 3 Not stated

4.7.6 Did the mother use other recreational drugs during the pregnancy?

Whether the mother used other recreational drugs at any time of the pregnancy.

Tick the box that corresponds to the mother's recreational drugs usage status.

Code:

Tick one of the boxes

- 1 No
- 2 Yes
- 3 Not stated

4.8 Vitamin supplements

Indicate those, if any, of the vitamin supplements that were consumed.

More than one box may be ticked. If no vitamin supplements were consumed tick 'None'.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Iron
- 3 Iodine
- 4 Vitamin D
- 5 Folate, pre-conceptually
- 6 Folate, post-conceptually
- 7 Multi vitamins (pregnancy)
- 8 Multi vitamins (other)

4.9 Vaccinations

4.9.1 Pertussis

Indicate whether a pregnant woman has been immunised with Pertussis.

Code:

Tick one of the boxes

- 1 Vaccinated during 1st trimester
- 2 Vaccinated during 2nd trimester
- 3 Vaccinated during 3rd trimester

4.9.2 Influenza

Indicate whether a pregnant woman has been immunised with Influenza.

Code:

Tick one of the boxes

- 1 Vaccinated during 1st trimester
- 2 Vaccinated during 2nd trimester
- 3 Vaccinated during 3rd trimester

4.10 Maternity Model of Care

Indicate which category of model of maternity care is allocated to a pregnant woman at start of care **AND** time of birth.

- **Private obstetrician** – Antenatal care provided by a private specialist obstetrician. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and may continue in the home, hotel or hostel.
- **Private midwifery care** – Antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives in collaboration with doctors in the event of identified risk factors. Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
- **GP obstetrician** – Antenatal care provided by a GP obstetrician. Intrapartum care is provided in either a private or public hospital by the GP obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community.
- **Shared care** – Antenatal care is provided by a community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff under an established agreement, and can occur both in the community and in hospital outpatient clinics. Intrapartum and early postnatal care usually takes place in the hospital by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).
- **Combined care** – Antenatal care provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care provided in the public hospital by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
- **Public hospital maternity care** – Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/or doctors. Care could also be provided by a multidisciplinary team. Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. Postnatal care may continue in the home or community by hospital midwives.
- **Public hospital high risk maternity care** – Antenatal care is provided to women with medical high risk/complex pregnancies by maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives) with an interest in high risk maternity

care in a public hospital. Intrapartum and postnatal care is provided by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives.

- **Team midwifery care** – Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors. Intrapartum care is usually provided in a hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.
- **MGP caseload care** – Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance with collaboration with doctors in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
- **Remote area maternity care** – Antenatal and postnatal care is provided in remote communities by a remote area midwife (or a remote area nurse) or group of midwives sometimes in collaboration with a remote area nurse and/or doctor. Antenatal care may also be provided via telehealth or fly-in-fly-out clinicians in an outreach setting. Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (involving temporary relocation prior to labour) by hospital midwives and doctors.
- **Private obstetrician and privately practising midwife joint care** – Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same collaborative private practice. Intrapartum care is usually provided in either a private or public hospital by the privately practising midwife and/or private specialist obstetrician in collaboration with hospital midwifery staff. Postnatal care is usually provided in the hospital and may continue on in the home, hotel or hostel by the privately practising midwife.

Code:

Tick one of the boxes in the start of care **AND** time of birth columns.

- 1 Private obstetrician
- 2 Private midwifery care
- 3 GP obstetrician
- 4 Shared care
- 5 Combined care
- 6 Public hospital maternity
- 7 Public hospital high risk maternity
- 8 Team midwifery care
- 9 MGP caseload care
- 10 Remote area maternity care
- 11 Private obstetrician and privately practising midwife joint care
- 12 Other

4.11 Admission

4.11.1 Date of admission (in which birth occurs)

The date on which a pregnant woman commences an episode of care as an in-patient, resulting in confinement (delivery) using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

4.11.2 Admitted patient election status

Indicate if the mother has elected to be treated as a public or private patient on admission to hospital.

- **Public** – An eligible person who, on admission to a recognised hospital or soon after, elects to be a public patient.
- **Private** – An eligible person who, on admission to a recognised hospital or soon after elects to be a private patient treated by a medical practitioner of his or her choice; or elects to occupy a bed in a single room.
- **N/A** – Use for non-admitted patients (e.g. home births).

Code:

Tick one of the boxes.

- 1 Public
- 2 Private
- 3 N/A

4.11.3 Transfer of patient prior to delivery

Indicate if the mother was transferred to the birthing hospital prior to delivery.

- **No transfer** – The patient was not transferred before delivery.
- **Hospital to hospital** – The patient was transferred from the hospital where the delivery was planned to occur to another hospital prior to delivery.
- **Birth centre to hospital** – The patient was transferred from a birthing centre to a hospital before delivery.
- **Home to hospital** – The patient was transferred from a home, where an intended home birth was planned, to hospital prior to delivery.

Code:

Tick one of the boxes.

- 1 No transfer
- 2 Hospital to hospital
- 3 Birth centre to hospital
- 4 Home to hospital

4.12 Obstetric complications

Indicate those, if any, of the listed conditions arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during pregnancy and/or pregnancy outcome.

More than one box may be ticked. If the mother has no obstetric complications, tick 'None'. Where 'Other' is ticked, please provide further detail.

- **None** – There were no obstetric complications.
- **Bleed < 20 weeks (threatened miscarriage)** – Any vaginal bleeding occurred before 20 weeks gestation.
- **Placenta praevia** – Ultrasound diagnosis of a placenta that is located partly or completely in the lower uterine segment of the uterus, **after 28 weeks gestation.**
- **APH undetermined origin** – Any bleeding from the genital tract occurring after 20 weeks, with estimated blood loss greater than 20 mls, for which no known cause can be found.
- **Placental abruption** – Premature separation of the placenta, with either or both of revealed (vaginal) or concealed bleeding between the placenta and the uterine wall.
- **Threatened premature labour** – Uterine contractions occurring between 20 and 37 completed weeks of pregnancy, requiring admission to hospital and treatment, with tocolytic therapy.
- **Pregnancy induced hypertension** – Gestational hypertension is characterised by the new onset of hypertension after 20 weeks gestation without any maternal or fetal features of preeclampsia, followed by return of blood pressure to normal within 3 months post-partum.
- **Pre-eclampsia** – Preeclampsia is a multi-system disorder unique to human pregnancy characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis.

A diagnosis of preeclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following: renal involvement, haematological involvement, liver involvement, neurological involvement, pulmonary oedema, fetal growth restriction, placental abruption.

Women with HELLP syndrome (which stands for Haemolysis, Elevated Liver Enzymes, Low Platelet count and is a variant of preeclampsia) are to be included under preeclampsia.

- **Eclampsia** – Eclampsia is characterised by grand mal seizures, hypertension, proteinuria, oedema and may progress to coma. Before a seizure, a patient may experience a body temperature of over

40°C, anxiety, epigastric pain, severe headache and blurred vision. Complications of eclampsia may include cerebral haemorrhage, pulmonary oedema, renal failure, abruption placentae and temporary blindness (National Centre for Classification in Health, 2010).

- **Prolonged rupture of membranes (> 18 hours)** – Confirmed rupture of membranes for 18 (eighteen) hours or longer (not dependent on gestation for this criterion to be met).
- **Pre-labour rupture of membranes** – Confirmed rupture of membranes prior to the onset of labour, but for less than 18 hours.
- **Gestational diabetes** – GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or if the condition persists after pregnancy.

Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines. If the clinician does not have information as to whether these guidelines have been used, available information about diagnosis of GDM is still to be reported.

- **Other** – Include conditions complicating pregnancy not listed above. For example, thrombosis, intrauterine growth restriction (IUGR), infection such as varicella etc.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Bleed < 20 weeks (threatened miscarriage)
- 3 Placenta praevia
- 4 APH undetermined origin
- 5 Placental abruption
- 6 Threatened premature labour
- 7 Hypertension
 - 7.1 Pregnancy induced hypertension
 - 7.2 Pre-eclampsia
 - 7.3 Eclampsia
- 8 Prolonged rupture of membranes (> 18 hours)
- 9 Pre-labour rupture of membranes
- 10 Gestational diabetes, treatment
 - 10.1 Insulin
 - 10.2 Oral Hypoglycaemic
 - 10.3 Diet and exercise
- 11 Other

Guide to use:

In the case of a birth after 20 weeks gestation where the birth weight is less than 400 grams and where the Intrauterine Fetal Death (IUFD) may have occurred some time before the birth, the birth is considered a stillbirth except in the case of fetus papyraceus where the fetus is not readily recognisable. Fetus papyraceus is recorded in obstetric complications.

Hypertension

More than one option can be selected when reporting on this item. For example, for a woman who has preeclampsia superimposed on chronic hypertension, select both preeclampsia (in the Obstetric complications section) and chronic hypertension (in the pre pregnancy conditions section). For a woman who develops pregnancy induced hypertension which progresses to eclampsia, select eclampsia and pregnancy induced hypertension.

4.13 Labour and delivery

4.13.1 Onset of labour

Indicate the manner in which labour commenced.

- **Spontaneous** – a labour that commences naturally and with no external aid.
- **Induced** – labour is initiated by the use of drugs (oral, intravaginal or intravenous) such as oxytocin (Syntocinon), prostaglandins or their derivatives (i.e. medical induction), or artificial rupture of the membranes either by hindwater or forewater rupture (i.e. surgical induction).
- **None** – the absence of labour (e.g. where there is an elective caesarean section or a failed induction followed by an emergency caesarean section).

Code:

Tick one of the boxes.

- 1 Spontaneous
- 2 Induced
- 3 None

Guide for use:

Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.13.2 Method of induction

Indicate the method(s) used to induce labour.

More than one box may be ticked. If the labour was spontaneous in onset or no labour, please leave this field blank.

Code:

Tick one or more of the boxes.

- 1 Prostaglandin
- 2 ARM
- 3 Balloon
- 4 Oxytocin
- 5 Antiprogestogen
- 6 Other

4.13.3 Indication for induction of labour

Indicate maximum of 5 reason(s) for which labour was induced.

More than one box may be numbered. Please rank the following items in order of importance with #1 being the main reason to #5 being the least important reason. If the labour was spontaneous in onset or no labour, please leave this field blank.

- **Prolonged pregnancy** – While prolonged pregnancy is commonly defined as greater than or equal to 41 weeks, in some circumstances a clinician may recommend inducing a woman earlier than this. Such circumstances include advanced maternal age which may elevate the degree of risk (Haavaldsen et al 2010). Other special circumstances may apply (see, for example, Yao et al 2014; Drysdale et al 2012).

With appropriate professional judgement, these cases may be coded under *Prolonged pregnancy*. Consideration could be given to coding *Maternal age* and other specific indications as additional indications where applicable.

- **Prelabour rupture of membranes** – Can refer to preterm or term spontaneous rupture of membranes, occurs before labour has commenced, and may be prolonged.
- **Hypertensive disorders** – Includes chronic (essential and secondary) and gestational hypertensive disorders, preeclampsia and HELLP syndrome (HELLP stands for Haemolysis, Elevated Liver enzymes, Low Platelet count).
- **Body Mass Index (BMI)** – May refer to low or high BMI.
- **Maternal mental health indication** – Refers to diagnosed mental health disorders and conditions.
- **Previous adverse perinatal outcome** – A woman who experienced a previous late unexplained stillbirth or other adverse perinatal outcome may wish to be induced.
- **Other maternal obs/med indication** – Examples include renal disease, abnormal liver function tests, cardiac disease, Deep Vein Thrombosis (DVT), antiphospholipid syndrome, chronic back pain,

dental infections, gestational thrombocytopenia, Lupus, hip dysplasia, history of pulmonary embolism etc.

Note that diagnosed maternal mental health disorders and conditions should be coded under *Maternal mental health indication*.

- **Fetal compromise (incl suspected)** – Includes oligohydramnios, reduced fetal movement, abnormal antenatal cardiotocography (CTG), abnormal Doppler, other abnormalities of fetal wellbeing (e.g. abnormal profile).
- **Fetal growth restriction (incl suspected)** – It is not always possible to determine fetal growth restriction (also known as intra uterine growth restriction (IUGR)) until the baby is born therefore this code is for actual or suspected fetal growth restriction.
- **Administrative/geographical indication** – Examples include: to fit with a caregiver's schedule, to ensure availability of theatre, anaesthetist or other staffing reasons. This code could also be used where a pregnant woman is normally resident in a rural or remote area or an area without adequate birthing facilities and the need for induction is determined by such factors as the available facilities and the woman's ability and availability to travel to a centre with suitable facilities.
- **Maternal choice** – Note this is not to be used in conjunction with other indications.

This should be used where the woman has requested an induction and none of the other permissible values, including *Other indication not elsewhere classified*, apply.

It is important to distinguish between a woman's choice, and other indications such as maternal medical/obstetric, fetal and administrative/geographical reasons for induction.

Where the clinician determines that a diagnosed maternal mental health indication is the reason for the induction, *Maternal mental health indication* should be selected. *Administrative or geographical indication* should also be considered for relevance as per the examples provided in the Guide for use for that code. These codes may be selected as main or additional indications.

- **Other indication not elsewhere classified** – Includes other fetal indications such as fetal anaemia and isoimmunisation; and other indications not coded under any other permissible value in the list of indications.

Code:

- 1 Prolonged pregnancy
- 2 Prelabour rupture of membranes
- 3 Diabetes
- 4 Hypertensive disorders
- 5 Multiple pregnancy
- 6 Chorioamnionitis (incl suspected)
- 7 Cholestasis of pregnancy
- 8 Antepartum haemorrhage
- 9 Maternal age
- 10 Body Mass Index (BMI)
- 11 Maternal mental health indication

- 12 Previous adverse perinatal outcome
- 13 Other maternal obs/med indication.
- 14 Fetal compromise (incl suspected)
- 15 Fetal growth restriction (incl suspected)
- 16 Fetal macrosomia (incl suspected)
- 17 Fetal death
- 18 Fetal congenital anomaly
- 19 Administrative/geographical indication
- 20 Maternal choice
- 21 Other indication not elsewhere classified

4.13.4 Augmentation of labour

Indicate the method(s) used to assist progress if the labour was induced or spontaneous in onset but subsequently augmented. If the labour was not augmented, tick 'Not augmented'.

Both ARM and Oxytocin may be ticked.

Code:

Tick one or more of the boxes. If no labour, please leave this field blank.

- 1 ARM
- 2 Oxytocin
- 3 Not augmented

4.13.5 Analgesia during labour

Indicate the type of analgesia administered to the woman to relieve pain during labour and delivery, excluding analgesia given for third stage labour. If no analgesia was administered or the mother did not have a labour, tick 'None'.

More than one agent or technique can be selected, except where 'None' applies.

Code:

Tick one or more of the boxes.

- 1 None
- 2 O₂ / Nitrous Oxide
- 3 IM Opioids
- 4 Epidural/caudal
- 5 IV Opioids
- 6 Pudendal
- 7 Spinal
- 8 Other

4.13.6 Principal accoucheur

Indicate the principal person who presented at, and managed the birth.

- **Obstetrician** – A medical doctor who is qualified in the field of obstetrics.
- **Midwife** – A registered midwifery nurse practitioner who is qualified in the field of midwifery or midwifery trainee who is trained to obtain qualifications in the field of midwifery.
- **GP Obstetrician** – A general practitioner with accredited clinical privileges in obstetrics.
- **Hospital Medical Officer** – Includes Registrars and Resident Medical Officers.
- **Other** – e.g. ambulance officer, relative, member of the public.

Code:

Tick one of the boxes.

- 1 Obstetrician
- 2 Midwife
- 3 GP Obstetrician
- 4 Hospital Medical Officer
- 5 Other

4.13.7 Labour & delivery complications

Indicate the type of medical and obstetric problem, necessitating intervention, arising after the onset of labour and before the completed delivery of the infant and placenta.

More than one box may be ticked. If no labour and delivery complications, tick 'None'.

- **None** – No labour & delivery complications.
- **Grade 2–3 meconium** – The presence of definite meconium in the amniotic fluid (excludes light or intermittent discolouration with meconium).
- **Shoulder dystocia** – Any delivery where specific manoeuvres such as McRoberts, rotation of anterior shoulder or delivery of posterior arm were required to effect delivery of the shoulders.
- **Primary PPH (>500 mls in the first 24 hours)** – Abnormal or excessive blood loss from the genital tract after childbirth, occurring within 24 hours of birth.
 - **Est amount of blood loss** – Estimated amount of abnormal or excessive blood loss from the genital tract within the first 24 hours postpartum.
 - **PPH requiring blood transfusion?** – Postpartum haemorrhage requiring transfusion of blood, blood products or blood substitutes (including autologous blood via a cell salvage procedure), but excludes volume expanders.
- **Retained placenta (requiring manual removal)** – A third stage lasting more than 30 minutes. Complications that contribute to intervention in labour should be recorded, e.g.
 - Delay in 2nd stage labour – Vacuum extraction
 - Fetal distress – Emergency caesarean section
 - Deep transverse arrest – Forceps rotation and delivery
- **Other** – If there are other complications of labour or delivery that are not listed with a tick box.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Grade 2-3 meconium
- 3 Shoulder dystocia
- 4 Primary PPH (>500 in first 24 hours)
 - 4.1 Est amount of blood loss
 - 4.2 PPH requiring blood transfusion?
- 5 Retained placenta (requiring manual removal)
- 6 Other

4.13.8 Perineal status

Indicate the stage of the perineum following birth. Does not include vaginal or labial grazes.

More than one box may be ticked. If a tear occurs in conjunction with an episiotomy, please tick the box indicating the degree of tear, as well as the box for episiotomy.

- **Intact** – The perineum is intact following delivery.
- **1st degree tear** – Includes those which require no suturing.
- **2nd degree tear** – Involves the perineal body and vagina, but not the anal sphincter(s).
- **3rd degree tear** – Involves the external anal sphincter, and the anal mucosa.
- **4th degree tear** – Includes the anal canal/rectum.
- **Episiotomy** – Surgical incision into the perineum and vagina to assist delivery.

Code:

Tick one or more of the boxes.

- 1 Intact
- 2 1st degree tear
- 3 2nd degree tear
- 4 3rd degree tear
- 5 4th degree tear
- 6 Episiotomy

4.13.9 Indication for caesarean section

Indicate maximum of 5 reason(s) for caesarean section to be performed.

More than one box may be numbered. Please rank the following items in order of importance with #1 being the main reason to #5 being the least important reason. If the type of birth is not a caesarean section, please leave this field blank.

- **Fetal compromise** – This includes suspected or actual fetal compromise and intra uterine growth restriction (IUGR).
- **Lack of progress; ≤ 3 cm cervical dilatation** – Lack of progress includes slow or no progress.
This code may be appropriate for cases of unsuccessful induction.
- **Lack of progress in the first stage; 4 to <10 cm cervical dilatation** – lack of progress includes slow or no progress.
- **Lack of progress in the second stage** – lack of progress includes slow or no progress.

- **Placenta praevia** – Record placental praevia as the indication for caesarean section if there is ultrasound or clinical evidence that the edge of the placenta covers the internal cervical os, or encroaches into the lower segment less than 2 cm away from the internal cervical os.
- **Placental abruption** – Record placental abruption as the indication for caesarean section if there is ultrasound or clinical evidence antenatally of abruption of the placenta prior to onset or during labour.
- **Vasa praevia** – Record vasa praevia as the indication for caesarean section if there is ultrasound or visual evidence of exposed fetal blood vessels running across the fetal membrane below or at the level of the fetal presenting part in the lower segment of the uterus. This code is to be used when the caesarean section is planned or in the case of an emergency when the vessels may have ruptured.
- **Antepartum/intrapartum haemorrhage** – Record antepartum/intrapartum haemorrhage as the indication for caesarean section if there has been any antenatal or intrapartum vaginal bleeding that leads to the immediate delivery of the baby by caesarean section. This code should only be used as a main indication if a more specific cause of the antepartum/intrapartum haemorrhage is not known.

Where there is a vasa praevia and an antepartum/intrapartum haemorrhage, *Vasa praevia* is to be recorded as the main indication and *Antepartum/intrapartum haemorrhage* as a less important indication.

- **Previous severe perineal trauma** – Includes previous 4th degree tears and other perineal damage or injury where a woman is symptomatic and the clinician determines the caesarean section if justified.
- **Other indication not elsewhere classified** – Where a woman has a psychopathological indication for caesarean section, e.g. extreme fear of natural childbirth, this code should be used. It is not to be used for psychosocial indications which should be coded under *Maternal choice*.
- **Maternal choice** – This includes psychosocial indications. Note that code is not to be used in conjunction with other indications.

Code:

- 1 Fetal compromise
- 2 Suspected fetal macrosomia
- 3 Malpresentation
- 4 Lack of progress ≤ 3 cm
- 5 Lack of progress in the 1st stage, 4 to <10 cm
- 6 Lack of progress in the 2nd stage
- 7 Placenta praevia
- 8 Placental abruption
- 9 Vasa praevia
- 10 Antepartum/intrapartum haemorrhage
- 11 Multiple pregnancy
- 12 Unsuccessful attempt at assisted delivery

- 13 Cord prolapse
- 14 Previous adverse perinatal outcome
- 15 Previous caesarean section
- 16 Previous severe perineal trauma
- 17 Previous shoulder dystocia
- 18 Other indication not elsewhere classified
- 19 Maternal choice

4.13.10 Was the caesarean section

If the type of birth is not a caesarean section, please leave this field blank.

a) Elective or emergency?

- **Elective** – A planned procedure performed
 - Prior to onset of labour and before spontaneous rupture of membranes and
 - Without any procedure to induce labour.
- **Emergency** – Emergency caesarean section includes any caesarean section performed as an unplanned (at that time) procedure, including booked elective caesarean section with ROM or contractions prior to elective procedure, caesarean section performed because of abnormal fetal monitoring prior to onset of labour, failure to progress, dystocia etc.

Code:

Tick one of the boxes.

- 1 Elective
- 2 Emergency

b) Primary or repeat?

- **Primary** – Caesarean section to mother with no previous history of caesarean section.
- **Repeat** – Caesarean section to mother with history of caesarean section.

Code:

Tick one of the boxes.

- 1 Primary
- 2 Repeat

4.13.11 Anaesthesia for delivery

Indicate the type of anaesthesia administered to the woman by injection or inhalation to remove sensation (feeling and pain) during birth and anaesthesia administered for the operative delivery of the baby (caesarean section or instrumental delivery). If the woman did not have caesarean section or instrumental delivery, tick 'None'.

More than one agent can be selected, except where 'None' applies.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Pudendal
- 3 Spinal
- 4 Local anaesthetic
- 5 Epidural/caudal
- 6 General anaesthetic

4.14 Baby's details

4.14.1 URN

This is the number allocated by the hospital to each baby. Please 'right adjust' your response if there are more boxes provided than are necessary.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.2 Date of birth (baby)

The date of birth of the baby using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.3 Presentation at birth

Indicate the presenting part of the fetus (that is, at lower segment of uterus) at birth. In a vaginal breech with forceps to the affronting head, code as "breech". ALL caesarean sections should have the presentation recorded.

- **Vertex** – Presentation is where the occiput is the point of reference.
- **Breech** – Presentation includes breech with extended legs, breech with flexed legs, footling and knee presentations.
- **Face** – Presentation where the fetal head is hyperextended and the area of the head below the root of the nose and the orbital ridges is at the uterine cervix.
- **Brow** – Presentation where the fetal head is partly extended and the area of the head between the anterior fontanelle and the root of the nose is at the uterine cervix.
- **Other** – Examples include compound presentations.

Code:

Tick one of the boxes.

- 1 Vertex
- 2 Breech
- 3 Face
- 4 Brow
- 5 Other

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.4 Mode of birth

Indicate the method of complete expulsion or extraction from its mother of a product of conception. In a vaginal breech with forceps to the affronting head, code as "forceps rotation". The final method of expulsion is to be selected. For example, where there is rotation with forceps followed by vacuum extraction the mode of birth should be recorded as vacuum extraction.

- **Non-instrumental vaginal** – spontaneous vaginal birth requiring no mechanical or surgical assistance (excluding spontaneous breech birth).
- **Forceps – low** – Station +2 or below
- **Forceps – mid** – Station 0 or +1
- **Forceps rotation** – Delivery by forceps involving rotation of fetal head from any position more than 45 degrees from direct OA (includes correction of transverse arrest, rotation from direct OP, but not including delivery as direct OP)
- **Vacuum extraction** – Delivery assisted by any type of vacuum device
- **Vacuum rotation** – As above for 'vacuum extraction', where rotation of the fetal head through more than 45 degrees is required to effect delivery
- **Caesarean section** – the delivery of a fetus through an abdominal incision.

Code:

Tick one of the boxes.

- 1 Non-instrumental vaginal
- 2 Forceps – low
- 3 Forceps – mid
- 4 Forceps rotation
- 5 Vacuum extraction
- 6 Vacuum rotation
- 7 Caesarean section

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.5 Indigenous status (baby)

Indigenous status is a measure of whether a person (baby) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community with which they live.

Code:

Tick one of the boxes

- 1 Aboriginal
- 2 Torres Strait Islander
- 3 Aboriginal and Torres Strait Islander
- 4 Neither

Guide for use:

The parent or guardian should be asked about the indigenous status of the child. If the parent or guardian of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors. Every parent or guardian of a newborn baby must be asked the following question:

'Is the baby of Aboriginal or Torres Strait Islander origin?'

If the parent or guardian answers 'Yes' to being of Aboriginal or Torres Strait Islander origin, then ask further questions to record correctly the person's Indigenous status.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.6 Actual place of birth

Indicate the actual place where the birth occurred.

- **Hospital** –The definition of hospitals include all registered hospitals as well as designated hospital beds in multi-purpose centres.
- **Born before arrival** – Being born before arrival at hospital or birth centre for planned hospital or birth centre births, or before the arrival of the homebirth midwife for planned home births.
- **Birth centre** – An approved facility for the provision of birthing services and staffed by a qualified midwife.
- **Home/other** – The birth occurred in the mother’s own home, or in the home of another person, or in any other location not listed above.

Code:

Tick one of the boxes.

- 1 Hospital
- 2 Born before arrival
- 3 Birth centre
- 4 Home/other

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.7 Birth status

Indicate the status of the infant immediately after birth.

- **Livebirth** – Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (World Health Organisation, 1992 definition).
- **Stillbirth** – Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Code:

Tick one of the boxes.

- 1 Liveborn
- 2 Stillborn

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

4.14.8 Apgar score

The numerical score to indicate the baby's condition at 1 minute, at 5 minutes and then at 10 minutes after birth.

The Apgar score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. It is also an indicator of the health of the baby.

The valid range of Apgar score is 00 – 10. Please 'right adjust' your response if there are more boxes provided than are necessary.

Guide for use:

If the Apgar score is unknown, for example, for babies born before arrival, report as 99.

For stillbirth episodes, report the Apgar score as 00.

[Apgar score at 5 minutes is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.9 Cord pH

Indicate whether pH of the umbilical cord was measured.

Code:

Tick one of the boxes.

- 1 None
- 2 < 7.2
- 3 > 7.2

4.14.10 Gestational age at birth

The estimated gestational age of the baby as determined by clinical assessment after birth.

The valid range of gestational age at birth is 20.0 – 45.6.

Enter the number of gestational age in the space provided. First two boxes record the gestational week and the last box (after the decimal point) records the gestational age in completed days. The valid range of completed days is 0-6. For example, a gestation of 28 weeks and 6 days would be recorded at this item as '6'. Therefore the gestational age is 28.6.

Guide for use:

For stillbirths, the gestational age is based on the duration of the pregnancy, which may be different from the gestation of the fetus at the time of death. For example, if the fetus dies in utero at 30 weeks gestation and is not delivered until 33.5 weeks gestation, the gestational age should be recorded as 33.5 weeks.

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.11 Weight

The first weight, in grams, of the baby (stillborn or liveborn) obtained after birth. The actual weight should be recorded to the degree of accuracy to which it is measured and should be obtained within one hour of birth. Please 'right adjust' your response if there are more boxes provided than are necessary.

The valid range of birthweight is 100 – 9998. Please 'right adjust' your response if there are more boxes provided than are necessary.

Guide for use:

In the case of babies born before arrival at the hospital, the birthweight should be taken shortly after the baby has been admitted to hospital.

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.12 Length

The length of the baby at birth measured in centimetres, to the nearest centimetre from crown to heel.

Guide for use:

For cases where a measurement is midway between two numbers, please round up e.g. 51.5 cm should be recorded as 52 cm.

4.14.13 Head circumference

The head circumference of the baby at birth in centimetres, to the nearest centimetre with the tape just above the eyebrows anteriorly and at the maximum point of the occiput posteriorly.

Guide for use:

For cases where a measurement is midway between two numbers, please round up e.g. 35.5 cm should be recorded as 36 cm.

4.14.14 Sex

The biological distinction between male and female.

If chromosomal or other testing is required to determine the sex of the baby, select 'Indeterminate'.

Code:

Tick one of the boxes.

- 1 M
- 2 F
- 3 Indeterminate

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.15 Birth order

Indicate the sequential order of each baby of a multiple birth.

- **Singleton** – a single birth
- **Twin/Triplet 1** – First of a multiple birth
- **Twin/Triplet 2** – Second of a multiple birth
- **Triplet 3** – Third of a multiple birth

Code:

Tick one of the boxes.

- 1 Singleton
- 2 Twin/Triplet 1
- 3 Twin/Triplet 2
- 4 Triplet 3

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.14.16 Resuscitation at birth

Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effect and to correct metabolic disturbances.

If no methods were used, tick 'None'.

More than one method can be selected, except where 'None' applies.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Suction
- 3 Passive oxygen therapy
- 4 Bag & mask IPPV
- 5 CPAP
- 6 Endotracheal intubation & IPPV
- 7 External cardiac massage
- 8 Adrenaline

4.14.17 Medical admission to SCN/ICU

Whether the baby was cared for in a special care nursery, or intensive care unit because of a medical condition.

Tick the box that corresponds to the baby's SCN/ICU admission status.

Code:

Tick one of the boxes

- 1 No
- 2 Yes

Guide to use:

If 'yes' to this question, record the number of days spent in the special care nursery or neonatal intensive care unit.

4.14.18 Congenital abnormalities

Any structural or anatomical abnormalities of the baby that is present at birth, in either a liveborn or stillborn baby, and diagnosed before separation from care.

If no congenital abnormalities were diagnosed, tick 'None'. Where 'Other' is ticked, please provide further detail in the box provided.

More than one abnormalities can be selected, except where 'None' applies.

If any of the congenital abnormalities is ticked, the Congenital Abnormality Notification Form must be completed and sent to the Health Information Unit, Department of Health together with the Tasmanian Perinatal Data Collection Form.

Code:

Tick one or more of the boxes.

- 1 None
- 2 Malformation of nervous system
- 3 Malformation of eye, ear, face & neck
- 4 Malformation of circulatory system
- 5 Cleft lip and cleft palate
- 6 Malformation of digestive system
- 7 Malformation of genital organs
- 8 Malformation of urinary system
- 9 Malformation of musculoskeletal system
- 10 Chromosomal malformations
- 11 Inborn errors of metabolism
- 12 Other

NOTE: The congenital abnormalities form should be completed.

4.15 Discharge status

4.15.1 Mother discharge status

Record the date and the mother's separation status from the hospital of birth. Formal separation is the administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. Separation can occur by one of the following means:

- **Discharged** – The mother was discharged from the hospital where the delivery, or immediate post-natal care took place.
- **Transferred** – The mother was transferred from the hospital where the delivery, or immediate post-natal care took place to another hospital.
- **Died** – The death of a woman, while pregnant or within 42 days of cessation of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management.

If the mother's discharge status is 'Died', the COPMM Maternal Death Reporting Form must be completed and sent to the Health Information Unit, Department of Health together with the Tasmanian Perinatal Data Collection Form.

Code:

Tick one of the boxes.

- 1 Discharged
- 2 Transferred
- 3 Died

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.15.2 Breastfeeding at discharge

Indicate if the baby was breastfed on mother's discharge from the birth hospital.

- **Fully** – The mother is fully breastfeeding the baby when discharged.
- **Partially** – The mother is feeding the baby through a combination of breast and bottle feeding when discharged.
- **Not at all** – The mother is not breastfeeding the child on discharge.

Code:

Tick one of the boxes.

- 1 Fully
- 2 Partially
- 3 Not at all

4.15.3 Baby discharge status

Record the date and the baby's separation status from the hospital of birth. Formal separation is the administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. Separation can occur by one of the following means.

- **Discharged** – The baby was discharged from the hospital where the delivery, or immediate post-natal care took place.
- **Transferred** – The baby was transferred from the hospital where the delivery, or immediate post-natal care took place to another hospital.
- **Died** – The baby died for any reason.
- **Still in hospital at 28 days** – The baby remains in hospital at 28 days of age.

If the baby's discharge status is 'Died', the National Perinatal Death Clinical Audit (NPDCA) Tool must be completed and sent to the Health Information Unit, Department of Health together with the Tasmanian Perinatal Data Collection Form.

Code:

Tick one of the boxes.

- 1 Discharged
- 2 Transferred
- 3 Died
- 4 Still in hospital at 28 days

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

4.15.4 Reason for transfer of baby

Indicate if the transfer occurred for medical or other reasons. If no transfer, please leave this field blank.

Code:

Tick one of the boxes.

1 Medical

2 Other

5 Congenital Abnormality Notification Form

The medical practitioner responsible for the baby should complete this part of the form which can be updated up to 28 days after the birth.

5.1.1 Hospital code

This refers to the establishment or hospital in which the birth occurred.

Code	Establishment / hospital
1111	Calvary Health Care
1113	Hobart Private Hospital
4182	Home Births (South)
4280	Launceston Birth Centre
4281	Home Births (North)
4384	Home Births (North West)

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

5.1.2 URN (mother)

This is the number allocated by the hospital to each patient. Please 'right adjust' your response if there are more boxes provided than are necessary.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

5.1.3 Suburb

The suburb/town where the mother usually resides (not postal address). The Australia Post listing of postcodes and suburbs is available from <http://www.auspost.com.au>.

NOTE: Changes in suburb may occur after these details are initially collected at a 'book-in' or antenatal visit. In these cases it will be necessary to amend the information on the form.

[This data item is a requirement of the National Perinatal Minimum Data Set.](#)

5.1.4 Surname

The legal surname of the mother.

5.1.5 First name

The full first name of the mother.

5.1.6 Date of birth (mother)

The date of birth of the mother using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

The default date of birth, when the date is not known, is 01011900. If a date is partially known, insert the known parts of the date and use the default values for any unknown parts. (e.g. a mother knows she was born in 1973, but does not know the month or day. The date of birth would therefore be recorded as 01011973).

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

5.1.7 URN (baby)

This is the number allocated by the hospital to each baby. Please 'right adjust' your response if there are more boxes provided than are necessary.

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

5.1.8 Date of birth (baby)

The date of birth of the baby using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

[*This data item is a requirement of the National Perinatal Minimum Data Set.*](#)

5.1.9 Birth order

Indicate the sequential order of each baby of a multiple birth.

- **Singleton** – a single birth
- **Twin/Triplet 1** – First of a multiple birth
- **Twin/Triplet 2** – Second of a multiple birth
- **Triplet 3** – Third of a multiple birth

Code:

Tick one of the boxes.

- 1 Singleton
- 2 Twin/Triplet 1
- 3 Twin/Triplet 2
- 4 Triplet 3

[This data item is a requirement for the National Perinatal Minimum Data Set.](#)

5.1.10 Anomalies

Please list all anomalies identified, being as specific as possible.

5.1.11 Case summary

Please record any relevant comments.

5.1.12 Printed name

The name of the medical practitioner.

5.1.13 Designation

The position/designation of the medical practitioner.

5.1.14 Signature

Sign by the medical practitioner who completes this part of the form.

5.1.15 Date

The date the medical practitioner signs the form using the full date (i.e. DDMMYYYY) and leading zeros where necessary.

6 COPMM Maternal Death Reporting Form

The COPMM Maternal Death Reporting Form is used for reporting of maternal deaths to the Council. The form is accessible on

http://www.health.tas.gov.au/about_the_department/partnerships/registration_boards/copmm/document_list.

The form should be completed by a senior clinician as soon as possible following maternal deaths.

Completed form should be sent together with the Tasmanian Perinatal Data Collection Form to the Health Information Unit as instructed on the tool. The information will be provided to the Maternal Mortality & Morbidity Subcommittee members to assist in reporting on causes of maternal deaths and to identify training needs in Tasmania.

7 National Perinatal Death Clinical Audit (NPDCA) Tool

The NPDCA tool is to replace all existing forms used for the reporting of perinatal deaths to the Council. The form is accessible on:

http://www.health.tas.gov.au/about_the_department/partnerships/registration_boards/copmm/document_list

Completion of the form

Section 1 should be completed by a senior clinician as soon as possible following all stillbirths and neonatal deaths. Section 2 is to be completed as part of the perinatal mortality review of the case.

Completed sections 1 and 2 should be sent together with the Tasmanian Perinatal Data Collection Form to the Health Information Unit as instructed on the tool. The information will be provided to the Perinatal Mortality & Morbidity Subcommittee members to assist in reporting on causes of perinatal deaths and to identify training needs in Tasmania.

8 Note



Contact us:
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