Maternity Care Summary Standard

HISO 10050:2023

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Te Kāwanatanga o Aotearoa
New Zealand Government

hiso Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Health New Zealand
Te Whatu Ora

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1 Introduction

1.1 Purpose

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

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

1.2 Scope

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

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

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

This standard provides the data set specification for maternity care. It does not specify how information sharing is to occur. 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The HISO 10050:2022 Maternity Care Summary Standard superseded HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which was withdrawn.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.

1.3 New Zealand legislation

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

- **Health Act 1956**
- **Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996**
- **Health Information Privacy Code 2020**

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

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

Te Pae Tata | interim New Zealand Health Plan 2022 (Te Pae Tata) sets out the first two years of action for 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.

1.5 Related specifications

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

- **HISO 10046:2022 Consumer Health Identity Standard**
- **HISO 10005:2008 Health Practitioner Index (HPI) Data Set**
- **HISO 10006:2008 Health Practitioner Index (HPI) Code Set**

The above two HPI standards, published in 2008, are due for replacement; while they can provide guidance on the particular HPI data elements referred to in this standard, they are not suitable for any other purpose. A copy of the revised draft standard can be requested from standards@health.govt.nz.

- **HISO 10033 SNOMED CT**

SNOMED CT is the standard clinical terminology for use in New Zealand. Accordingly, this standard uses SNOMED CT in various data elements. The **SNOMED NZ Edition** includes all content from the SNOMED International Edition alongside New Zealand-specific content in the SNOMED NZ Extension. See the 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.

1.6 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.

1.7 Data element template

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

Data element format

Name	Data element name		
Definition	A statement that expresses the essential nature of the data element and its differentiation from other elements in the data set		
Source standards	Established data definitions or guidelines pertaining to the data element		
Data type	Alphabetic (A) Date Date/time Numeric (N) Alphanumeric (X) Boolean SNOMED CT identifier (SCTID)	**Representational class**	Code, free text, value or identifier For date and time data types, use full date or partial date
Field size	Maximum number of characters	**Representational layout**	The formatted arrangement of characters in alphanumeric elements, eg: X(50) for a 50-character alphanumeric string NNN for a 3-digit number

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

			NNAAAA for a formatted alphanumeric identifier
Value domain	The valid values or codes that are acceptable for the data element Each coded data element has a specified code set Code sets use the SNOMED CT clinical terminology standard where possible. Enumerated SNOMED concepts are denoted by preferred term and linked to descriptions in the **SNOMED International browser**. Where there are many member concepts, a reference set is published in the **SNOMED NZ Edition**, available from the **SNOMED Member Licensing and Distribution Service**. New Zealand Medicines Terminology (NZMT) is the standard used to identify medicines		
Obligation	Indicates if the data element is mandatory or optional in the context, or whether its appearance is conditional		
Guide for use	Additional guidance to inform the use of the data element		
Verification rules	Quality control mechanisms that preclude invalid values. **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		

2 Maternity care summary data set specification

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

2.1 Personal information

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

Information from the NHI is available to registered health care providers; it includes demographic and other generic information. The format and content of available fields is documented in **HISO 10046:2022 Consumer Health Identity Standard**.

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

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

2.2 Health care provider information

This section specifies the health care provider information that is related to this maternity event. The information should only be obtained from the HPI system. This is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in

- **HISO 10005:2008 Health Practitioner Index (HPI) Data Set**
- **HISO 10006:2008 Health Practitioner Index (HPI) Code Set**

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

The following data elements relate to the woman/person and are appropriate for use in the individual maternity situation. ‘Provider person’ is information related to the Lead Maternity Carer (LMC) and General Practitioner (GP). This information must be recorded as part of each maternity event.

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

2.3 Medicines information

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**
- use the NZePS application programming interface (API)
- use the **New Zealand Universal List of Medicines (NZULM) and New Zealand Formulary (NZF)**
- conform to **HISO 10042 Medication Charting and Medicine Reconciliation Standards**
- conform to New Zealand prescribing guidelines in the Medicines Regulations 1984

2.4 Booking information

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

2.4.1 Pregnancy intention

Definition	Pregnancy planning		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Ambivalent	169569009
Planned pregnancy	169565003
Unplanned pregnancy	83074005
Declined to answer	426544006

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.4.2 Method of assisted reproduction

Definition	Method of assisted reproduction if conception occurred via assisted reproduction		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Hormonal stimulation	71841000210107
Intrauterine insemination (IUI)	71851000210105
In vitro fertilisation (IVF)	10231000132102
Other	71861000210108

Obligation	Mandatory if assisted reproduction occurred
Guide for use	Three instances of this field may be recorded
Verification rules	Valid code only

2.4.3 Method of assisted reproduction – other detail

Definition	Other method of assisted reproduction		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Method of assisted reproduction.		
Guide for use			
Verification rules			

2.4.4 Gravida

Definition	Total number of times the woman/person has been pregnant		
Source standards			
Data type	Numeric	Representational class	Value
Field size	2	Representational layout	NN
Value domain	01–99		
Obligation	Mandatory		
Guide for use	This includes the current pregnancy. For example, someone who has had one prior pregnancy and is currently pregnant is designated Gravida 2 (G2) This value may be derived from previous pregnancy records or be provided by the woman/person If the number is self-reported it may not be accurate, as the woman/person may not know or wish to disclose the full number		
Verification rules	Valid value only		

2.4.5 Parity

Definition	The number of previous pregnancies where the outcome was a birth with a gestation greater than or equal to 20 weeks and 0 days		
Source standards			
Data type	Numeric	Representational class	Value
Field size	2	Representational layout	NN
Value domain	00–99		
Obligation	Mandatory		
Guide for use	Count twins or multiple births as one birth This value may be derived from previous pregnancy records or be provided by the woman/person		

	If the number is self-reported it may not be accurate, as the woman/person may not wish to disclose the full number
Verification rules	A value less than or equal to the value reported in Gravida is required

2.4.6 Last menstrual period

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

2.4.7 Estimated due date by dates

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

2.4.8 Estimated due date by ultrasound scan

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

2.4.9 Agreed estimated due date

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

2.4.10 Height

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

2.4.11 Weight

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

2.4.12 Eligibility

Definition	Eligibility for publicly funded maternity care in New Zealand

Source standards	**https://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services/pregnancy-services**		
Data type	Alphabetic	Representational class	Code
Field size	1	Representational layout	A
Value domain	**Agreed term** / **Code** Eligible / Y Not eligible / N		
Obligation	Mandatory		
Guide for use	The 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		

2.4.13 Lead Maternity Carer (LMC) type

Definition	Registration type of the LMC with the Medical Council or the Midwifery Council		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain	**Agreed term** / **Code** Registrant with the Medical Council of New Zealand / 1 Registrant with the Midwifery Council of New Zealand / 2		
Obligation	Mandatory if the woman/person is registered with an LMC during the pregnancy, labour and birth, or postnatal period		
Guide for use			
Verification rules	Valid code only		

2.4.14 Planned place of birth

Definition	Place or facility where the woman/person plans to give birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107) **Agreed term** / **SCTID** Home / 310586008		

	Primary birthing facility	91731000210104
	Secondary birthing facility	91741000210107
	Tertiary birthing facility	91751000210105
	Other	310585007
Obligation	Mandatory	
Guide for use		
Verification rules	Valid code only	

2.4.15 Planned place of birth – other detail

Definition	Detail of 'Other' planned place of birth		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Planned place of birth.		
Guide for use			

2.4.16 Planned place of birth – facility

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

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

2.5 Previous pregnancies

This section covers information about the woman/person's obstetric history. Information is collected at the first full contact the woman/person has with a maternity service provider. This is likely to be at the booking visit or first contact with acute maternity services during this pregnancy, if this occurs prior to registering with an LMC.

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

2.5.1 Previous miscarriage

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

2.5.2 Previous miscarriage – date

This element defines the date that the previous miscarriage occurred. The format is set out in the common **Date and time value domain** specification. The data element is optional upon a response to section **2.5.1 Previous miscarriage.** The element is to be recorded for each event.

2.5.3 Previous termination

<table>
<tr><td>Definition</td><td colspan="3">Terminations (if known)</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Medical termination of pregnancy</td><td>412758008</td></tr>
<tr><td>Surgical termination of pregnancy</td><td>71571000210104</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a termination having occurred</td></tr>
<tr><td>Guide for use</td><td colspan="3">A code is to be recorded for each termination</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.4 Previous termination – date

This element defines the date that the previous termination occurred. The format is set out in the common **Date and time value domain** specification. The data element is optional upon a response to section **2.5.3 Previous termination.** The element is to be recorded for each event.

2.5.5 Termination reason

<table>
<tr><td>Definition</td><td colspan="3">Reason(s) a previous pregnancy was terminated</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)
<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Congenital anomaly of fetus</td><td>72161000210106</td></tr><tr><td>Chromosomal anomaly
(SNOMED CT term: ‘History of fetus with chromosomal abnormality’)</td><td>71871000210102</td></tr><tr><td>Unplanned pregnancy</td><td>71881000210100</td></tr><tr><td>Other medical or social reason</td><td>417662000</td></tr><tr><td>Declined to answer</td><td>426544006</td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response to Previous termination</td></tr>
<tr><td>Guide for use</td><td colspan="3">One response should be recorded for each instance identified in section 2.5.3 Previous termination.</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.6 Termination reason – other detail

Definition	Detail of the ‘Other reason’ for termination		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of ‘Other reason’ for Termination reason.		
Guide for use			

2.5.7 Maternal antenatal complications in previous pregnancy

<table>
<tr><td>Definition</td><td colspan="3">Complications during any previous pregnancies</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous complications reference set</u> (72541000210103)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No previous complications</td><td>443508001</td></tr>
<tr><td>Antenatal depression and/or anxiety</td><td>71891000210103</td></tr>
<tr><td>Antepartum haemorrhage</td><td>161804005</td></tr>
<tr><td>Eclampsia</td><td>161806007</td></tr>
<tr><td>Gestational diabetes</td><td>472971004</td></tr>
<tr><td>Epilepsy</td><td>161480008</td></tr>
<tr><td>Hyperemesis</td><td>71901000210102</td></tr>
<tr><td>Infection</td><td>161413004</td></tr>
<tr><td>Obstetric cholestasis</td><td>16216781000119107</td></tr>
<tr><td>Placental abruption</td><td>789776003</td></tr>
<tr><td>Pre–eclampsia</td><td>105651000119100</td></tr>
<tr><td>Preterm labour</td><td>441493008</td></tr>
<tr><td>Preterm birth</td><td>161765003</td></tr>
<tr><td>Small for gestational age fetus (SGA)</td><td>726565008</td></tr>
<tr><td>Other complication occurring during pregnancy</td><td>91461000210102</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a previous pregnancy having occurred</td></tr>
<tr><td>Guide for use</td><td colspan="3">‘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</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.8 Maternal complication – other detail

Definition	Detail of the 'Other complication' that occurred during a previous pregnancy		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other complication occurring during pregnancy' for Maternal antenatal complications in previous pregnancy.		
Guide for use			

2.5.9 Onset of labour in previous pregnancies

Definition	Onset of labour in previous pregnancies		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous findings reference set** (72531000210106)		

Agreed term	SCTID
Induction of labour	725954003
Planned Caesarean section before labour	725949007
Spontaneous labour	726597008

Obligation	Mandatory on a response greater than zero for section 2.4.5 Parity.
Guide for use	
Verification rules	Valid code only

2.5.10 Induction reason

Definition	Reason for the previous induction of labour		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous findings reference set** (72531000210106)		

Agreed term	SCTID
Pre-labour rupture of membranes without spontaneous labour	108951000119100
Prolonged pregnancy	71911000210100

	Other clinical reason	417662000
Obligation	Mandatory on a response of ‘Induction of labour’ for Onset of labour in previous pregnancies.	
Guide for use		
Verification rules	Valid code only	

2.5.11 Induction reason – other detail

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

2.5.12 Length of previous labours

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

2.5.13 Maternal complications in previous labours

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** (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

2.5.14 Maternal complications in previous labours – other labour finding detail

Definition	Detail of the 'Other labour finding' reason for maternal complications in previous labours		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other labour finding' for Maternal complications in previous labours.		
Guide for use			

2.5.15 Mode of birth

Definition	Previous baby or babies mode of birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous mode of delivery reference set** (72521000210109)		

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

Obligation	Mandatory on a response greater than zero to section 2.4.5 Parity.
Guide for use	A minimum of one code is to be selected and recorded for each previous birth. This is to be reported in terms of spontaneity or assistance required
Verification rules	Valid code only

2.5.16 Type of Caesarean section

Definition	Type of Caesarean section incision in any previous pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous procedures reference set** (72501000210101)		

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

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

2.5.17 Indications for planned Caesarean section

<table>
<tr><td>Definition</td><td colspan="3">Clinical indication for performing a planned Caesarean section as an elective procedure prior to labour commencing</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Breech presentation</td><td>72031000210101</td></tr>
<tr><td>Congenital anomaly</td><td>161572004</td></tr>
<tr><td>Chromosomal anomaly</td><td>71871000210102</td></tr>
<tr><td>Medical or obstetric complication
(SNOMED CT term: ‘History of complication in pregnancy’)</td><td>91461000210102</td></tr>
<tr><td>Maternal request</td><td>720266003</td></tr>
<tr><td>Previous third-degree perineal tear</td><td>725941005</td></tr>
<tr><td>Previous fourth-degree perineal tear</td><td>725942003</td></tr>
<tr><td>Previous caesarean section</td><td>161805006</td></tr>
<tr><td>Transverse lie</td><td>72041000210109</td></tr>
<tr><td>Unstable lie</td><td>72051000210107</td></tr>
<tr><td>Other malpresentation</td><td>72001000210106</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Caesarean section’ to Mode of birth.</td></tr>
<tr><td>Guide for use</td><td colspan="3">A minimum of one code is to be selected and recorded for each previous birth
This table incorporates a mix of SNOMED CT concepts from the Disorder and Situation hierarchies</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.5.18 Indications for planned Caesarean section – other malpresentation detail

Definition	Detail of the ‘Other malpresentation’ as an indication for planned Caesarean section		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			

Obligation	Mandatory on a response of 'Other malpresentation' for Indications for planned Caesarean section.
Guide for use	
Verification rules	

2.5.19 Indications for unplanned Caesarean section

Definition	Clinical indication for performing an unplanned Caesarean section during labour, either latent or established		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous disorders reference set** (72551000210100)		

Agreed term	SCTID
Antepartum haemorrhage	161804005
Failed induction of labour	72061000210105
Failed instrumental/assisted delivery	772006002
Fetal distress	72071000210104
Fetal malposition	72081000210102
Fetal malpresentation	72001000210106
Intrapartum haemorrhage	71931000210107
Obstructed labour	71941000210104
Seizure	72091000210100

Obligation	Mandatory on a response of 'Caesarean section' to Mode of birth.
Guide for use	Eight instances of this field may be recorded
Verification rules	Valid code only

2.5.20 Previous labour analgesia

Definition	Type of analgesia used during previous labours		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain			

Agreed term	SCTID
No previous analgesia	101571000210101

	Non-pharmacological: 111491000210101 Pharmacological – non-opiate: 101591000210102 Pharmacological – opiate: 12275951000119104
Obligation	Mandatory on a response greater than zero to section 2.4.5 Parity.
Guide for use	A minimum of one code is to be selected and recorded for each previous birth
Verification rules	Valid code only

2.5.21 Previous labour anaesthesia

Definition	Type of anaesthesia administered during previous labours		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous procedures reference set** (72501000210101)		

Agreed term	SCTID
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

2.5.22 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** (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

2.6 Previous babies

This section covers information related to babies from previous pregnancies. It should be left blank unless the woman/person has previously given birth at 20 weeks gestation or later. This information should be collected at the first full contact the woman/person has with a maternity service provider. This is likely to be the booking visit or first contact with acute maternity services during this pregnancy if this occurs prior to registering with an LMC.

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

2.6.1 Outcome of previous babies

Definition	Outcome for each baby in previous pregnancies		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous outcomes reference set** (72511000210104) **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		

2.6.2 Date of birth – previous babies

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

2.6.3 Antenatal fetal complications

Definition	Complications related to the fetus during previous pregnancies		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous complications reference set** (72541000210103)		

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

2.6.4 Antenatal fetal complications – other detail

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

2.6.5 Intrapartum fetal complications

Definition	Complications related to the fetus during previous labours		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous complications reference set** (72541000210103)		

Agreed term	SCTID
None	443508001
Fetal blood sample abnormality	72701000210108
Fetal heart rate abnormality	72131000210102
Meconium-stained liquor	72191000210101
Other	1156096005

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

2.6.6 Intrapartum fetal complications – other detail

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

2.6.7 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** (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

2.6.8 Gestation of previous babies

Definition	Gestational age of previous babies, in weeks and days		
Source standards			
Data type	Numeric	Representational class	Value
Field size	4	Representational layout	NN.N
Value domain	Weeks and days		
Obligation	Mandatory		
Guide for use	This value is provided by previous pregnancy records (if held) or by the woman/person If the value is self-reported it may not be accurate, as the woman/person may not know the exact gestation 20 instances of this field may be recorded		
Verification rules	Valid value only		

2.6.9 Gender of previous babies

Definition	Gender of previous babies, as recorded at birth
Source standards	Refer to the gender code set of HISO 10046 Consumer Health Identity Standard

Data type	Alphabetic	Representational class	Code
Field size	1	Representational layout	A
Value domain	**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		

2.6.10 Birth weight of previous babies

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

2.6.11 Stillbirth cause

Definition	Causes of, or factors that contributed to, the stillbirth of a previous baby		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Stillborn' for Outcome of previous babies.		
Guide for use			

2.6.12 Gestation at fetal demise

Definition	Gestational age of a previous baby at demise		
Source standards			
Data type	Numeric	Representational class	Value
Field size	4	Representational layout	NN.N
Value domain	Weeks and days		
Obligation	Mandatory on a response of Stillborn to Outcome of previous babies.		
Guide for use	This value is provided by previous pregnancy records (if held) or by the woman/person If the value is self-reported it may not be accurate, as the woman/person may not know the exact gestation Record one instance of this field for each fetal demise		
Verification rules	Valid value only		

2.6.13 Neonatal complications

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** (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

2.6.14 Neonatal complications – other detail

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

2.6.15 Neonatal care admissions

Definition	Indicates whether a previous baby required admission to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain			
Obligation	Mandatory		

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

Guide for use	20 instances of this field may be recorded
Verification rules	Valid code only

2.6.16 Reason for admission to neonatal care

Definition	Reason a previous baby was admitted to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU)		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous disorders reference set** (72551000210100)		

Agreed term	SCTID
Asphyxia	161581005
Cardiovascular disease	72271000210106
Congenital anomaly	161572004
Chromosomal anomaly	71871000210102
Extremely preterm infant (born before 27 weeks plus 6 days)	72281000210108
Fetal disorder caused by medicinal agent transmitted via placenta	284801000210106
Neonatal disorder caused by medicinal agent transmitted via breast milk	284811000210108
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

2.6.17 Feeding history

Definition	Feeding history of previous babies in the first six months of life		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	**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		

2.6.18 Duration of breastfeeding

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

2.6.19 Cause of death

Definition	Cause of death of a previous baby or child		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of ‘Infant death’ or ‘Neonatal death’ for Outcome of previous babies.		

Guide for use	

2.6.20 Date of death – previous babies

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

2.7 Medical history

This section covers information related to the woman/person's medical history. It records relevant current or past conditions to help recognise risk factors.

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

2.7.1 Medical conditions

<table>
<tr><td>Definition</td><td colspan="3">Medical conditions</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity previous disorders reference set</u> (72551000210100)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>No relevant medical history</td><td>443508001</td></tr>
<tr><td>Autoimmune disorder</td><td>72331000210104</td></tr>
<tr><td>Cardiac disorder</td><td>266995000</td></tr>
<tr><td>Congenital abnormality</td><td>161572004</td></tr>
<tr><td>Diabetes mellitus type 1</td><td>472970003</td></tr>
<tr><td>Diabetes mellitus type 2</td><td>472969004</td></tr>
<tr><td>Endocrine disorder</td><td>266990005</td></tr>
<tr><td>Gastrointestinal disorder</td><td>266997008</td></tr>
<tr><td>Haematological disorder</td><td>266992002</td></tr>
<tr><td>Hypertension</td><td>161501007</td></tr>
<tr><td>Infectious diseases</td><td>161413004</td></tr>
<tr><td>Liver disorder</td><td>161535005</td></tr>
<tr><td>Malignancy</td><td>266987004</td></tr>
</table></td></tr>
</table>

	Mental health disorder	72711000210105
	Monogenic diabetes (MODY)	472972006
	Musculoskeletal disorder	267004000
	Neurological disorder	32451000119107
	Respiratory disorder	161523006
	Skin disorder	161560005
	Thrombosis and related disorder	275546001
	Other medical disorder	312850006
Obligation	Mandatory	
Guide for use	20 instances of this field may be recorded	
Verification rules	Valid code only	

2.7.2 Medical conditions – other disorder detail

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

2.8 Surgical history

This section covers information related to the woman/person's surgical history. It records relevant current or past conditions to help recognise risk factors.

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

2.8.1 Operations

Definition	Type of previous operations		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)

<table>
<tr><td>Value domain</td><td>The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>No previous surgery
(SNOMED CT Term: ‘No history of procedure’)</td><td>416128008</td></tr><tr><td>Breast</td><td>71661000210109</td></tr><tr><td>Cone biopsy</td><td>108941000119102</td></tr><tr><td>Genital tract</td><td>71671000210103</td></tr><tr><td>Large loop excision of transformation zone (LLETZ/LEEP)</td><td>59251000119102</td></tr><tr><td>Uterine</td><td>133581000119103</td></tr><tr><td>Other</td><td>161615003</td></tr></table></td></tr>
<tr><td>Obligation</td><td>Mandatory</td></tr>
<tr><td>Guide for use</td><td>Four instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td>Valid code only</td></tr>
</table>

2.8.2 Operations – date

This element defines the date of each operation. The format is set out in the common **Date and time value Domain** specification. The data element is optional upon a response to the **2.8.1 Operations** section above. It is to be recorded for each operation.

2.8.3 Operations – other detail

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

2.8.4 Previous anaesthetic

Definition	Types of anaesthetic previously administered, except during childbirth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)

<table>
<tr><td>Value domain</td><td>The following SNOMED CT terms are from the <u>New Zealand maternity previous procedures reference set</u> (72501000210101)<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>General anaesthetic</td><td>71621000210102</td></tr><tr><td>Local anaesthetic</td><td>71631000210100</td></tr><tr><td>Regional anaesthetic</td><td>131501000210104</td></tr></table></td></tr>
<tr><td>Obligation</td><td>Mandatory on a response other than ‘No previous surgery’ for Operations within this section.</td></tr>
<tr><td>Guide for use</td><td>Three instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td>Valid code only</td></tr>
</table>

2.8.5 Anaesthetic complications

<table>
<tr><td>Definition</td><td colspan="3">Complications when the woman was previously administered an anaesthetic</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>Boolean</td><td>Representational class</td><td>N/A</td></tr>
<tr><td>Field size</td><td>1</td><td>Representational layout</td><td>N(1,0)</td></tr>
<tr><td>Value domain</td><td colspan="3"><table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Unknown</td><td>2</td></tr><tr><td>Yes</td><td>1</td></tr><tr><td>No</td><td>0</td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response to Previous anaesthetic.</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.8.6 Anaesthetic complications – detail

<table>
<tr><td>Definition</td><td colspan="3">Detail of anaesthetic complications, where a complication occurred during administration, or as a result of an anaesthetic</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>Alphanumeric</td><td>Representational class</td><td>Free text</td></tr>
<tr><td>Field size</td><td>1000</td><td>Representational layout</td><td>X(1000)</td></tr>
<tr><td>Value domain</td><td colspan="3"></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory if there is a response of ‘1 – Yes’ for Anaesthetic complications.</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
</table>

2.9 Gynaecological history

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

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

2.9.1 Cervical screening status

<table>
<tr><td>Definition</td><td colspan="3">The period in which the individual has been involved in some form of cervical screening (if known)</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Within the last year
(SNOMED CT term: ‘History of cervical screening performed within last 12 months’)</td><td>466301000210105</td></tr>
<tr><td>Within the last two years
(SNOMED CT term: ‘History of cervical screening performed within last two years’)</td><td>466311000210107</td></tr>
<tr><td>Within the last three years
(SNOMED CT term: ‘History of cervical screening performed within last three years’)</td><td>466321000210102</td></tr>
<tr><td>More than three years ago
(SNOMED CT term: ‘History of cervical screening performed for more than three years’)</td><td>466331000210100</td></tr>
<tr><td>Never had cervical screening</td><td>466341000210108</td></tr>
<tr><td>Unknown
(SNOMED CT term: Screening status unknown)</td><td>406011002</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Optional</td></tr>
<tr><td>Guide for use</td><td colspan="3">The default is ‘Unknown’</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.9.2 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** (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

2.9.3 Sexual health history – diagnoses

Definition	Diagnosed sexually transmitted infections		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous disorders reference set** (72551000210100)		

Agreed term	SCTID
None	704007002
Bacterial vaginosis	72381000210100
Chlamydia	472954000
Genital herpes simplex	91531000210107

	Genital warts	91521000210105
	Gonorrhoea	72421000210108
	Human immunodeficiency virus (HIV)	101651000210108
	Syphilis	1087151000119108
	Trichomonas vaginalis	72441000210102
	Other	275881005
	Unknown	396782006
Obligation	Mandatory	
Guide for use	16 instances of this field may be recorded	
Verification rules	Valid code only	

2.9.4 Gynaecological history – diagnoses

Definition	Diagnosed gynaecological conditions		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity previous disorders reference set** (72551000210100)		

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

2.9.5 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** (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

2.10 Mental health history

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

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

2.10.1 Previous mental illness treatment

Definition	History of treatment for mental illness		
Source standards			
Data type	Boolean	Representational class	N/A
Field size	1	Representational layout	N(1,0)
Value domain	1 – Yes 0 – No		

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.10.2 Current mental illness treatment

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

2.10.3 Serious mental illness treatment

Definition	Detail of pharmacological treatment or talking therapies for serious mental illness in the past		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory if there is a history of treatment for serious mental illness noted		
Guide for use			
Verification rules	Valid code only		

2.11 Allergies and adverse reactions

This section records any allergies and adverse reactions the woman/person has experienced. This includes the type of reaction, the type of substance that caused the reaction and the severity of the reaction.

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

2.11.1 Allergies present

Definition	Known allergies to medicines or other substances		
Source standards	HISO 10042.2 Medicine Reconciliation Standard		
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

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

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.11.2 Allergies – medicines

Definition	Known allergies to specific medicines		
Source standards	HISO 10042.2 Medicine Reconciliation Standard		
Data type	Alphanumeric	Representational class	Value
Field size	250	Representational layout	X(250)
Value domain	Record the relevant medicine		
Obligation	Mandatory on an 'Allergy to medicine' response to Allergies present		
Guide for use	Nine instances of this field may be recorded		
Verification rules	Valid value only		

2.11.3 Allergies – substances

Definition	Known allergies to specific substances		
Source standards	HISO 10042.2 Medicine Reconciliation Standard		
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	**SCTID**

	<table><tr><td>Dairy (SNOMED CT term: ‘Cow’s milk’)</td><td>3718001</td></tr><tr><td>Egg</td><td>102263004</td></tr><tr><td>Latex</td><td>111088007</td></tr><tr><td>Nut</td><td>13577000</td></tr><tr><td>Seafood</td><td>44027008</td></tr><tr><td>Other</td><td>105590001</td></tr></table>
Obligation	Mandatory on a response of ‘Allergy to substance’ for Allergies present
Guide for use	Record the substances the women/person is allergic to, other than medicines Six instances of this field may be recorded
Verification rules	Valid code only

2.11.4 Allergies – other substance detail

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

2.11.5 Adverse reactions

Definition	Known adverse drug reactions (ADR) to a medicine		
Source standards	HISO 10042.2 Medicine Reconciliation Standard		
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response other than ‘No known allergies’ to Allergies present		
Guide for use	Nine instances of this field may be recorded		

2.12 Alcohol and other drugs

This section records information about a woman/person’s consumption of alcohol and other drugs. This information should be collected at the first full contact the woman/person has with a maternity service provider and routinely thereafter. Women/people may not reveal their alcohol use the first

time they are asked, and they may not stop drinking straight away; it is important to have this conversation more than once.

Information about the alcohol and other drug use is collected at the booking visit, at the end of the antenatal period and the postnatal period. Primary health and allied health professionals asking about alcohol, tobacco, and other drugs as part of routine health care checks will help break down the stigma associated with its use.

2.12.1 Alcohol consumption

<table>
<tr><td>Definition</td><td colspan="3">Current alcohol consumption</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand alcohol consumption reference set</u> (72671000210109)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Does not drink alcohol</td><td>105542008</td></tr>
<tr><td>Currently drinks alcohol</td><td>219006</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.12.2 Timing of alcohol cessation

<table>
<tr><td>Definition</td><td colspan="3">When the woman/person stopped drinking alcohol</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Pre-pregnancy</td><td>91601000210103</td></tr>
<tr><td>First trimester of pregnancy</td><td>101491000210103</td></tr>
<tr><td>Second trimester of pregnancy</td><td>101501000210108</td></tr>
<tr><td>Third trimester of pregnancy</td><td>101511000210105</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
<tr><td>Ongoing alcohol consumption</td><td>427013000</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Currently drinks alcohol’ in Alcohol consumption</td></tr>
</table>

Guide for use	
Verification rules	Valid code only

2.12.3 Amount of alcohol consumed

Definition	Units of alcohol consumed per week		
Source standards	**https://www.alcohol.org.nz/help-advice/standard-drinks/whats-a-standard-drink**		
Data type	Numeric	Representational class	Value
Field size	3	Representational layout	NNN
Value domain			
Obligation	Mandatory on a response of 'Currently drinks alcohol' to Alcohol consumption		
Guide for use	An approximate number of units is acceptable		
Verification rules	Valid value only		

2.12.4 Brief alcohol cessation advice

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

2.12.5 Referred to alcohol use services

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

2.12.6 History of drug use

Definition	History of illegal drug use		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand non-medicinal drug use reference set** (72681000210106).		

Agreed term	SCTID
Current drug user	417284009
Declined to answer	426544006
Ex-drug user	44870007
Has never misused drugs	228368007
Misuse of prescription drugs	191939002

Obligation	Mandatory
Guide for use	This covers illegal drugs or misuse of drugs prescribed for the woman/person or others
Verification rules	Valid code only

2.12.7 Current drugs used

Definition	Currently used illegal drugs		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand non-medicinal drug reference set** (72691000210108)		

Agreed term	SCTID
Amphetamines	703842006
Aromatic solvent	117499009
Benzodiazepine sedative	372616003
Cannabis	398705004
Cocaine	387085005
Codeine phosphate	261000
Crack cocaine	229003004
Gas (nitrous oxide)	111132001

	Hallucinogenic agent: 373469002 Heroin: 387341002 Methadone: 387286002 Methamphetamine: 387499002 Morphine: 373529000 Synthetic cannabinoid: 788540007 Other: 410942007 Declined to answer: 426544006
Obligation	Mandatory on a response of 'Current drug user' to History of drug use.
Guide for use	This covers illegal drugs or misuse of drugs prescribed for the woman/person or others
Verification rules	Valid code only

2.12.8 Current drugs used – other detail

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

2.13 Smoking and vaping status

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

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

2.13.1 Smoking status

<table>
<tr><td>Definition</td><td colspan="3">Current use of tobacco</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand smoking status reference set</u> (72741000210106)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Currently smokes tobacco</td><td>77176002</td></tr>
<tr><td>Never smoked</td><td>266919005</td></tr>
<tr><td>Ex-smoker, greater than 12 months abstinent</td><td>48031000119106</td></tr>
<tr><td>Ex-smoker, less than 12 months abstinent</td><td>735128000</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Three instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.13.2 Vaping status

<table>
<tr><td>Definition</td><td colspan="3">Current use of a vaping device</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand vaping status reference set</u> (72721000210100)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Currently vaping with nicotine</td><td>785889008</td></tr>
<tr><td>Currently vaping without nicotine</td><td>786063001</td></tr>
<tr><td>Ex-vaper for less than 1 year</td><td>1137688001</td></tr>
<tr><td>Ex-vaper for more than 1 year</td><td>1137692008</td></tr>
<tr><td>Trying to give up vaping</td><td>1137691001</td></tr>
<tr><td>Never vaped</td><td>1137690000</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Three instances of this field may be recorded</td></tr>
</table>

Verification rules	Valid code only

2.13.3 Change from smoking to vaping

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

2.13.4 Date quit smoking

Definition	Date the woman/person stopped smoking tobacco		
Source standards			
Data type	Date	Representational class	Full or partial date
Field size	8	Representational layout	YYYY[MM[DD]]
Value domain	Valid date or valid partial date		
Obligation	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		

2.13.5 Number of cigarettes smoked per day

Definition	Number of tobacco cigarettes smoked per day		
Source standards			
Data type	Numeric	Representational class	Value
Field size	3	Representational layout	NNN
Value domain			
Obligation	Mandatory on a response of 'Currently smokes' for Smoking status		
Guide for use	An approximate number is acceptable		

Verification rules	A value greater than zero

2.13.6 Brief smoking cessation advice

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

2.13.7 Referral to smoke free services

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

2.13.8 Exposure to second-hand smoke

Definition	If and where the woman/person has had regular exposure to second-hand tobacco smoke		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	**SCTID**
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

2.14 Family health

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

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

2.14.1 Maternal family history

Definition	Relevant medical history of the woman/person's close family		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity family history reference set** (72661000210103)		

Agreed term	SCTID
Allergies	160469004
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	

2.14.2 Maternal family history – other detail

Definition	Detail of 'Other condition' maternal family history		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Maternal family history		
Guide for use	A response is to be recorded for each identified 'Other condition' instance of maternal family history		

2.14.3 Paternal family history

Definition	Relevant medical history of the baby's biological father and their close family		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity family history reference set** (72661000210103)		

Agreed term	SCTID
Allergies	160469004
Chromosomal anomaly	160425006
Congenital anomaly	160417009
Intellectual disability	763598005
Mental illness	160324006
No relevant family history	160266009
Not known	407559004
Other condition	281666001

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

2.14.4 Paternal family history – other detail

Definition	Detail of the 'Other condition' paternal family history		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Paternal family history		
Guide for use	A response is to be recorded for each identified 'Other condition' paternal family history		

2.14.5 Consanguinity

Definition	Blood relationship of the baby's parents to each other		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain			

Agreed term	**Code**
Yes	1
No	2
Not known	3

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.14.6 Degree of relationship

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

2.15 Tuberculosis risk assessment

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.

2.15.1 Lives with person with tuberculosis

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

2.15.2 Lives in country with tuberculosis

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** (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		

2.15.3 Lived in country with tuberculosis

Definition	Have one or both parents or household members or carers, within the last five years, lived in a country with high rates of TB		
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

2.16 Current pregnancy

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

2.16.1 Blood tests

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** (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

2.16.2 Blood test – other test detail

Definition	Detail of 'Other blood test' taken		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other blood tests' for Blood tests		
Guide for use	A response is to be recorded for each instance of 'Other'		

2.16.3 Antenatal screening

Definition	Screening tests during the current pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity screening and tests reference set** (72641000210104)		
Obligation	Mandatory		
Guide for use	10 instances of this field may be recorded		
Verification rules	Valid code only		

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

2.16.4 Antenatal screening – other detail

Definition	Detail of 'Other' antenatal screening undertaken		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Antenatal screening		
Guide for use	A response is to be recorded for each instance of 'Other'		

2.16.5 Antenatal vaccinations

Definition	Vaccinations during the current pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

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

2.16.6 Family violence screening

Definition	Screening for family violence undertaken by the health professional		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain			

Agreed term	**Code**
No, not screened	1
Yes, screened	2

	Declined to answer: 3 Unable to ask: 4
Obligation	Mandatory
Guide for use	
Verification rules	Multiple responses can be recorded

2.16.7 Fetal anomaly screening

Definition	Fetal anomaly screening tests during the current pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	**Agreed term** / **SCTID** Declined fetal anomaly screening: 111511000210108 Non-invasive prenatal screening (NIPS): 121511000210100 First trimester combined screening: 111521000210103 Second trimester maternal serum screening: 111531000210101 Unknown: 406011002		
Obligation	Mandatory		
Guide for use	Three instances of this field may be recorded		
Verification rules	Valid code only		

2.16.8 Ultrasound scans

Definition	Ultrasound scans during the current pregnancy		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain	The following SNOMED CT terms are from the **New Zealand maternity procedures reference set** (72561000210102) **Agreed term** / **Code** Dating: 169229007 Anatomy: 271442007 Growth: 241493005 Placental location: 164817009		

	Suspected malpresentation: 169228004 Other: 241491007 Declined ultrasound scans: 71771000210106
Obligation	Mandatory
Guide for use	Seven instances of this field may be recorded
Verification rules	Valid code only

2.16.9 Ultrasound scan total

Definition	Total number of ultrasound scans during the current pregnancy		
Source standards			
Data type	Numeric	Representational class	Value
Field size	2	Representational layout	NN
Value domain	00–99		
Obligation	Mandatory on any response other than 'Declined ultrasound scans' in Ultrasound scans		
Guide for use			
Verification rules	Valid value only		

2.16.10 Chorionic villus sampling

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

2.16.11 Amniocentesis

Definition	Amniocentesis during the current pregnancy		
Source standards			
Data type	Boolean	Representational class	N/A
Field size	1	Representational layout	N(1,0)

Value domain	1 – Yes 0 – No
Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.16.12 Pregnancy complications

Definition	Complications experienced during the current pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity complications reference set** (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

2.16.13 Pregnancy complications – other detail

Definition	Detail of 'Other' pregnancy complications		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Pregnancy complications		
Guide for use			

2.16.14 Antenatal referral – date

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

2.16.15 Antenatal referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-obstetric-and-related-medical-services-referral-guidelines/ See Table 2: Conditions and referral categories		
Data type	Number	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services*		
Obligation	Mandatory if a referral was made to a specialist service during the antenatal period Antenatal referral date.		
Guide for use			
Verification rules	Valid code only		

2.16.16 Pregnancy loss – date

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

2.16.17 Antenatal admission – date and time

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

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

2.16.18 Antenatal discharge – date and time

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

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

2.16.19 Current alcohol consumption

<table>
<tr><td>Definition</td><td colspan="3">Current alcohol consumption</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand alcohol consumption reference set</u> (72671000210109)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Does not drink alcohol</td><td>105542008</td></tr>
<tr><td>Currently drinks alcohol</td><td>219006</td></tr>
<tr><td>Declined to answer</td><td>426544006</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">The information collected for this section is distinct from that collected for section 2.12.1 Alcohol consumption, as this section records a value at the end of the pregnancy</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.16.20 Current drug use

<table>
<tr><td>Definition</td><td colspan="3">Current use of illegal drugs</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand non-medicinal drug use reference set</u> (72681000210106)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>Current drug user</td><td>417284009</td></tr>
</table></td></tr>
</table>

	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

2.16.21 Current drugs used

Definition	Currently used illegal drugs		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)

Value domain

The following SNOMED CT terms are from the **New Zealand non-medicinal drug reference set** (72691000210108)

Agreed term	SCTID
Amphetamines	703842006
Aromatic solvent	117499009
Benzodiazepine sedative	372616003
Cannabis	398705004
Cocaine	387085005
Codeine phosphate	261000
Crack cocaine	229003004
Gas (nitrous oxide)	111132001
Hallucinogenic agent	373469002
Heroin	387341002
Methadone	387286002
Methamphetamine	387499002
Morphine	373529000
Synthetic cannabinoid	788540007
Other	74964007
Declined to answer	426544006

Obligation	Mandatory on a response of ‘Current drug user’ to section 2.16.20 Current drug use

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

2.16.22 Current drugs used – other detail

Definition	Detail of 'Other' drugs currently in use		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for section 2.16.21 Current drugs used.		
Guide for use			

2.16.23 Current smoking status

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

Agreed term	**SCTID**
Currently smokes tobacco	77176002
Current non-smoker	160618006
Declined to answer	426544006

Obligation	Mandatory
Guide for use	The information collected for this section is distinct from that collected for section 2.13.1 Smoking status, as section 2.16.23 records status at the end of the pregnancy
Verification rules	Valid code only

2.16.24 Current vaping status

Definition	Current use of a vaping device		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand vaping status reference set** (72721000210100)		

Agreed term	SCTID
Currently vaping with nicotine	785889008
Currently vaping without nicotine	786063001
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

2.16.25 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** (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

2.16.26 Antenatal prescriptions – other detail

Definition	Detail of 'Other' antenatal prescriptions		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Antenatal prescriptions		
Guide for use			

2.16.27 Antenatal complementary therapies

Definition	Use of complementary therapies during the current pregnancy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity complementary therapies reference set** (72631000210107)		

Agreed term	SCTID
None (SNOMED CT Term 'Procedure not indicated')	428119001
Acupressure	231107005
Acupuncture	231081007
Aromatherapy	394615007
Chiropractic	182548004
Herbal medicine	414392008
Homeopathy	182968001
Massage	387854002

	Naturopathy	439809005
	Osteopathy	182549007
	Reflexology	394614006
	Rongoā Māori	789789009
	Other	225423004
Obligation	Mandatory	
Guide for use	10 instances of this field may be recorded	
Verification rules	Valid code only	

2.16.28 Antenatal visits – first trimester

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

2.16.29 Antenatal visits – second trimester

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

2.16.30 Antenatal visits – third trimester

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

2.17 Labour and birth

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

2.17.1 Onset of labour

Definition	Manner by which the labour started		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

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

2.17.2 Gestation at onset of labour

Definition	Gestational age of the baby at the onset of labour		
Source standards			
Data type	Numeric	Representational class	Value
Field size	4	Representational layout	NN.N
Value domain	Weeks and days		
Obligation	Mandatory		
Guide for use	This is a system calculation that is conditional on the request of the LMC The result of the calculation may be stored within the maternity database as requested by the LMC The value for this field is created by: subtracting the: EDD date (a value recorded in section 2.4.9 Agreed estimated due date from the: recorded date for the onset of labour (a value recorded in section 2.17.1 Onset of labour)		
Verification rules	A value greater than or equal to 20		

2.17.3 Labour established – date and time

This element defines the date and time that labour was established, as measured by duration, frequency, and strength of contractions. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory upon a response of either 'Induced' or 'Spontaneous' for **Onset of labour**.

2.17.4 Actual place of birth

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

2.17.5 Actual place of birth – other detail

Definition	Detail of 'Other' actual place of birth		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Actual place of birth		
Guide for use			

2.17.6 Actual place of birth – facility

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

2.17.7 Maternity facility admission – date and time

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

2.17.8 Labour augmented – first stage

Definition	Augmentation of the first stage of labour with an artificial rupture of membranes (ARM) and/or oxytocin		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain			

Agreed term	**SCTID**
No augmentation	91721000210101
Augmented with ARM	408818004
Augmented with oxytocin	816966004
Augmented with both ARM and oxytocin	101621000210104

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.17.9 Reason labour augmented – first stage

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

2.17.10 Reason labour augmented in first stage – other detail

Definition	Detail of 'Other' reason for augmentation of labour		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	250	Representational layout	X(250)
Value domain			
Obligation	Mandatory on a response of 'Other' for Reason labour augmented – first stage		
Guide for use			

2.17.11 Complications – first stage

Definition	Complications during the first stage of labour		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity disorders reference set** (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

2.17.12 Complications in first stage – other detail

Definition	Detail of 'Other first stage of labour problem'		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	250	Representational layout	X(250)
Value domain			

Obligation	Mandatory on a response of 'Other' for Complications – first stage
Guide for use	

2.17.13 Cervix fully dilated – date and time

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

2.17.14 Length of active first stage of labour

Definition	Calculated length of first stage of labour		
Source standards			
Data type	Numeric	Representational class	Value
Field size	5	Representational layout	HH:MM
Value domain	Up to 99 hours, 59 minutes		
Obligation	Mandatory on a valid response to Cervix fully dilated -= date and time		
Guide for use	This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database as requested by the LMC The value for this field is created by: subtracting the: time labour established (a time value recorded in Labour established – date and time) section from the: recorded time for the end of first stage labour (a value recorded in Cervix fully dilated – date and time)		
Verification rules	Valid value only		

2.17.15 Labour augmentation – second stage

Definition	Augmentation of the second stage of labour with ARM and/or oxytocin		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain			

Agreed term	**SCTID**
No augmentation	91721000210101
Augmented with ARM	408818004
Augmented with oxytocin	816966004
Augmented with both ARM and oxytocin	101621000210104

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.17.16 Reason labour augmented – second stage

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

2.17.17 Reason labour augmented in second stage – other detail

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

2.17.18 Pushing commenced – date and time

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

2.17.19 Complications – second stage

Definition	Complications during the second stage of labour		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity disorders reference set** (72611000210100)		

Agreed term	SCTID
No complications (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

2.17.20 Complications in second stage – other detail

Definition	Detail of 'Other first stage of labour problem'		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	250	Representational layout	X(250)
Value domain			
Obligation	Mandatory on a response of 'Other' for Complications – second stage		

Guide for use	

2.17.21 Length of second stage of labour

Definition	Calculated length of second stage of labour		
Source standards			
Data type	Numeric	Representational class	Value
Field size	5	Representational layout	HH:MM
Value domain	Up to 99 hours, 59 minutes		
Obligation	Mandatory on a valid response to Cervix fully dilated – date and time		
Guide for use	This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database as requested by the LMC The value for this field is created by: subtracting the: time value recorded for the start of the second stage of labour (a time value recorded in Cervix fully dilated – date and time) from the: recorded time of the birth of the baby (a time value recorded in section 2.21.1 Birth – date and time)		
Verification rules	Valid value only		

2.17.22 Rupture of membranes – date and time

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

2.17.23 Amniotic fluid

Definition	Description of the amniotic fluid		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set (72591000210107)**		

Agreed term	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	

2.17.24 Labour and birth referral – date

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

2.17.25 Labour and birth referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-obstetric-and-related-medical-services-referral-guidelines/See Table 2: Conditions and referral categories		
Data type	Number	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services*		
Obligation	Mandatory if a referral was made to a specialist service during the labour and birth		
Guide for use			
Verification rules	Valid code only		

2.17.26 Number of babies born

Definition	Number of babies born during this labour and birth, including stillbirths		
Source standards			
Data type	Numeric	Representational class	Value
Field size	1	Representational layout	N

Value domain	
Obligation	Mandatory
Guide for use	
Verification rules	A value greater than zero

2.17.27 Type of birth

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

2.17.28 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** (72591000210107)		
Obligation	Mandatory		
Guide for use	Record one entry for each baby born		
Verification rules	Valid code only		

Agreed term	**SCTID**
Kneeling	277773003
Lateral	32185000
Lithotomy	14205002
Semi-reclined	272580008
Sitting (eg, birth stool)	33586001
Squatting	408797004
Standing	10904000
Supine	40199007

2.17.29 Water birth

Definition	Indicates whether the baby was born into water		
Source standards			
Data type	Boolean	Representational class	N/A
Field size	1	Representational layout	N(1,0)
Value domain	1 – Yes 0 – No		

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

2.17.30 Vaginal birth after Caesarean section

Definition	Identifies whether the birth was a vaginal birth after a previous Caesarean section		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Yes (SNOMED CT Term: 'Vaginal delivery following previous caesarean section')	237313003
Not known (SNOMED CT Term: 'No clinical detail given)	281337006
Not applicable	385432009
No	373067005

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

2.17.31 Length of third stage of labour

Definition	Calculated length of third stage of labour		
Source standards			
Data type	Numeric	Representational class	Value
Field size	5	Representational layout	HH:MM
Value domain	Up to 99 hours, 59 minutes		
Obligation	Mandatory		
Guide for use	This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database as requested by the LMC The value for this field is created by:		

	subtracting the: recorded time of the birth of the baby (a value recorded in section 2.21.1 Birth – date and time) from the: recorded time for the end of third stage of labour (a time value recorded in section 2.20.3 Placenta delivery – date and time)
Verification rules	Valid value only

2.17.32 Analgesia in labour

Definition	Types of analgesia used during the first, second or third stage of labour		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain			

Agreed term	SCTID
No analgesia	91631000210108
Codeine	387494007
Diamorphine	387341002
Gas (nitrous oxide)	111132001
Fentanyl	373492002
Paracetamol	387517004
Pethidine	387298007
Morphine	373529000
Remifentanil	386839004
Non-pharmacological	111481000210103

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

2.17.33 Analgesia in labour – date and time

If analgesia was administered during the first, second or third stage of labour, this element defines the date and time each instance of analgesia was administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on any response other than ‘no analgesia’ to **Analgesia in labour**.

2.17.34 Anaesthesia in labour

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

2.17.35 Anaesthesia in labour – date and time

If anaesthesia was administered during the first, second or third stage of labour, this element defines the date and time each instance of anaesthesia was administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response to **Analgesia in labour.**

2.17.36 Labour and birth 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)

<table>
<tr><td>Value domain</td><td>The following SNOMED CT terms are from the <u>New Zealand maternity substances reference set</u> (72651000210101)<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>No prescriptions
(SNOMED CT Term: ‘No drug therapy prescribed’)</td><td>182849000</td></tr><tr><td>Analgesic</td><td>373265006</td></tr><tr><td>Antacid</td><td>372794006</td></tr><tr><td>Antibacterial</td><td>419241000</td></tr><tr><td>Antiemetic</td><td>372776000</td></tr><tr><td>Intravenous fluid</td><td>118431008</td></tr><tr><td>Non-steroidal anti-inflammatory drug (NSAID)</td><td>372665008</td></tr><tr><td>Uterotonic drug</td><td>410937004</td></tr><tr><td>Other</td><td>410942007</td></tr></table></td></tr>
<tr><td>Obligation</td><td>Optional</td></tr>
<tr><td>Guide for use</td><td>Nine instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td>Valid code only</td></tr>
</table>

2.17.37 Labour and birth prescriptions administered – date

- This element defines the date and time any medication was administered during the labour and birth. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on any response to **Labour and birth prescriptions** other than ‘No prescriptions’.

2.17.38 Labour and birth prescriptions – other detail

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

2.17.39 Coping strategies

<table>
<tr><td>Definition</td><td colspan="3">Types of coping strategies and complementary therapies used during labour</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity complementary therapies reference set</u> (72631000210107)
<table>
<tr><th>Agreed term</th><th>SCTID</th></tr>
<tr><td>None
(SNOMED CT Term ‘Procedure not indicated’)</td><td>428119001</td></tr>
<tr><td>Acupressure</td><td>231107005</td></tr>
<tr><td>Acupuncture</td><td>231081007</td></tr>
<tr><td>Aromatherapy</td><td>394615007</td></tr>
<tr><td>Heat packs</td><td>398074008</td></tr>
<tr><td>Herbal medicine</td><td>414392008</td></tr>
<tr><td>Homeopathy</td><td>182968001</td></tr>
<tr><td>Hypnobirthing techniques</td><td>19997007</td></tr>
<tr><td>Massage</td><td>387854002</td></tr>
<tr><td>Naturopathy</td><td>439809005</td></tr>
<tr><td>Positional techniques</td><td>226048001</td></tr>
<tr><td>Reflexology</td><td>394614006</td></tr>
<tr><td>Rongoā Māori</td><td>789789009</td></tr>
<tr><td>Sterile water injection</td><td>144711000146107</td></tr>
<tr><td>Support people</td><td>816968003</td></tr>
<tr><td>TENS machine</td><td>229559001</td></tr>
<tr><td>Water immersion</td><td>229204004</td></tr>
<tr><td>Other</td><td>225423004</td></tr>
</table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">13 instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.17.40 Coping strategies – other detail

Definition	Detail of 'Other' coping strategies		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other' for Coping strategies		
Guide for use			

2.18 Induction of labour

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

2.18.1 Induction date and time

This element defines the date and time an induction of labour was commenced. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response of 'Induced' for section **2.17.1 Onset of labour**. This field records the date and time of the first method (as listed in **2.18.2 Induction method(s)** below) used in the induction of labour process.

2.18.2 Induction method(s)

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** (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

2.18.3 Induction method – other detail

Definition	Detail of 'Other' induction method		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of 'Other method' in Induction method(s)		
Guide for use			

2.18.4 Induction reason

Definition	Reason for the induction of labour		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	**SCTID**
Abnormal dopplers	312370006
Advanced maternal age	416413003
Antepartum haemorrhage	34842007
Blood group antibodies	166167002
Chromosomal anomaly of fetus	267253006
Congenital anomaly of fetus	609520005
Diabetes	10754881000119104
Eclampsia	15938005
Fetal heart rate abnormality	267257007
Gestational hypertension	48194001
Hypertension	106005003
In vitro fertilisation (IVF)	10231000132102
Intrauterine fetal death	14022007

	Intrauterine growth restriction/small for gestational age (IUGR/SGA) — 22033007 Large for gestational age — 199616008 Long latent phase — 387700009 Maternal anomaly complicating pregnancy — 721153000 Maternal medical condition — 281667005 Maternal request — 408855004 Multiple pregnancy — 16356006 Obesity — 10750551000119100 Obstetric cholestasis — 10750161000119106 Oligohydramnios — 59566000 Polyhydramnios — 86203003 Poor obstetric history — 169584000 Pre-eclampsia — 398254007 Prelabour rupture of membranes — 44223004 Preterm rupture of membranes — 312974005 Previous shoulder dystocia — 816150000 Prolonged pregnancy — 90968009 Reduced fetal movements — 276369006 Termination of pregnancy — 57797005 Unstable lie — 86356004 Other — 173300003
Obligation	Mandatory if Induction date and time is entered
Guide for use	Five instances of this field may be recorded
Verification rules	Valid code only

2.18.5 Induction reason – other detail

Definition	Detail of ‘Other’ induction reason		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of ‘Other’ in Induction reason		
Guide for use			

2.19 Caesarean section

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

2.19.1 Caesarean section type

<table>
<tr><td>Definition</td><td colspan="3">Type of uterine incision</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>SNOMED CT identifier</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>18</td><td>Representational layout</td><td>N(18)</td></tr>
<tr><td>Value domain</td><td colspan="3">The following SNOMED CT terms are from the <u>New Zealand maternity procedures reference set</u> (72561000210102)
<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Classical caesarean section</td><td>84195007</td></tr><tr><td>Lower uterine segment Caesarean section (LUSCS)</td><td>788180009</td></tr><tr><td>Other</td><td>11466000</td></tr><tr><td>Not known
(SNOMED CT Term: ‘No clinical detail given’)</td><td>281337006</td></tr></table></td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory on a response of ‘Caesarean section’ for section 2.17.27 Mode Type of birth</td></tr>
<tr><td>Guide for use</td><td colspan="3"></td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.19.2 Caesarean section type – other detail

Definition	Detail of ‘Other’ Caesarean section type		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory on a response of ‘Other’ in Caesarean section type		
Guide for use			

2.19.3 Caesarean grade

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

2.19.4 Caesarean category

Definition	Category of the Caesarean section		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	**SCTID**
Category 1 Immediately life threatening to the woman or fetus	91771000210102
Category 2 Woman or fetus compromised, not immediately life threatening	101531000210103
Category 3 Decision for earlier delivery made by health service	101541000210106
Category 4 Decision for rescheduled delivery made by health service and the woman	101551000210109

Obligation	Mandatory on a response of ‘Unplanned (emergency)’ for Caesarean grade
Guide for use	
Verification rules	Valid code only

2.19.5 Dilation before Caesarean section

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

2.19.6 Caesarean section primary indication

Definition	Primary indication for performing the Caesarean section		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity disorders reference set** (72611000210100)		

Agreed term	**SCTID**
Abnormal fetal blood sample	71701000210104
Antepartum haemorrhage	34842007
Augmentation causing uterine hyperstimulation	34981006
Chorioamnionitis	11612004
Chronic hypertension	8762007
Cord presentation	237305004
Cord prolapse	270500004
Diabetes	73211009
Failed induction of labour	42571002
Failed instrumental delivery	772006002
Fetal anomaly	609520005
Fetal distress – intolerance of augmented labour	816967008
Fetal distress – spontaneous labour	288274003
Fetal heart rate abnormality	312668007
Hypertensive disorder	38341003

	Inefficient uterine action – no oxytocin: 387699008 Inefficient uterine action – with oxytocin: 816969006 Large for gestational age: 199616008 Malposition: 289365005 Malpresentation: 15028002 Maternal age: 416413003 Maternal medical condition: 281667005 Maternal request: 408855004 Multiple pregnancy: 16356006 Obstructed labour: 199746004 Other fetal reason: 106009009 Other maternal reason: 106008001 Placenta praevia: 36813001 Placental abruption: 415105001 Pre-eclampsia: 398254007 Previous caesarean section: 200151008 Small for gestational age (SGA): 267258002 Suboptimal augmentation: 91484005 Uterine rupture: 34430009 Unknown: 281337006
Obligation	Mandatory on a response of ‘Caesarean section’ for section 2.17.27ModeType of birth
Guide for use	
Verification rules	Valid code only

2.19.7 Caesarean section primary indication – other fetal reason detail

Definition	Detail of ‘Other fetal reason’ for Caesarean information		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory upon a response of ‘Other fetal reason’ for section 2.19.6 Caesarean section primary indication		
Guide for use			

2.19.8 Caesarean section primary indication – other maternal reason detail

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

2.19.9 Complications during Caesarean section

Definition	Complications that occurred during the Caesarean section		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from **the New Zealand maternity complications reference set** (72601000210102)		

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

Obligation	Mandatory on a response of 'Caesarean section' for section 9 Type of birth
Guide for use	Nine instances of this field may be recorded
Verification rules	Valid code only

2.19.10 Complications during Caesarean section – other detail

Definition	Detail of 'Other' complications during Caesarean section		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory upon a response of 'Other' for Complications during Caesarean section		
Guide for use			

2.20 Post-birth

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

2.20.1 Placenta mode of delivery

Definition	Mode of delivery of the placenta		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity procedures reference set** (72561000210102)		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

Agreed term	**SCTID**
Caesarean section	50791000210101
Controlled cord traction with uterotonic	302384005
Manual removal of retained placenta	28233006
Physiological	1141750000

2.20.2 Uterotonic drugs

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

2.20.3 Placenta delivery – date and time

This element defines the date and time the placenta was delivered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory. This field signifies the third stage of labour date and time.

2.20.4 Perineal status

Definition	Status of the perineum after the birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	**SCTID**
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	

2.20.5 Episiotomy type

Definition	Episiotomy type		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Anterior	71981000210106
J shaped	71831000210104
Mediolateral	71991000210108
Midline	71821000210101

Obligation	Mandatory on a response of ‘Episiotomy incision’ for Perineal status
Guide for use	
Verification rules	Valid code only

2.20.6 Episiotomy reason

Definition	Clinical indication for performing the episiotomy		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

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

2.20.7 Episiotomy reason – other detail

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

2.20.8 Non-perineal genital tract trauma type

Definition	Description of any non-perineal genital tract trauma		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Cervical laceration	237090005
Labial graze or tear	249221003
Vaginal laceration	410062001

Obligation	Mandatory if non-perineal genital tract trauma is present
Guide for use	At least one and up to three instances of this field may be recorded.

2.20.9 Repair required

Definition	Perineal or genital tract trauma suturing or repair		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity procedures reference set** (72561000210102)		

Agreed term	SCTID
Repair not required	418014008
Repair declined (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

2.20.10 Placenta and membranes

Definition	Indicates whether the placenta was complete		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Complete	249170006
Incomplete	268479002
Ragged membranes	249182002

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

2.20.11 Placenta appearance

Definition	Description of the appearance of the placenta		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

Agreed term	SCTID
Normal	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

2.20.12 Number of cord vessels

Definition	Number of vessels identified in the umbilical cord		
Source standards			
Data type	Numeric	Representational class	Value
Field size	1	Representational layout	N
Value domain	**Agreed term** / **Code** One vessel / 1 Two vessels / 2 Three vessels / 3 Other / 8 Unknown / 9		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid value only		

2.20.13 Placenta kept by the woman/person

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

2.20.14 Total blood loss

Definition	Estimated and/or measured total blood loss within 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		

2.21 Newborn baby

This section collates information about the baby or babies resulting from the birth. This includes information about each baby and its care immediately after birth. There is one set of coded entries per baby born.

2.21.1 Birth – date and time

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

2.21.2 Gestation at birth

Definition	Gestational age of the baby at birth		
Source standards			
Data type	Numeric	Representational class	Value
Field size	4	Representational layout	NN:N
Value domain	Weeks and days		
Obligation	Mandatory		
Guide for use	This is a system calculation that is conditional on the request of the LMC The result of the calculation may be stored within the maternity database as requested by the LMC The value for this field is created by: subtracting the: Agreed EDD (a value recorded in section 2.4.9 Agreed estimated due date from the: recorded date for the date and time of birth (a value recorded in section 2.21.1 Birth – date and time)		
Verification rules	Valid value only		

2.21.3 Birth outcome

Definition	Outcome of the birth		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity outcomes reference set** (72571000210108)		

Agreed term	**SCTID**
Live born	281050002
Stillborn – antepartum	44174001
Stillborn – indeterminate	17766007
Stillborn – intrapartum	1762004

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.4 Mode of birth

Definition	How the baby was born		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity mode of delivery reference set** (72581000210105)		

Agreed term	**SCTID**
Caesarean section	200144004
Forceps	200130005
Spontaneous vaginal birth (cephalic)	309469004
Spontaneous vaginal birth (breech)	271373005
Vacuum extraction	267278005

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.5 Presenting part of baby

Definition	Presenting part of the baby at birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

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

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.6 Presenting part of baby – other detail

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

2.21.7 Type of breech

Definition	Type of breech presentation		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		

	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	

2.21.8 Mode of breech birth

Definition	Mode of the breech birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107) **Agreed term** / **SCTID** Assisted vaginal breech / 71711000210102 Caesarean section / 712654009 Spontaneous vaginal breech / 271373005		
Obligation	Mandatory on a response of 'Breech' for Presenting part of baby		
Guide for use			
Verification rules	Valid code only		

2.21.9 Shoulder dystocia

Definition	Indicates whether there was a shoulder dystocia during the birth		
Source standards			
Data type	Numeric	Representational class	N/A
Field size	1	Representational layout	N
Value domain	**Agreed term** / **Code** Yes / 1 No / 2 Unknown / 3		

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.10 Shoulder dystocia procedures

Definition	Procedures required to deliver the baby during the shoulder dystocia		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity procedures reference set** (72561000210102)		

Agreed term	SCTID
Delivery of posterior arm	237012001
Internal manoeuvres (Rubin's II/Wood's screw/Reverse Wood's screw)	237011008
Maternal position change	229824005
McRoberts' position	237009004
Suprapubic pressure (Rubin's I)	237010009
Other manoeuvre	237008007

Obligation	Mandatory on a response of '1 – Yes' for Shoulder dystocia
Guide for use	Six instances of this field may be recorded
Verification rules	Valid code only

2.21.11 Shoulder dystocia procedures – other manoeuvre detail

Definition	Description of the type of 'Other manoeuvre'		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory upon a response of 'Other manoeuvre' for Shoulder dystocia procedures		
Guide for use			

2.21.12 Cord blood sample

Definition	A record of cord blood tests taken		
Source standards			
Data type	SNOMED CT identifier	**Representational class**	Code
Field size	18	**Representational layout**	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity screening and tests reference set** (72641000210104)		

Agreed term	**SCTID**
Laboratory test not necessary	165330008
Arterial pH	27051004
Arterial base excess	263441000210107
Arterial lactate	394960005
Blood group and rhesus factor	165745004
Coombs (antibodies)	165771000
Cord blood taken – put on hold	6708002
Electrophoresis	814007
Serum bilirubin	166610007
Venous pH	9456006
Venous base excess	263451000210105
Venous lactate	263431000210104
Other	15220000
Unknown	69466000

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.13 Baby sex

Definition	Baby sex		
Source standards			
Data type	Alphabetic	**Representational class**	Code
Field size	1	**Representational layout**	A
Value domain			

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

2.21.14 Birth weight

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

2.21.15 Baby National Health Index number

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

2.21.16 Apgar 1 minute

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** (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

2.21.17 Apgar 5 minutes

Definition	Apgar score received at 5 minutes of age		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity Apgar score reference set** (72621000210105)		

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

2.21.18 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** (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

2.21.19 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** (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	

2.21.20 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** (72561000210102)		

Agreed term	SCTID
Intramuscular	736388004
Oral	698350008
Declined	15651391000119108

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.21.21 Vitamin K administered – date and time

This element defines the date and time Vitamin K was administered. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response of 'Intramuscular' or 'Oral' for **Vitaman K**.

2.21.22 Skin to skin start – date and time

This element defines the start date and time of skin to skin contact. The format is set out in the common **Date and time value domain** specification. The data element is mandatory upon skin to skin contact occurring within the early postnatal period.

2.21.23 Skin to skin end – date and time

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

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

2.21.24 Skin to skin – reason for end

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

2.21.25 Skin to skin – reason for end – other detail

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

2.21.26 Infant feeding method

Definition	Method by which the baby was first fed after the birth		
Source standards			
Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN

Value domain	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Exclusively breastfed at the mother's breast ('exclusively breastfed')</td><td>1</td></tr><tr><td>Expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>3</td></tr><tr><td>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')</td><td>4</td></tr><tr><td>Breastfeeding at someone else's breast ('exclusively breastfed')</td><td>5</td></tr><tr><td>Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>8</td></tr><tr><td>Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube ('artificially fed')</td><td>14</td></tr><tr><td>Parenteral nutrition</td><td>16</td></tr></table>
Obligation	Mandatory
Guide for use	Up to two instances of this field may be recorded
Verification rules	Valid code only

2.21.27 Breastfeeding start – date and time

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

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

2.21.28 Breastfeeding end – date and time

This element defines the date and time the initial breastfeed ended after the birth. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a valid response to **Breastfeeding start - date and time**. The element must be a date and time greater than the value specified in **Breastfeeding start - date and time.**

2.21.29 Newborn referral – date

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

2.21.30 Newborn referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-obstetric-and-related-medical-services-referral-guidelines/See Table 2: Conditions and referral categories		
Data type	Numeric	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services*		
Obligation	Mandatory if a referral was made to a specialist service during the immediate post-birth period		
Guide for use			
Verification rules	Valid code only		

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

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

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

This element defines the date and time the baby was admitted to a NICU or SCBU after the birth. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on any response other than 'No, not needed' to **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU).**

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

This element records the facility of NICU or SCBU admission in the immediate postnatal period. The information to be recorded is the 'Provider facility identification number' as specified in section **2.2 Health care provider information**. The data element is mandatory upon a response to **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) – date and time.**

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

This element defines the date and time the baby was discharged from a NICU or SCBU. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response other than 'No, not needed' to **Admission to Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU).**

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

2.22 Postnatal baby

This section collates the postnatal information about the baby or babies resulting from the birth. The information is collected throughout the six weeks following the birth and should be summarised at the end of the postnatal period. There is one set of coded entries per baby born. Postnatal details pertaining to the woman/person are collated in section **2.23 Postnatal woman/person**.

2.22.1 Maternity facility discharge – date and time

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

2.22.2 Infant feeding on discharge from facility

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	<table><tr><th>Agreed term</th><th>Code</th></tr><tr><td>Exclusively breastfed at the mother's breast ('exclusively breastfed')</td><td>1</td></tr><tr><td>Expressed breast milk from the mother's breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>3</td></tr><tr><td>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')</td><td>4</td></tr><tr><td>Breastfeeding at someone else's breast ('exclusively breastfed')</td><td>5</td></tr><tr><td>Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')</td><td>8</td></tr><tr><td>Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed')</td><td>9</td></tr><tr><td>Mixed feeding, where the infant has taken a mixture of breast milk and infant formula ('partially breastfed')</td><td>12</td></tr><tr><td>Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube ('artificially fed')</td><td>14</td></tr><tr><td>Infant formula, fed via bottle ('artificially fed')</td><td>15</td></tr></table>
Obligation	Mandatory
Guide for use	Two instances of this field may be recorded
Verification rules	Valid code only

2.22.3 Baby safe sleep information

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

2.22.4 Baby sleep environment

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

2.22.5 Red eye reflex screening – right eye

Definition	Result of red eye reflex screening test – right eye		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity findings reference set** (72591000210107)		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

Agreed term	**SCTID**
Normal	43408002
Abnormal	247079003
Screening declined	31021000119100
Not completed	394908001

2.22.6 Red eye reflex screening (right eye) – date

This element defines the date the red eye reflex screening (right eye) was undertaken. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on any response other than 'Not completed' to **Red eyed reflex screening – right eye**.

2.22.7 Red eye reflex screening – left eye

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

2.22.8 Red eye reflex screening (left eye) – date

This element defines the date the red eye reflex screening (left eye) was undertaken. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on any response other than 'Not completed' to **Red eye reflex screening – left eye.**

2.22.9 Metabolic screening

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

2.22.10 Newborn hearing screening

Definition	Result of the newborn hearing screening test		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N
Value domain			

Agreed term	SCTID
Pass	91651000210102
Pass, surveillance required	91661000210104
Referral needed	91671000210105
Screening declined	11911000175100
Did not attend/lost contact	410543007
Unsuitable for screening – medical	702371008
Missed (older than three months) (SNOMED CT Term: 'Procedure not done')	101521000210100

Obligation	Mandatory
Guide for use	
Verification rules	Valid code only

2.22.11 Infant feeding

Definition	Indicates whether the baby has ever fed at the mother's breast (breastfeeding initiation)		
Source standards			
Data type	Boolean	Representational class	N/A
Field size	1	Representational layout	N(1,0)
Value domain	1 – Yes 0 – No		
Obligation	Mandatory		
Guide for use			
Verification rules	Valid code only		

2.22.12 Infant feeding at 48 hours

<table>
<tr><td>Definition</td><td colspan="3">Method by which the baby was being fed at 48 hours of age</td></tr>
<tr><td>Source standards</td><td colspan="3"></td></tr>
<tr><td>Data type</td><td>Numeric</td><td>Representational class</td><td>Code</td></tr>
<tr><td>Field size</td><td>2</td><td>Representational layout</td><td>NN</td></tr>
<tr><td>Value domain</td><td colspan="3">
<table>
<tr><th>Agreed term</th><th>Code</th></tr>
<tr><td>Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)</td><td>1</td></tr>
<tr><td>Expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)</td><td>3</td></tr>
<tr><td>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’)</td><td>4</td></tr>
<tr><td>Breastfeeding at someone else’s breast (‘exclusively breastfed’)</td><td>5</td></tr>
<tr><td>Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘exclusively breastfed’)</td><td>8</td></tr>
<tr><td>Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours (‘fully breastfed’)</td><td>9</td></tr>
<tr><td>Mixed feeding, where the infant has taken a mixture of breast milk and infant formula fed via syringe, cup, spoon, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube (‘partially breastfed’)</td><td>13</td></tr>
<tr><td>Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’)</td><td>14</td></tr>
<tr><td>Infant formula, fed via bottle (‘artificially fed’)</td><td>15</td></tr>
<tr><td>Parenteral nutrition</td><td>16</td></tr>
</table>
</td></tr>
<tr><td>Obligation</td><td colspan="3">Mandatory</td></tr>
<tr><td>Guide for use</td><td colspan="3">Two instances of this field may be recorded</td></tr>
<tr><td>Verification rules</td><td colspan="3">Valid code only</td></tr>
</table>

2.22.13 Infant feeding at two weeks

Definition	Method by which the baby was being fed at two weeks of age		
Source standards			
Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN

Value domain

Agreed term	Code
Exclusively breastfed at the mother's breast ('exclusively breastfed')	1
Expressed breast milk from the mother's breast, fed via bottle or nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')	2
Breastfeeding at someone else's breast ('exclusively breastfed')	5
Donor breast milk, fed via bottle or nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('exclusively breastfed')	6
Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours ('fully breastfed')	9
Mixed feeding, where the infant has taken a mixture of breast milk and infant formula, fed via bottle, nasogastric (NG) feeding tube or supplemental nursing system (SNS) tube ('partially breastfed')	11
Infant formula, fed via bottle ('artificially fed')	15

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

2.22.14 Infant feeding at discharge from LMC

Definition	Method by which the baby was being fed at the time of discharge from LMC		
Source standards			
Data type	Numeric	Representational class	Code
Field size	2	Representational layout	NN

Value domain

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	

2.22.15 Neonatal referral – date

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

2.22.16 Neonatal referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-obstetric-and-related-medical-services-referral-guidelines/See Table 2: Conditions and referral categories		
Data type	Number	Representational class	Code
Field size	4	Representational layout	N(4)
Value domain	Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services*		
Obligation	Mandatory if a referral to neonatal or paediatric specialist services was made for the baby during the postnatal period		
Guide for use			
Verification rules	Valid code only		

2.22.17 Neonatal admission – date and time

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

2.22.18 Facility of neonatal admission

This element records the facility of neonatal or paediatric admission. The information to be recorded is the 'Provider facility identification number' as specified in section **2.2 Health care provider information**. The data element is mandatory if a value is recorded in **Neonatal admission – date and time.**

2.22.19 Postnatal visits

Definition	Number of postnatal visits provided by the LMC to the baby in the six weeks after the birth		
Source standards			
Data type	Numeric	Representational class	Value
Field size	2	Representational layout	NN
Value domain	00–99		
Obligation	Mandatory		
Guide for use	This value is distinct from that provided in 2.23.19 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		

2.22.20 Well Child provider referral

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

2.22.21 Well Child provider

Definition	Well Child provider referred to		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain	**Agreed term** / **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		

2.22.22 Well Child provider referral – date

This element defines the date a notification was sent to a Well Child provider. The format is set out in the common **Date and time value domain** specification. The data element is Mandatory on a response of 'Yes – 1' for **Well Child Provider referral**.

2.22.23 General practice referral

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

2.22.24 General practice referral – date

This element defines the date and time a notification was sent to general practice. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response of 'Yes – 1' to **General practice referral**.

2.22.25 Neonatal death

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

2.23 Postnatal woman/person

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

2.23.1 Maternity facility discharge – date and time

This element defines the date and time the woman/person was discharged from a maternity facility, if they were admitted to a facility during the labour and birth, or in the immediate postpartum period. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on admission to a maternity facility.

2.23.2 Postnatal referral – date

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

2.23.3 Postnatal referral code

Definition	Unique referral code		
Source standards	*Guidelines for Consultation with Obstetric and Related Medical Services*: https://www.tewhatuora.govt.nz/publications/guidelines-for-consultation-with-obstetric-and-related-medical-services-referral-guidelines/ See Table 2: Conditions and referral categories		
Data type	Number	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	Codes in Table 2 of *Guidelines for Consultation with Obstetric and Related Medical Services*		
Obligation	Mandatory if a referral was made to a specialist service during the postnatal period		
Guide for use			
Verification rules	Valid code only		

2.23.4 Postnatal complications

Definition	Complications during the six weeks after the birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity complications reference set** (72601000210102)		

Agreed term	SCTID
No complications (SNOMED CT Term: Postnatal examination normal)	169784003
Anaemia	271737000
Bladder dysfunction	236632007
Breast infection (Mastitis)	198108005
Breastfeeding issues	289084000
Hypertensive disorder	40521000119100
Other infection	40733004
Peripartum cardiomyopathy	62377009
Postnatal depression	58703003
Postnatal distress	300894000
Postpartum hysterectomy	860602007

	Postpartum psychosis: 18260003 Secondary postpartum haemorrhage: 23171006 Sepsis: 91302008 Thromboembolism: 371039008 Urinary retention: 267064002 Urinary tract infection: 68566005 Uterine infection (Endometritis): 301775005 Venous thromboembolism (VTE): 429098002 Wound dehiscence: 225553008 Wound infection: 76844004 Other: 198609003
Obligation	Mandatory
Guide for use	Nine instances of this field may be recorded
Verification rules	Valid code only

2.23.5 Postnatal complications – other detail

Definition	Detail of the 'Other' postnatal complications		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory upon a response of 'Other' for Postnatal complications		
Guide for use			

2.23.6 Postnatal admission – date and time

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

2.23.7 Facility of postnatal admission

This element provides the actual facility when there has been a postnatal admission. The information to be recorded is the 'Provider facility identification number' as specified in section **2.2 Health care provider information**. The data element is mandatory upon any response to **Postnatal admission – date and time**.

2.23.8 Postnatal discharge – date and time

This element defines the date and time the woman/person was discharged from a postnatal facility. The format is set out in the common **Date and time value domain** specification. The data element is mandatory on a response to **Postnatal admission – date and time** The date must be greater than or equal to that recorded in **Postnatal admission – date and time.**

2.23.9 Contraception

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** (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

2.23.10 Contraception – other detail

Definition	Detail of the ‘Other’ contraception method		
Source standards			
Data type	Alphanumeric	Representational class	Free text
Field size	1000	Representational layout	X(1000)
Value domain			
Obligation	Mandatory upon a response of ‘Other’ for Contraception.		
Guide for use			

2.23.11 Postnatal complementary therapies

Definition	Complementary therapies used in the six weeks after the birth		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand maternity complementary therapies reference set** (72631000210107)		

Agreed term	SCTID
Acupressure	231107005
Acupuncture	231081007
Aromatherapy	394615007
Chiropractic	182548004
Herbal medicine	414392008
Homeopathy	182968001
Lactation support	408883002
Massage	387854002
Naturopathy	439809005
Reflexology	394614006
Rongoā Māori	789789009
Osteopathy	182549007
Other	225423004

Obligation	Optional
Guide for use	10 instances of this field may be recorded
Verification rules	Valid code only

2.23.12 Family violence screening

Definition	A record of whether the woman/person was screened postnatally for family violence		
Source standards			
Data type	Numeric	Representational class	Code
Field size	1	Representational layout	N
Value domain			

Agreed term	Code
No, not screened	1
Yes, screened	2

	Declined to answer: 3 Unable to ask: 4
Obligation	Mandatory
Guide for use	
Verification rules	Multiple responses can be recorded

2.23.13 Current alcohol consumption

Definition	Current alcohol consumption		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand alcohol consumption reference set** (72671000210109)		

Agreed term	SCTID
Does not drink alcohol	105542008
Current drinker	219006
Declined to answer	426544006

Obligation	Mandatory
Guide for use	The information collected for this section is distinct from that collected for section 2.16.19 Current alcohol consumption, as this section records status at the end of the postnatal period
Verification rules	Valid code only

2.23.14 Current drug use

Definition	Current use of illegal drugs		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)
Value domain	The following SNOMED CT terms are from the **New Zealand non-medicinal drug use reference set** (72681000210106)		

Agreed term	SCTID
Does not misuse drugs	228367002
Current drug user	417284009
Declined to answer	426544006

Obligation	Mandatory
Guide for use	The information collected for this section is distinct from that collected for section 2.12.6 History of drug use, as this section records status at the end of the postnatal period
Verification rules	Valid code only

2.23.15 Current drugs used

Definition	Currently used illegal drugs		
Source standards			
Data type	SNOMED CT identifier	Representational class	Code
Field size	18	Representational layout	N(18)

Value domain

The following SNOMED CT terms are from the **New Zealand non-medicinal drug reference set** (72691000210108)

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

2.23.16 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.		

2.23.17 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		

2.23.18 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)

<table>
<tr><td>Value domain</td><td>The following SNOMED CT terms are from the <u>New Zealand vaping status reference set</u> (72721000210100)<table><tr><th>Agreed term</th><th>SCTID</th></tr><tr><td>Currently vaping with nicotine</td><td>785889008</td></tr><tr><td>Currently vaping without nicotine</td><td>786063001</td></tr><tr><td>Ex-vaper for more than 1 year</td><td>1137692008</td></tr><tr><td>Ex-vaper for less than 1 year</td><td>1137688001</td></tr><tr><td>Trying to give up vaping</td><td>1137691001</td></tr><tr><td>Never vaped</td><td>1137690000</td></tr><tr><td>Declined to answer</td><td>426544006</td></tr></table></td></tr>
<tr><td>Obligation</td><td>Mandatory</td></tr>
<tr><td>Guide for use</td><td>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</td></tr>
<tr><td>Verification rules</td><td>Valid code only</td></tr>
</table>

2.23.19 Postnatal visits

Definition	Number of postnatal visits provided by the LMC in the six weeks after the birth		
Source standards			
Data type	Numeric	Representational class	Value
Field size	2	Representational layout	NN
Value domain	00–99		
Obligation	Mandatory		
Guide for use	This value is distinct from that provided in section 2.22.19 Postnatal visits, as this field records visits provided to a woman/person who either has their baby with them, or whose baby is in the care of another person		
Verification rules	Valid value only		

2.23.20 General practice notification

Definition	Notification of the birth event sent to general practice		
Source standards			
Data type	Boolean	Representational class	N/A
Field size	1	Representational layout	N(1,0)
Value domain	1 – Yes 0 – No		
Obligation	Mandatory		

Guide for use	
Verification rules	Valid code only

2.23.21 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		

3 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