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Maternity Care Summary

Standard

HISO 10050:2023

August 2023

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1. Introduction
   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. 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. Health New Zealand | Te Whatu Ora (Health NZ) will specify this in a separate implementation guide that will define the required data structures and exchange protocols using the HL7® FHIR® standard.

The HISO 10050:2022 Maternity Care Summary Standard superseded HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which was withdrawn.

Medication information is out of scope for this standard. See 2.3 Medicines information for further details.

* 1. 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](https://www.legislation.govt.nz/act/public/1956/0065/latest/whole.html)
* [Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996](https://www.legislation.govt.nz/regulation/public/1996/0078/latest/whole.html)
* [Health Information Privacy Code 2020](https://www.privacy.org.nz/privacy-act-2020/codes-of-practice/hipc2020/)
* [Health Practitioners Competence Assurance Act 2003](https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html)
* [New Zealand Public Health and Disability Act 2000](https://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html)
* [Pae Ora (Healthy Futures) Act 2022](https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx)
* [Privacy Act 2020](https://www.legislation.govt.nz/act/public/2020/0031/latest/LMS23223.html)
* [Public Records Act 2005](https://www.legislation.govt.nz/act/public/2005/0040/latest/DLM345529.html)
* [Retention of Health Information Regulations 1996](https://www.legislation.govt.nz/regulation/public/1996/0343/latest/DLM225616.html).
* [Abortion Legislation Act 2020](https://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237600.html)
  1. 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 Health NZ 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. Related specifications

Health NZ used or referenced the following documents to develop this standard:

* [HISO 10046:2022 Consumer Health Identity Standard](https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-information-standards/approved-standards/identity-standards/)
* [HISO 10005:2008 Health Practitioner Index (HPI) Data Set](https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-information-standards/approved-standards/identity-standards/)
* [HISO 10006:2008 Health Practitioner Index (HPI) Code Set](https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-information-standards/approved-standards/identity-standards/)

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](https://www.health.govt.nz/publication/hiso-10033-snomed-ct)

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

Health NZ 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. Health NZ 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. Data element template

Data element specifications in this standard conform to the requirements of ISO/IEC 11179 Information Technology – Metadata Registries (MDR).[[1]](#footnote-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](http://browser.ihtsdotools.org/). Where there are many member concepts, a reference set is published in the [SNOMED NZ Edition](https://www.health.govt.nz/nz-health-statistics/classification-and-terminology/new-zealand-snomed-ct-national-release-centre/snomed-ct-subsets-and-maps), available from the[SNOMED Member Licensing and Distribution Service](https://mlds.ihtsdotools.org/#/landing/NZ?lang=en).  New Zealand Medicines Terminology (NZMT) is the standard used to identify medicines | | |
| Obligation | Indicates if the data element is mandatory or optional in the context, or whether its appearance is conditional | | |
| Guide for use | Additional guidance to inform the use of the data element | | |
| Verification rules | Quality control mechanisms that preclude invalid values. **This row is only included when relevant.** | | |

#### 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 | | |

1. 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.

* 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](https://www.health.govt.nz/publication/hiso-10046-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 |

* 1. 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](https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-information-standards/approved-standards/identity-standards/)
* [HISO 10006:2008 Health Practitioner Index (HPI) Code Set](https://www.tewhatuora.govt.nz/our-health-system/digital-health/health-information-standards/approved-standards/identity-standards/)

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 |

* 1. Medicines information

Medicine information directly related to the woman/person and baby or babies is out of scope for this standard.

However, medication information about a woman/person and baby or babies may be sourced from existing records held in the New Zealand ePrescription Service (NZePS).

Prescribing may:

* integrate with the NZePS [New Zealand ePrescription service](https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-eprescription-service)
* use the NZePS application programming interface (API)
* use the [New Zealand Universal List of Medicines (NZULM) and New Zealand Formulary (NZF)](file:///C:\Users\tchristi\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\QNWQN935\HISO%2010024.1:2018%20New%20Zealand%20Universal%20List%20of%20Medicines%20and%20New%20Zealand%20Formulary)
* conform to [HISO 10042 Medication Charting and Medicine Reconciliation Standards](https://www.health.govt.nz/publication/hiso-10042-medication-charting-and-medicine-reconciliation-standards)
* conform to New Zealand prescribing guidelines in the Medicines Regulations 1984
  1. Booking information

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

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Ambivalent | 169569009 | | Planned pregnancy | 169565003 | | Unplanned pregnancy | 83074005 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Hormonal stimulation | 71841000210107 | | Intrauterine insemination (IUI) | 71851000210105 | | In vitro fertilisation (IVF) | 10231000132102 | | Other | 71861000210108 | | | |
| Obligation | Mandatory if assisted reproduction occurred | | |
| Guide for use | Three instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 Health NZ 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | |

* + 1. 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 |  | | |

* + 1. 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.**

* 1. 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.

* + 1. Previous miscarriage

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

* + 1. 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.

* + 1. Previous termination

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Terminations (if known) | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | Medical termination of pregnancy | 412758008 | | Surgical termination of pregnancy | 71571000210104 | | | |
| Obligation | Mandatory on a termination having occurred | | |
| Guide for use | A code is to be recorded for each termination | | |
| Verification rules | Valid code only | | |

* + 1. 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.

* + 1. Termination reason

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

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | No previous complications | 443508001 | | Antenatal depression and/or anxiety | 71891000210103 | | Antepartum haemorrhage | 161804005 | | Eclampsia | 161806007 | | Gestational diabetes | 472971004 | | Epilepsy | 161480008 | | Hyperemesis | 71901000210102 | | Infection | 161413004 | | Obstetric cholestasis | 16216781000119107 | | Placental abruption | 789776003 | | Pre–eclampsia | 105651000119100 | | Preterm labour | 441493008 | | Preterm birth | 161765003 | | Small for gestational age fetus (SGA) | 726565008 | | Other complication occurring during pregnancy | 91461000210102 | | | |
| Obligation | Mandatory on a previous pregnancy having occurred | | |
| Guide for use | ‘Other complication occurring during pregnancy’ is only to be selected when none of the preceding options in this category are clearly correct  A minimum of one code is to be selected for each previous pregnancy | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72531000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72531000210106)   |  |  | | --- | --- | | Agreed term | SCTID | | Induction of labour | 725954003 | | Planned Caesarean section before labour | 725949007 | | Spontaneous labour | 726597008 | | | |
| Obligation | Mandatory on a response greater than zero for section 2.4.5 Parity. | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. Induction reason

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

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. Maternal complications in previous labours

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

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72521000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72521000210109)   |  |  | | --- | --- | | Agreed term | SCTID | | Caesarean section | 161805006 | | Forceps | 161813007 | | Spontaneous vaginal birth (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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | Classical Caesarean section | 71581000210102 | | Lower uterine segment Caesarean section (LUSCS) | 71591000210100 | | 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 | | |

* + 1. Indications for planned Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Clinical indication for performing a planned Caesarean section as an elective procedure prior to labour commencing | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Breech presentation | 72031000210101 | | Congenital anomaly | 161572004 | | Chromosomal anomaly | 71871000210102 | | Medical or obstetric complication  (SNOMED CT term: ‘History of complication in pregnancy’) | 91461000210102 | | Maternal request | 720266003 | | Previous third-degree perineal tear | 725941005 | | Previous fourth-degree perineal tear | 725942003 | | Previous caesarean section | 161805006 | | Transverse lie | 72041000210109 | | Unstable lie | 72051000210107 | | Other malpresentation | 72001000210106 | | | |
| Obligation | Mandatory on a response of ‘Caesarean section’ to Mode of birth. | | |
| Guide for use | A minimum of one code is to be selected and recorded for each previous birth  This table incorporates a mix of SNOMED CT concepts from the Disorder and Situation hierarchies | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Antepartum haemorrhage | 161804005 | | Failed induction of labour | 72061000210105 | | Failed instrumental/assisted delivery | 772006002 | | Fetal distress | 72071000210104 | | Fetal malposition | 72081000210102 | | Fetal malpresentation | 72001000210106 | | Intrapartum haemorrhage | 71931000210107 | | Obstructed labour | 71941000210104 | | 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 | | |

* + 1. 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 | | |

* + 1. Previous labour anaesthesia

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Type of anaesthesia administered during previous labours | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | No previous anaesthesia  (SNOMED CT term: ‘No history of procedure’) | 416128008 | | Combined spinal/epidural | 71601000210105 | | Epidural | 71611000210107 | | General anaesthetic | 71621000210102 | | Local anaesthetic | 71631000210100 | | Pudendal block | 71651000210106 | | Spinal | 71641000210108 | | | |
| Obligation | Mandatory | | |
| Guide for use | One code may be selected and recorded for each previous birth | | |
| Verification rules | Valid code only | | |

* + 1. Maternal complications immediately postpartum

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

* 1. 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.

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72511000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72511000210104)   |  |  | | --- | --- | | Agreed term | SCTID | | Infant death | 739682007 | | Live born | 726001007 | | Neonatal death | 726626004 | | Stillborn | 161743003 | | | |
| Obligation | Mandatory where a previous birth has occurred | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. Date of birth – previous babies

This element defines the date of birth of previous babies. The format is set out inthe common **Date and time value domain** specification. The data element is optional upon a response to section **2.6.1 Outcome of previous babies.** It is to be recorded for each baby.

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | None | 443508001 | | Chromosomal anomaly | 71871000210102 | | Congenital anomaly | 161572004 | | Fetal growth abnormality | 72121000210104 | | Fetal heart rate abnormality | 72131000210102 | | Oligohydramnios | 72141000210105 | | Polyhydramnios | 72151000210108 | | Other | 72171000210100 | | | |
| Obligation | Mandatory | | |
| Guide for use | Five instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | None | 443508001 | | Fetal blood sample abnormality | 72701000210108 | | Fetal heart rate abnormality | 72131000210102 | | Meconium-stained liquor | 72191000210101 | | Other | 1156096005 | | | |
| Obligation | Mandatory | | |
| Guide for use | Four instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | How previous babies were born | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72521000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72521000210109)   |  |  | | --- | --- | | Agreed term | SCTID | | Caesarean section | 394699000 | | Forceps | 395681004 | | Spontaneous vaginal birth (cephalic) | 395683001 | | Spontaneous vaginal birth (breech) | 407613009 | | Vacuum extraction | 407614003 | | | |
| Obligation | Mandatory | | |
| Guide for use | Three instances of this field may be recorded  This is to be reported in terms of spontaneity or assistance required | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | |  |  | | --- | --- | | Agreed term | Code | | Male | M | | Female | F | | Another term | O | | Unspecified or unknown | U | | | |
| 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 | | |

* + 1. 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 | | |

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. Neonatal complications

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Complications with the previous babies in the immediate postpartum period | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72541000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72541000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | None | 72201000210104 | | Fetal disorder caused by substance transmitted via placenta | 285161000210104 | | Neonatal disorder caused by substance transmitted via breast milk | 294671000210101 | | Hypoglycaemia | 72221000210107 | | Large for gestational age | 72241000210101 | | Low birth weight | 37251000119108 | | Neonatal encephalopathy | 72211000210102 | | Respiratory distress syndrome (RDS) | 72251000210103 | | Small for gestational age (SGA) | 726565008 | | Transient tachypnoea | 72261000210100 | | Other | 161579008 | | | |
| Obligation | Mandatory | | |
| Guide for use | Provided any value other than ‘None’ is selected, five instances of this field may be recorded  The values ‘Large for gestational age’ and ‘Small for gestational age’ cannot both be selected | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Asphyxia | 161581005 | | Cardiovascular disease | 72271000210106 | | Congenital anomaly | 161572004 | | Chromosomal anomaly | 71871000210102 | | Extremely preterm infant  (born before 27 weeks plus 6 days) | 72281000210108 | | Fetal disorder caused by medicinal agent transmitted via placenta | 284801000210106 | | Neonatal disorder caused by medicinal agent transmitted via breast milk | 284811000210108 | | Hypoglycaemia | 72221000210107 | | Hypothermia | 72291000210105 | | Infection | 161413004 | | Jaundice | 161536006 | | Late preterm infant (born between 32 weeks and 36 weeks plus 6 days) | 72301000210109 | | Very preterm infant (born between 28 weeks and 31 weeks plus 6 days) | 72311000210106 | | Respiratory distress syndrome (RDS) | 72251000210103 | | Seizures | 161583008 | | Weight loss | 72321000210101 | | | |
| Obligation | Mandatory on a response other than ‘No, not needed’ for Neonatal care admissions. | | |
| Guide for use | 10 instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | |  |  | | --- | --- | | Agreed term | SCTID | | Exclusively breastfed | 91711000210106 | | Fully breastfed | 101471000210102 | | Partially breastfed | 121491000210107 | | Artificially fed | 101611000210109 | | | |
| Obligation | Mandatory on a response other than ‘Stillborn’ to Outcome of previous babies. | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 |  | | |

* + 1. 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.

* 1. 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.

* + 1. Medical conditions

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Medical conditions | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | No relevant medical history | 443508001 | | Autoimmune disorder | 72331000210104 | | Cardiac disorder | 266995000 | | Congenital abnormality | 161572004 | | Diabetes mellitus type 1 | 472970003 | | Diabetes mellitus type 2 | 472969004 | | Endocrine disorder | 266990005 | | Gastrointestinal disorder | 266997008 | | Haematological disorder | 266992002 | | Hypertension | 161501007 | | Infectious diseases | 161413004 | | Liver disorder | 161535005 | | Malignancy | 266987004 | | Mental health disorder | 72711000210105 | | Monogenic diabetes (MODY) | 472972006 | | Musculoskeletal disorder | 267004000 | | Neurological disorder | 32451000119107 | | Respiratory disorder | 161523006 | | Skin disorder | 161560005 | | Thrombosis and related disorder | 275546001 | | Other medical disorder | 312850006 | | | |
| Obligation | Mandatory | | |
| Guide for use | 20 instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* 1. 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.

* + 1. Operations

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

* + 1. 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.

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72501000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72501000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | General anaesthetic | 71621000210102 | | Local anaesthetic | 71631000210100 | | Regional anaesthetic | 131501000210104 | | | |
| Obligation | 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 | | |

* + 1. 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 | |  |  | | --- | --- | | Agreed term | Code | | Unknown | 2 | | Yes | 1 | | No | 0 | | | |
| Obligation | Mandatory on a response to Previous anaesthetic. | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* 1. 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.

* + 1. Cervical screening status

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The period in which the individual has been involved in some form of cervical screening (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 screening performed within last 12 months’) | 466301000210105 | | Within the last two years  (SNOMED CT term: ‘History of cervical screening performed within last two years’) | 466311000210107 | | Within the last three years  (SNOMED CT term: ‘History of cervical screening performed within last three years’) | 466321000210102 | | More than three years ago  (SNOMED CT term: ‘History of cervical screening performed for more than three years’) | 466331000210100 | | Never had cervical screening | 466341000210108 | | Unknown  (SNOMED CT term: Screening status unknown) | 406011002 | | | |
| Obligation | Optional | | |
| Guide for use | The default is ‘Unknown’ | | |
| Verification rules | Valid code only | | |

* + 1. Cervical screening results

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

* + 1. Sexual health history – diagnoses

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Diagnosed sexually transmitted infections | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | None | 704007002 | | 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 | | |

* + 1. Gynaecological history – diagnoses

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Diagnosed gynaecological conditions | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity previous disorders reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72551000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72551000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | None | 443508001 | | Bacterial vaginosis | 72381000210100 | | Bicornuate uterus | 72391000210103 | | 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 | | | |
| Obligation | Mandatory | | |
| Guide for use | 16 instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. Gynaecological history – procedures

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

* 1. 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.

* + 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* 1. 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.

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | No known allergies | 716186003 | | Allergy to medicine | 416098002 | | Allergy to substance  (SNOMED CT term: Allergic disposition) | 609328004 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Dairy  (SNOMED CT term: ‘Cow’s milk’) | 3718001 | | Egg | 102263004 | | Latex | 111088007 | | Nut | 13577000 | | Seafood | 44027008 | | Other | 105590001 | | | | |
| Obligation | Mandatory on a response of ‘Allergy to substance’ for 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* 1. 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.

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109)   |  |  | | --- | --- | | Agreed term | SCTID | | Does not drink alcohol | 105542008 | | Currently drinks alcohol | 219006 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106).   |  |  | | --- | --- | | Agreed term | SCTID | | Current drug user | 417284009 | | Declined to answer | 426544006 | | Ex-drug user | 44870007 | | Has never misused drugs | 228368007 | | Misuse of prescription drugs | 191939002 | | | |
| Obligation | Mandatory | | |
| Guide for use | This covers illegal drugs or misuse of drugs prescribed for the woman/person or others | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108)   |  |  | | --- | --- | | Agreed term | SCTID | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other | 410942007 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory on a response of ‘Current drug user’ to 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 | | |

* + 1. 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 | | |

* 1. 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.

* + 1. Smoking status

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

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Ex-vaper for less than 1 year | 1137688001 | | Ex-vaper for more than 1 year | 1137692008 | | Trying to give up vaping | 1137691001 | | Never vaped | 1137690000 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use | Three instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | Mandatory on a response to Smoking status of either Ex-smoker, greater than 12 months abstinent or Ex-smoker, less than 12 months abstinent. | | |
| Guide for use | 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. Exposure to second-hand smoke

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

* 1. 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.

* + 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 |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity family history reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72661000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72661000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | Allergies | 160469004 | | Asthma | 160377001 | | Chromosomal anomaly | 160425006 | | Congenital anomaly | 160417009 | | Diabetes mellitus | 160303001 | | Hypertensive disorders of pregnancy | 160401003 | | Intellectual disability | 763598005 | | Malignant hyperthermia | 401052005 | | Mental illness | 160324006 | | Multiple pregnancy | 266906006 | | Not known | 407559004 | | No relevant family history | 160266009 | | Other condition | 281666001 | | | |
| Obligation | Mandatory | | |
| Guide for use | 10 instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72661000210103&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72661000210103)   |  |  | | --- | --- | | Agreed term | SCTID | | Allergies | 160469004 | | Chromosomal anomaly | 160425006 | | Congenital anomaly | 160417009 | | Intellectual disability | 763598005 | | Mental illness | 160324006 | | No relevant family history | 160266009 | | Not known | 407559004 | | Other condition | 281666001 | | | |
| Obligation | Mandatory | | |
| Guide for use | Six instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* 1. Tuberculosis risk assessment

Health NZ 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.

* + 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 | | |

* + 1. Lives in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The likelihood that during their first five years, that the infant will be living for three months or longer in a country with high rates of TB | | |
| Source standards | *Use of high burden country lists for TB by WHO in the post-2015 era*: https://www.who.int/[tb/publications/global\_report/high\_tb\_burdencountrylists2016-2020.pdf](https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf)  (page 3) | | |
| Data type | Numeric | Representational class | Code |
| Field size | 1 | Representational layout | N |
| Value domain | |  |  | | --- | --- | | Agreed term | Code | | No | 1 | | Yes | 2 | | Unknown | 3 | | | |
| Obligation | Mandatory | | |
| Guide for use | New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information  Page 3 of the above report states that the World Health Organization considers the following ‘high burden countries’ for tuberculosis:  Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe | | |
| Verification rules | Valid code only | | |

* + 1. Lived in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Have one or both parents or household members or carers, within the last five years, lived in a country with high rates of TB | | |
| Source standards | *Use of high burden country lists for TB by WHO in the post-2015 era*:  <https://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf> (page 3) | | |
| Data type | Numeric | Representational class | Code |
| Field size | 1 | Representational layout | N |
| Value domain | |  |  | | --- | --- | | Agreed term | Code | | No | 1 | | Yes | 2 | | Unknown | 3 | | | |
| Obligation | Mandatory | | |
| Guide for use | New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information  Page 3 of the above report states that the World Health Organization considers the following ‘high burden countries’ for tuberculosis:  Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe | | |
| Verification rules | Valid code only | | |

* 1. 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.

* + 1. Blood tests

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

* + 1. 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’ | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72641000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72641000210104)   |  |  | | --- | --- | | Agreed term | SCTID | | Red blood cell antibodies | 89754000 | | Gestational diabetes | 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 | | |

* + 1. 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’ | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Influenza | 73701000119109 | | Pertussis | 72011000210108 | | SARS COV-2 | 101631000210102 | | Other | 713404003 | | | |
| Obligation | Optional | | |
| Guide for use | Three instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | Code | | Dating | 169229007 | | Anatomy | 271442007 | | Growth | 241493005 | | Placental location | 164817009 | | Suspected malpresentation | 169228004 | | Other | 241491007 | | Declined ultrasound scans | 71771000210106 | | | |
| Obligation | Mandatory | | |
| Guide for use | Seven instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72601000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72601000210102)   |  |  | | --- | --- | | 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 | | |

* + 1. 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 |  | | |

* + 1. 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.

* + 1. 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 | | |

* + 1. 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.

* + 1. 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.**

* + 1. 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.** Thevalue must be on or after the date and time recorded in **Antenatal admission – date and time**.

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109)   |  |  | | --- | --- | | Agreed term | SCTID | | Does not drink alcohol | 105542008 | | Currently drinks alcohol | 219006 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use | The information collected for this section is distinct from that collected for section 2.12.1 Alcohol consumption, as this section records a value at the end of the pregnancy | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106)   |  |  | | --- | --- | | Agreed term | SCTID | | Current drug user | 417284009 | | Declined to answer | 426544006 | | Does not misuse drugs | 228367002 | | | |
| Obligation | Mandatory | | |
| Guide for use | The information collected for this section is distinct from that collected for section 2.12.6 History of drug use, as this section records a value at the end of the pregnancy | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108)   |  |  | | --- | --- | | Agreed term | SCTID | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other | 74964007 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory on a response of ‘Current drug user’ to section 2.16.20 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 | | |

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Ex-vaper for more than 1 year | 1137692008 | | Ex-vaper for less than 1 year | 1137688001 | | Trying to give up vaping | 1137691001 | | Never vaped | 1137690000 | | 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 | | |

* + 1. Antenatal prescription type

|  |  |  |  |
| --- | --- | --- | --- |
| 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72651000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72651000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | Analgesics | 373265006 | | Antacids | 372794006 | | Antibacterials | 419241000 | | Antifungals | 373219008 | | Minerals | 373460003 | | Non-steroidal anti-inflammatories (NSAIDs) | 372665008 | | Vitamins | 87708000 | | Other | 410942007 | | No prescriptions | 182849000 | | | |
| Obligation | Optional | | |
| Guide for use | Eight instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* 1. 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**.

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Induced | 112070001 | | Planned caesarean section before labour | 200148001 | | Spontaneous | 84457005 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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**.

* + 1. Actual place of birth

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

* + 1. 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 |  | | |

* + 1. 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**.

* + 1. 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.

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72611000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72611000210100)   |  |  | | --- | --- | | 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 | | |

* + 1. 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 |  | | |

* + 1. 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.

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 |  | | |

* + 1. 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.

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72611000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72611000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | No complications  (SNOMED CT Term ‘Normal second stage of labour’) | 289223001 | | 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 | | |

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. 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.

* + 1. Amniotic fluid

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Description of the amniotic fluid | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | |  |  | | --- | --- | | The following SNOMED CT terms are from the [**New Zealand maternity findings reference set**](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107) | | | **Agreed term** | **Code** | | Amniotic fluid not present | 284831000210101 | | Amniotic fluid - clear | 168090003 | | Bloodstained liquor | 249134008 | | Malodorous liquor | 284821000210103 | | Particulate matter | 284841000210109 | | Thin (insignificant) meconium | 408792005 | | Thick (significant) meconium | 289294000 | | Not known  (SNOMED CT term: No clinical detail given) | 281337006 | | Other | 366334007 | | | |
| Obligation | Mandatory | | |
| Guide for use | 4 instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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.

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. Type of birth

This information can be pulled from the data captured in a system under 2.21.4 Mode of birth.

* + 1. Birth position

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

* + 1. 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 | | |

* + 1. 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**](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | No | 373067005 | | | |
| Obligation | Mandatory | | |
| Guide for use | Record one entry for each baby born | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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**.

* + 1. Anaesthesia in labour

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Types of anaesthesia administered 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 | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | No anaesthesia | 263421000210101 | | Combined spinal/epidural (CSE) | 231261002 | | Dural puncture epidural | 1285642008 | | Epidural | 18946005 | | Epidural top-up for procedure | 231260001 | | General anaesthetic | 50697003 | | Local anaesthetic | 408803000 | | Injection of anaesthetic agent into pudendal nerve | 68248001 | | Sedation | 72641008 | | Spinal | 231249005 | | | |
| Obligation | Mandatory | | |
| Guide for use | Five instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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.**

* + 1. Labour and birth prescription type

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Prescriptions supplied during the labour and birth | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity substances reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72651000210101&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72651000210101)   |  |  | | --- | --- | | Agreed term | SCTID | | No prescriptions  (SNOMED CT Term: ‘No drug therapy prescribed’) | 182849000 | | Analgesic | 373265006 | | Antacid | 372794006 | | Antibacterial | 419241000 | | Antiemetic | 372776000 | | Intravenous fluid | 118431008 | | Non-steroidal anti-inflammatory drug (NSAID) | 372665008 | | Uterotonic drug | 410937004 | | Other | 410942007 | | | |
| Obligation | Optional | | |
| Guide for use | Nine instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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’.
  + 1. 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 |  | | |

* + 1. Coping strategies

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Types of coping strategies and complementary therapies used during labour | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity complementary therapies reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72631000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | 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 | | |

* + 1. 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 |  | | |

* 1. 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.

* + 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.

* + 1. Induction method(s)

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Method(s) by which the labour was induced | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | Artificial rupture of membranes (ARM) | 408816000 | | Cervical ripening balloon | 425861005 | | Mifepristone | 71721000210107 | | Misoprostol | 71731000210109 | | Oxytocin infusion | 177135005 | | Prostaglandin | 177136006 | | Other method | 236958009 | | | |
| Obligation | Mandatory if Induction date and time is completed | | |
| Guide for use | Four instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. Induction reason

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Reason for the induction of labour | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Abnormal dopplers | 312370006 | | Advanced maternal age | 416413003 | | Antepartum haemorrhage | 34842007 | | Blood group antibodies | 166167002 | | 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 | | |

* + 1. 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 |  | | |

* 1. 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.

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | Classical caesarean section | 84195007 | | Lower uterine segment Caesarean section (LUSCS) | 788180009 | | Other | 11466000 | | Not known  (SNOMED CT Term: ‘No clinical detail given’) | 281337006 | | | |
| Obligation | Mandatory on a response of ‘Caesarean section’ for section 2.17.27 Mode Type of birth | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 2.17.27ModeType of birth | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* + 1. 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 |  | | |

* + 1. Complications during Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Complications that occurred during the Caesarean section | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from [the New Zealand maternity complications reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72601000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72601000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | 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 9 Type of birth | | |
| Guide for use | Nine instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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 |  | | |

* 1. Post-birth

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

* + 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | Caesarean section | 50791000210101 | | Controlled cord traction with uterotonic | 302384005 | | Manual removal of retained placenta | 28233006 | | Physiological | 1141750000 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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 | | |

* + 1. 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.

* + 1. Perineal status

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

* + 1. Episiotomy type

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

* + 1. Episiotomy reason

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

* + 1. 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 |  | | |

* + 1. Non-perineal genital tract trauma type

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

* + 1. Repair required

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Perineal or genital tract trauma suturing or repair | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity procedures reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72561000210102)   |  |  | | --- | --- | | Agreed term | SCTID | | Repair not required | 418014008 | | Repair declined  (SNOMED CT: Procedure declined by patient) | 105480006 | | 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Complete | 249170006 | | Incomplete | 268479002 | | Ragged membranes | 249182002 | | | |
| Obligation | Mandatory | | |
| Guide for use | Two instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. Placenta appearance

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the appearance of the placenta | | |
| **Source standards** |  | | |
| **Data type** | SNOMED CT identifier | Representational class | Code |
| **Field size** | 18 | Representational layout | N(18) |
| **Value domain** | The following SNOMED CT terms are from the [New Zealand maternity findings reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Normal | 289279004 | | Calcifications | 249174002 | | Fetus papyraceous | 90127001 | | Gritty | 249173008 | | Infarctions | 268585006 | | Oedematous | 56425003 | | Offensive | 289275005 | | Retroplacental clot | 249177009 | | Succenturiate lobe | 82664003 | | True knot in umbilical cord | 27696007 | | Velamentous insertion of cord | 77278008 | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Five instances of this field may be captured | | |
| **Verification rules** | Valid code only | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. Total blood loss

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Estimated and/or measured total blood loss within 24 hours following 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 | | |

* 1. 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.

* + 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.

* + 1. 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 | | |

* + 1. Birth outcome

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

* + 1. Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | How the baby was born | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity mode of delivery reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72581000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72581000210105)   |  |  | | --- | --- | | Agreed term | SCTID | | Caesarean section | 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 | | |

* + 1. Presenting part of baby

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

* + 1. 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 |  | | |

* + 1. Type of breech

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

* + 1. Mode of breech birth

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

* + 1. 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 | | |

* + 1. Shoulder dystocia procedures

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

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72641000210104&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | |

* + 1. Baby sex

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

* + 1. 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 | | |

* + 1. 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.**

* + 1. Apgar 1 minute

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Apgar score received at 1 minute of age | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity Apgar score reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105)   |  |  | | --- | --- | | Agreed term | SCTID | | Apgar score 0 at 1 minute | 169896003 | | Apgar score 1 at 1 minute | 169897007 | | Apgar score 2 at 1 minute | 169898002 | | Apgar score 3 at 1 minute | 169899005 | | Apgar score 4 at 1 minute | 169901001 | | Apgar score 5 at 1 minute | 169902008 | | Apgar score 6 at 1 minute | 169903003 | | Apgar score 7 at 1 minute | 169904009 | | Apgar score 8 at 1 minute | 169905005 | | Apgar score 9 at 1 minute | 169906006 | | Apgar score 10 at 1 minute | 169907002 | | | |
| Obligation | Mandatory | | |
| Guide for use | Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105)   |  |  | | --- | --- | | Agreed term | SCTID | | Apgar score 0 at 5 minutes | 169910009 | | Apgar score 1 at 5 minutes | 169911008 | | Apgar score 2 at 5 minutes | 169912001 | | Apgar score 3 at 5 minutes | 169913006 | | Apgar score 4 at 5 minutes | 169914000 | | Apgar score 5 at 5 minutes | 169915004 | | Apgar score 6 at 5 minutes | 169916003 | | Apgar score 7 at 5 minutes | 169917007 | | Apgar score 8 at 5 minutes | 169918002 | | Apgar score 9 at 5 minutes | 169919005 | | Apgar score 10 at 5 minutes | 169920004 | | | |
| Obligation | Mandatory | | |
| Guide for use | Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| Verification rules | Valid code only | | |

* + 1. Apgar 10 minutes

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Apgar score received at 10 minutes of age | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity Apgar score reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72621000210105&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72621000210105)   |  |  | | --- | --- | | Agreed term | SCTID | | Apgar score 0 at 10 minutes | 169923002 | | Apgar score 1 at 10 minutes | 169924008 | | Apgar score 2 at 10 minutes | 169925009 | | Apgar score 3 at 10 minutes | 169926005 | | Apgar score 4 at 10 minutes | 169927001 | | Apgar score 5 at 10 minutes | 169928006 | | Apgar score 6 at 10 minutes | 169929003 | | Apgar score 7 at 10 minutes | 169930008 | | Apgar score 8 at 10 minutes | 169931007 | | Apgar score 9 at 10 minutes | 169932000 | | Apgar score 10 at 10 minutes | 169933005 | | | |
| Obligation | Mandatory | | |
| Guide for use | Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| Verification rules | Valid code only | | |

* + 1. Neonatal resuscitation

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Requirement for neonatal resuscitation, including the outcome | | |
| Source standards |  | | |
| Data type | SNOMED CT identifier | Representational class | Code |
| Field size | 18 | Representational layout | N(18) |
| Value domain | The following SNOMED CT terms are from the [New Zealand maternity outcomes reference set](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72571000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72571000210108)   |  |  | | --- | --- | | Agreed term | SCTID | | Not performed | 71761000210100 | | Successful | 71741000210101 | | Unsuccessful | 71751000210103 | | Unknown  (SNOMED CT Term ‘Procedure status unknown’) | 399714002 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. Vitamin K

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

* + 1. 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**.

* + 1. 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.

* + 1. 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**.

* + 1. 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 | | |

* + 1. 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 |  | | |

* + 1. Infant feeding method

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Method by which the baby was first fed after the birth | | |
| Source standards |  | | |
| Data type | Numeric | Representational class | Code |
| Field size | 2 | Representational layout | NN |
| Value domain | |  |  | | --- | --- | | Agreed term | Code | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | Expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 3 | | Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 4 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 5 | | Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 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 | | |

* + 1. 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**.

* + 1. 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.**

* + 1. 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.

* + 1. 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 | | |

* + 1. 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 | SCTID | | 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 | | |

* + 1. 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).**

* + 1. 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.**

* + 1. 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.**

* 1. 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**.

* + 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.

* + 1. Infant feeding on discharge from facility

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Infant feeding method on discharge from maternity facility | | |
| Source standards |  | | |
| Data type | Numeric | Representational class | Code |
| Field size | 2 | Representational layout | NN |
| Value domain | |  |  | | --- | --- | | Agreed term | Code | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | Expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 3 | | Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 4 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 5 | | Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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**](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72591000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72591000210107) | | | **Agreed term** | **SCTID** | | Normal | 43408002 | | Abnormal | 247079003 | | Screening declined | 31021000119100 | | Not completed | 394908001 | | | |
| Obligation | Mandatory | | |
| Guide for use |  | | |
| Verification rules | Valid code only | | |

* + 1. 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**.

* + 1. 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 | | |

* + 1. 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.**

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 3 | | Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 4 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 5 | | Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 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 | | |

* + 1. 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 | | |

* + 1. Infant feeding at discharge from LMC

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Method by which the baby was being fed at the time of discharge from LMC | | |
| Source standards |  | | |
| Data type | Numeric | Representational class | Code |
| Field size | 2 | Representational layout | NN |
| Value domain | |  |  | | --- | --- | | Agreed term | Code | | Exclusively breastfed at the mother’s breast (‘exclusively breastfed’) | 1 | | Expressed breast milk from the mother’s breast, fed via supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 17 | | Breastfeeding at someone else’s breast (‘exclusively breastfed’) | 5 | | Donor breast milk, fed via bottle or supplemental nursing system (SNS) tube (‘exclusively breastfed’) | 7 | | 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 or supplemental nursing system (SNS) tube (‘partially breastfed’) | 10 | | 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 | | |

* + 1. 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.

* + 1. 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 | | |

* + 1. 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.

* + 1. 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.**

* + 1. 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 2.23.19 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 | | |

* + 1. 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 | | |

* + 1. 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 | SCTID | | 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 | | |

* + 1. 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**.

* + 1. 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 | | |

* + 1. 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**.

* + 1. 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 | | |

* 1. 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.**

* + 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.

* + 1. 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.

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72561000210102&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (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 | | |

* + 1. 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 |  | | |

* + 1. 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.

* + 1. 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**.

* + 1. 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.**

* + 1. Contraception

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

* + 1. 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 |  | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72631000210107&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72631000210107)   |  |  | | --- | --- | | Agreed term | SCTID | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Aromatherapy | 394615007 | | 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 | | |

* + 1. 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 | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72671000210109&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72671000210109)   |  |  | | --- | --- | | Agreed term | SCTID | | Does not drink alcohol | 105542008 | | Current drinker | 219006 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use | The information collected for this section is distinct from that collected for section 2.16.19 Current alcohol consumption, as this section records status at the end of the postnatal period | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72681000210106&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72681000210106)   |  |  | | --- | --- | | Agreed term | SCTID | | Does not misuse drugs | 228367002 | | Current drug user | 417284009 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use | The information collected for this section is distinct from that collected for section 2.12.6 History of drug use, as this section records status at the end of the postnatal period | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72691000210108&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72691000210108)   |  |  | | --- | --- | | Agreed term | SCTID | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Synthetic cannabinoid | 788540007 | | Other  (SNOMED CT Term: ‘Drug or medicament’) | 410942007 | | | |
| Obligation | Mandatory on a response of ‘Current drug user’ to section 2.23.14 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 status at the end of the postnatal period | | |
| Verification rules | Valid code only | | |

* + 1. 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 2.23.15 Current drugs used | | |
| Guide for use | One response should be recorded for each ‘Other’ instance of use identified in Current drugs used. | | |

* + 1. 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 | | Current smoker | 77176002 | | Current non-smoker | 160618006 | | Declined to answer | 426544006 | | | |
| Obligation | Mandatory | | |
| Guide for use | The information collected for this section is distinct from that collected for section 2.16.23 Current smoking status, as this section records status at the end of the postnatal period  Three instances of this field may be recorded | | |
| Verification rules | Valid code only | | |

* + 1. 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](https://browser.ihtsdotools.org/?perspective=full&conceptId1=72721000210100&edition=MAIN/SNOMEDCT-NZ/2021-10-01&release=&languages=en,mi) (72721000210100)   |  |  | | --- | --- | | Agreed term | SCTID | | Currently vaping with nicotine | 785889008 | | Currently vaping without nicotine | 786063001 | | Ex-vaper for more than 1 year | 1137692008 | | Ex-vaper for less than 1 year | 1137688001 | | Trying to give up vaping | 1137691001 | | Never vaped | 1137690000 | | 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

* + 1. 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 | | |

1. Revision history

|  |  |
| --- | --- |
| Date of publication | **Change details** |
| August 2024 | Updates to the following sections:   * 2.9.1 Changed to Cervical screening status an updated SNOMED CT terms and identifiers. * 2.9.2 Changed to Cervical screening results * 2.13.4 Date quite smoking – obligation updated * 2.16.24 & 2.23.19 Current vaping status – list of values updated * 2.16.25 Heading changed to Antenatal prescription type and obligation changed to optional * 2.17.23 Amniotic fluid – additional value added for clear amniotic fluid * 2.17.27 Type of birth – changed to reflect that systems are to pull information from 2.21.4 Mode of birth. * 2.17.30 Vaginal birth after Caesarean section – additional value for ‘no’ * 2.17.36 Heading changed to Labour and birth prescription type and obligation changed to optional * 2.20.8 Non-perineal genital tract trauma type – content added to guide for use. * 2.20.14 Total blood loss – definition updated. * 2.23 Postnatal woman/person - removal of data element Postnatal prescriptions * Updated SNOMED CT Identifiers for:   + 2.6.17 Fully breastfed   + 2.13.2 Never vaped |

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