Government of **Western Australia**
Department of **Health**

Guidelines for Midwives Notification of Case Attended

How to complete and submit Form 2

Required by Health (Notifications by Midwives) Regulations 1994

health.wa.gov.au

Document control

Document Version Number	1.3
Document Version Released	July 2023
What's new in this version?	Addition of three data items relating to syphilis screening during pregnancy. Changed references from woman to person. Changed requirements are highlighted in yellow.
Document Author	Maternal and Child Health, Data Management Information and Performance Governance Unit Information & System Performance Directorate Purchasing & System Performance Division Department of Health, Western Australia
Reply Paid Postal Address	Principal Data Management Officer MCH, Data Management Reply Paid 70042 Delivery to Locked Bag 52 Perth BC WA 6849
Contact	Telephone: (08) 6373 1882 Fax: (08) 9222 4408 Email: BirthData@health.wa.gov.au
Web	http://ww2.health.wa.gov.au/Articles/J_M/Midwives-Notification-System

Contents

Introduction

This document guides midwives to complete reporting of information listed on Form 2, Notification of Case Attended (NOCA). Form 2 is also referred to as the Birth Notification, NOCA, or MR15. These guidelines provide context and definitions for all data included on Form 2. They aim to enable completion and submission of notifications easily, accurately, and on time.

Form 2 contains all information to be notified by a registered midwife to the Chief Health Officer when an infant was liveborn or stillborn in WA of at least 20 weeks gestation, or if gestation is unknown, with birthweight of at least 400 grams.

Submitting this birth information is a requirement of the *Health (Miscellaneous Provisions) Act 1911* and the Health (Notifications by Midwives) Regulations 1994. Amendments to Form 2 are published in the Government Gazette. The most recent amendment being scheduled to be published in the Western Australian (WA) Government Gazette before July 2023.

Midwives may submit Form 2 information in digital form with the use of a clinical software application like Stork, PROD used at St John of God owned or managed services, Meditech used at Ramsay owned or managed services, or e-Form provided by the Department of Health (DoH). To notify of births that occurred at home with Private Practice Midwife (PPM) or at other places clinicians use the e-Form or paper version of Form 2.

The Midwives Notification System

The Midwives' Notification System (MNS) was introduced in WA in 1974. Information from Form 2 notifications for all births occurring since 1980 are included in the data collection.

MNS data are used to compile annual reports about births in WA. These data also assist in planning for maternity services, neonatal care units, and community health services. The data have a major contribution to population research in WA that is recognised nationally and internationally.

More than 99 per cent of notifications of birth are submitted via clinical software applications or the e-Form. The paper version of Form 2 is available if these other processes are not able to be used.

To contribute meaningfully in these ways the information held in MNS must be complete and of a high quality. MNS data has a good reputation for being complete, valid, and timely. The process for managing the data from these notifications has multiple levels of validation. All information on these processes is publicly available at Midwives Notification System (health.wa.gov.au).

Quality of MNS data

The quality of these data is determined and improved using a multi-step process.

1. Completeness and validity of data confirmed before submission by data providers (health services, midwives).
2. Data files received are confirmed to be complete and in the correct format specified as file format "N3" to be used for submitting data for births occurring from 1st July 2023.
3. At time of loading data files:
   - records that pass validation rules are accepted,
   - records with erroneous data are held with label "Error", and
   - records with suspect data are held with label "Warning" and require checking before correcting or confirming the unusual data.
4. "Error" and "Warning" records are returned to data providers for correction.
5. Data in MNS are checked against data in the Hospital Morbidity Data System (HMDS) to find all women with a hospital stay with birth procedure who did not have a birth notification in MNS. The MNS notification is then requested from the maternity service.
6. MNS data is checked for unusual changes in frequency of events or unusual combinations of data items. These are discussed with midwives when necessary.
7. Occasionally, a record audit or other quality assessment will be conducted. Recommendations from these are aimed at improving the data quality and may result in changes to specifications, instructions, and validation processes.

Validation steps 3 and 4 are comprehensively described in the following documents available at Midwives Notification System (health.wa.gov.au):

- MNS – Validation Process Manual Private Health.pdf
- MNS – Validation Process Manual WA Health.pdf

Notification of Case Attended

Responsibility for notification

It is the responsibility of the registered midwife in attendance at the time of the birth to notify the Chief Health Officer via information described on Form 2. If no midwife was in attendance then the medical officer in attendance is responsible. If there is no midwife or medical officer in attendance, the first midwife or medical officer to attend the person is responsible for notifying the Chief Health Officer of the birth.

Completing the paper form

If a clinical software system is not available or suitable for use, a 2-page paper version of Form 2 must be completed and submitted using the following process:

- Each of the pages must have enough identifying information to ensure separated pages can be put back together with correct mother and baby matches.
- Complete the birth information as soon after birth as practicable.
- Submit the completed paper Form 2 within 48 hours of birth.
- Discharge information for the infant is a description of discharge from the site where it was born. This includes the date of discharge from a hospital or the date of birth for a homebirth.
- Provide any updates to a previously submitted Form 2 within seven days of discharge.
- A multiple (twin, triplet) birth requires completion of page 1 once for mother and page 2 once for each infant born.
- File a copy of the completed Form 2 in the mother's medical record held by the health service.
- To complete Form 2:
    - Ensure legibility by:
        - Using ballpoint pen
        - Print all text in BLOCK LETTERS
        - Limit abbreviations to those in common use
    - Ensure completeness by:
        - Providing responses to ALL questions
        - For Unknown items record 'Unknown' in a text field or insert a number '9' in each block of a numeric field
        - If used, addressograph labels must be placed on every page of the NOCA Form
        - Providing the person's telephone number to enable continuity of care by Child Health Services. Or state that no contact number is available.
        - For all dates, eight boxes are provided, two for the day, two for the month, and four for the year. If only month and year are known, day boxes can be blank.
        - e.g. mother's date of birth – 6 June 1975.

0	6	0	6	1	9	7	5

        - Where there are more boxes provided than necessary, 'right adjust' your response e.g. birthweight of infant – 975 grams.

	9	7	5

- Some items enable no response or more than one response e.g. 'Medical Conditions' section. Tick the boxes for all appropriate responses. Where no item is appropriate do not tick any box.

☐ 1 essential hypertension	☐ 5 type 1 diabetes
☑ 3 asthma	☐ 6 type 2 diabetes
☐ 4 genital herpes	☑ 8 other (specify): RETINOPATHY

- Ensure timely submission by submitting Form 2:
  - within 48 hours of birth (even without discharge information available).
  - Again within 7 days of the infant being discharged from the service.

Notification via clinical software application

Process must include:

1. Digital capture of all data items specified on Form 2.
2. Submission within 48 hours of the birth of batched data records to a shared secure network folder or by encrypted email as Birth Notifications. The current specification for batches of Birth Notifications data records is "BN7".
3. Submission within one month of the birth month of batched data records to a shared secure network folder or by encrypted email as NOCA Extract. The current specification for the NOCA Extract is "N3". This is a complete record that includes discharge information for each infant born. It has been found to be efficient if a one month birth cohort is included in each batch file and this batch file is provided within one month.
4. Ensure completeness by:
   - including all data in the format specified
   - providing the person's telephone number to enable continuity of care by Child Health Services. Or state that no contact number is available
   - providing multiple responses when enabled and if applicable
5. Ensure timely submission of Birth Notifications and NOCA Extracts by using the shared secure folder provided in the specifications.
6. When not able to use shared secure folder then submit via encrypted email:
   - Birth Notifications "BN7" to RoyalStCHN@health.wa.gov.au and
   - NOCA Extract "N3" to Birthdata@health.wa.gov.au.

Description of Data

The following tables provide context and descriptions of data listed in Form 2 and the associated specifications for digital data submission.

Maternal Demographics

Must be completed once for person who gave birth

	Data Item	Commenced	Description
1.	Last Name	1975	The legal family name of the person who gave birth.
2.	First Name	1975	The legal first name of the person who gave birth. Anglicised versions of first names should not be provided.
3.	Second Name		The legal second name of the person who gave birth. An initial can be provided if the full name is not known.
4.	Maiden Name	1979	This should be the family name of the person who gave birth at the time of her own birth. If the person has never married, Last Name and Maiden Name should be the same name. Do not report an ALIAS or other name in this data field.
5.	Address of usual residence	1975	The street number and street name of the usual residential address of the person, including property name if appropriate. Do provide the person's permanent address in the NOCA Extract. This data enables birth rates and conditions in the area in which the person usually lives to be determined. Do not provide a post office box number or road mail box number. Do provide any temporary address in the Birth Notification. For example, a person and baby residing in Perth until both are well enough to return to rural home. Child health services require the temporary address information to enable appropriate and immediate community care.
6.	Town or Suburb	1975	The Town or Suburb of the person's address of usual residence.
7.	State	1998	The State or Territory of the person's Address of usual residence e.g. WA.
8.	Postcode	1975	The postcode for the Suburb of the person's Address of usual residence. For international address report 8888.
9.	Unit record number	1975	The hospital record number allocated to the person who gave birth. If number has less digits than the boxes provided 'right adjust' the response e.g. Unit Record No. 17234 would be displayed as: 0 0 0 1 7 2 3 4
10.	Birth date (Mother)	1975	The date of birth of the person who gave birth. Provide the date as an 8 digit response, i.e. ddmmyyyy.
11.	Height	1975	The height in whole centimetres of the person who gave birth. If height is reported with a decimal place, report as a number rounded to nearest whole number.
12.	Weight	1975-1977 Jan 2012	The weight in kilograms at time of booking for birth of the person who gave birth. If the person has no weight recorded before 20 weeks gestation, report the self-reported weight at conception.
13.	Telephone number	1990	The home or contact telephone number of the person who gave birth. A contact telephone number is valuable to child health nurses. For a person intending to reside temporarily at other than their usual address, please record best contact number.
14.	Email Address	Jul 2019	The person's email address as provided by them. E.g. Jane.Smith@mail.com.au.

	Data Item	Commenced	Description
15.	Language requiring Interpreter	Jul 2016	The language that the person speaks for which an Interpreter can be used by the health care provider. For paper forms, write the name of the language. For data file submission report the Australian Bureau of Statistics (ABS) Australian Standard Classification of Language 4-digit code provided in Table 3.1 of the document found at http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1267.02011?OpenDocument. Do not report "English" (ABS Code 1201). A response must be reported if Interpreter Required = Yes.
16.	Establishment	1975	Assigned WA establishment number of the health service where the person gave birth. For a planned homebirth occurring at home record 0906 or Homebirth. For births designated "born before arrival" report the Establishment number and state "Yes" for Born Before Arrival.
17.	Ward	1998	Location of birth within Establishment. e.g. Delivery Suite, Family Birth Centre, CMP Birth Centre, CMP homebirth, PPM homebirth, Freebirth, In ambulance.
18.	Marital Status, Values available:	1975 Update 1998	Self reported marital state at the time the person who gave birth. Not necessarily the legal marital status.
1	Never married		Person was never married and has no defacto partner. Family Name should be the same as Maiden Name.
2	Widowed		Person was married and husband died. Has no current marital or defacto partner. Family Name may not be same as Maiden Name.
3	Divorced		Person was married and is now legally divorced. Has no current marital or defacto partner. Family Name may not be same as Maiden Name.
4	Separated		Person was married and is now legally separated from marital partner husband. Has no current defacto partner. Family Name may not be same as Maiden Name.
5	Married (inc. defacto)		Person is legally married to current marital partner or has a defacto partner. Family Name may not be same as Maiden Name.
6	Unknown or not stated		Person's marital status is unable to be determined or is not stated. Family Name may not be same as Maiden Name.
19.	Ethnic status, Values available:	1975 (Race) Update 1998, Jan 2013	Self reported ethnic origin of the person who gave birth. A person who identifies as more than one of the listed descriptions can be reported as Other, however, where Aboriginal or Torres Strait Island is included report as item 10, 11 or 12.
1	Caucasian		Person who self reports ethnic origin as Caucasian, which usually includes people of Western European origin i.e. anglosaxon, celtic, germanic, nordic etc.
2	Aboriginal/TSI	1998 Deactivated Dec 2012	Person who self reports ethnic origin as Aboriginal and/or Torres Strait Islander which usually includes descendants of people originating from Australia or the Torres Strait Islands. Within WA, the term "Aboriginal" is preferred to "indigenous". Superseded by values 10, 11 and 12 from Jan 2013.
3	Asian		Person who self reports ethnic origin as Asian, which usually includes people of Asia, Japan and SE Asian origin i.e. Chinese, Japanese, Vietnamese, Cambodian etc.
4	Indian (sub-continent)		Person who self reports ethnic origin as Indian, which usually includes descendants of people originating in the area of the Indian subcontinent, Pakistan etc.
5	African		Person who self reports ethnic origin as African, which usually includes descendants of black people from Africa i.e. Nigerian, Somalian etc.

	Data Item	Commenced	Description
6	Polynesian		Person who self reports ethnic origin as Polynesian, which usually includes descendants of people from the Pacific Island areas excluding New Zealand i.e. Samoa, Tonga, Cook Islands, Hawaii etc.
7	Maori		Person who self reports ethnic origin as Maori, which usually includes people of New Zealand origin
8	Other		Person who self reports any ethnic origin not elsewhere specified in this list or who is unable to specify any ethnic origin. May include, women reporting more than one ethnic origin other than Aboriginal or Torres Strait Islander. May include women from Mediterranean or middle eastern areas.
10	Aboriginal, not Torres Strait Islander	Jan 2013	Person who self reports ethnic origin as Aboriginal and not Torres Strait Islander
11	Torres Strait Islander, not Aboriginal	Jan 2013	Person who self reports ethnic origin as Torres Strait Islander and not Aboriginal
12	Aboriginal and Torres Strait Islander	Jan 2013	Person who self reports ethnic origin as both Aboriginal and Torres Strait Islander

Pregnancy Details

Must be completed once for person who gave birth

	Data Item	Commenced	Description
20.	Previous Pregnancies (excluding this pregnancy)	1975	The total number of known previous pregnancies of any gestation regardless of outcome e.g. livebirth, stillbirth, termination, or spontaneous abortion. Excludes the present pregnancy.
21.	Parity (excluding this pregnancy)	Jul 2014	The total number of known previous pregnancies that resulted in the birth of one or more infants of at least 20 weeks gestation regardless of outcome e.g. livebirth or stillbirth. Count total pregnancies not total infants born. Excludes the present pregnancy.
Previous Pregnancy Outcomes			
22.	Liveborn, now living	1975	The total number of all children born alive to this person that are still alive. Include any child born that was relinquished for adoption. Only include infants born at 20 weeks or more gestation, or if gestation unknown of 400 grams birthweight.
23.	Liveborn, now dead	1975	The total number of all children born alive to this person that are no longer alive. Only include infants born at 20 weeks or more gestation, or if gestation unknown of 400 grams birthweight.
24.	Stillborn	1975	The total number of all infants born to this person that were stillborn. Only include infants born at 20 weeks or more gestation, or if gestation unknown of 400 grams birthweight.
25.	Number of previous caesareans	Jan 2012	The total number of caesareans sections prior to this pregnancy.
26.	Caesarean last delivery	1998	Flag for whether the last pregnancy had a birth mode of Caesarean Section. If so, respond Yes, otherwise respond No. If Yes, must have more than 0 for Number of Previous Caesareans and Number of Previous Pregnancies.
27.	Previous multiple births	1998	Flag for whether there were any previous pregnancies that resulted in two or more infants born at least 20 weeks gestation, or if gestation unknown, at least 400 grams birthweight.
This Pregnancy			
28.	Estimated gestation at first antenatal visit	Jan 2010	Number of completed gestational weeks of this pregnancy at the time of the first presentation for antenatal care. The first presentation is considered the first contact with a health care provider where medical or midwifery antenatal care was provided. Does not include contacts where only confirmation of pregnancy occurred or care not related to the pregnancy was provided. It is not usual for antenatal care to be provided before 4 weeks gestation. Report 98 if the person had no antenatal care prior to this birth event. Report 99 if the gestation at time of first antenatal care provision is unable to be estimated.

	Data Item	Commenced	Description
29.	Total Number of Antenatal Visits	1 July 2012	The total number of antenatal care visits attended by the person who gave birth. Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record. An antenatal care visit does not include a visit where the sole purpose of contact is to confirm the pregnancy, or those contacts that occurred during the pregnancy that were for non-pregnancy related issues. An antenatal care visit does not include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of bloods or tissue for pathology testing. Unless the health professional performing the procedure or test is a doctor or midwife and the appointment directly relates to this pregnancy and the health and wellbeing of the fetus.
30.	Date of last menstrual period (LMP)	1975	Date of first day of the menstrual period occurring immediately prior to this pregnancy. If the person cannot provide a certain date or did not experience a menstrual period prior to this pregnancy consider the Date of LMP to be unknown and do not provide a value for Date of LMP.
31.	LMP Date Certain	1979	Indication of whether the LMP date reported was a certain date. Report 2(No) if LMP date was unknown or not experienced**.**
32.	Expected Date of Delivery (EDD)	1979	Estimated date for when this pregnancy will have a gestation of 40 weeks exactly. The EDD is usually determined as 286 days after first day of LMP. If the EDD is not able to be determined from the LMP then it must be determined from an ultrasound, clinical assessment of the pregnant uterus, or the infant following birth. Do not leave blank.
33.	Expected Delivery Date based on:	1998 Update 2013	The method used to determine the Date on which this pregnancy would be 40 weeks gestation.
1	Clinical signs/dates		EDD calculated by certain LMP, measurement of uterine height during pregnancy, or assessment of newborn infant.
2	Ultrasound dating at less than 20 weeks gestation		EDD calculated by fetal features observed via ultrasound including Crown to Rump length where ultrasound was conducted at a confirmed gestation of less than 20 weeks.
3	Ultrasound dating at 20 weeks gestation or more		EDD calculated by fetal features observed via ultrasound including Crown to Rump length where ultrasound was conducted at a confirmed gestation of 20 weeks or more.
34.	Influenza vaccination during pregnancy:	Jul 2016	The self-reported trimester of this pregnancy in which the person received vaccination against influenza. A response must be reported.
01	Vaccinated during 1st trimester		Influenza vaccination was received by person in first trimester (between 1 and 14 weeks gestation) of this pregnancy.
02	Vaccinated during 2nd trimester		Influenza vaccination was received by person in second trimester (between 15 and 28 weeks gestation) of this pregnancy.
03	Vaccinated during 3rd trimester		Influenza vaccination was received by person in third trimester (after 28 weeks gestation) of this pregnancy.
04	Vaccinated in unknown trimester		Person did receive influenza vaccination during pregnancy but is unable to state gestation at time of vaccination.
05	Not vaccinated		Person did not receive influenza vaccination during this pregnancy.
99	Unknown if vaccinated		Not able to be determined if person received influenza vaccination during this pregnancy.

	Data Item	Commenced	Description
35.	Pertussis vaccination during pregnancy:	Jul 2016	The self-reported trimester of this pregnancy in which the person received vaccination against pertussis (whooping cough). A response must be reported.
01	Vaccinated during 1st trimester		Pertussis vaccination was received by person in first trimester (between 1 and 14 weeks gestation) of this pregnancy.
02	Vaccinated during 2nd trimester		Pertussis vaccination was received by person in second trimester (between 15 and 28 weeks gestation) of this pregnancy.
03	Vaccinated during 3rd trimester		Pertussis vaccination was received by person in third trimester (after 28 weeks gestation) of this pregnancy.
04	Vaccinated in unknown trimester		Person did receive pertussis vaccination during pregnancy but is unable to state gestation at time of vaccination.
05	Not vaccinated		Person did not receive pertussis vaccination during this pregnancy.
99	Unknown if vaccinated		Not able to be determined if person received pertussis vaccination during this pregnancy.
36.	Number of tobacco cigarettes usually smoked each day during first 20 weeks of pregnancy "Usually" is defined as "according to established or frequent usage, commonly, ordinarily, as a rule".	Jan 2010	The self-reported average number of tobacco cigarettes usually smoked each day by the pregnant person during first 20 weeks of pregnancy. This information should be determined after the first 20 weeks of pregnancy is completed. The first antenatal visit at more than 20 weeks gestation would be an ideal time. If a person has quit smoking at some point in the period being reported, report the number usually smoked daily prior to quitting. Report 000 if the person did not smoke during the period reported Report 998 if the person smoked less than one cigarette per day in the period reported. Report 999 if the person's tobacco smoking is unable to be determined.
37.	Number of tobacco cigarettes usually smoked each day after the first 20 weeks of pregnancy "Usually" is defined as "according to established or frequent usage, commonly, ordinarily, as a rule".	Jan 2010	The self-reported average number of tobacco cigarettes usually smoked each day by the pregnant person after the first 20 weeks of pregnancy until birth. This information should be determined after the person has given birth. If a person has quit smoking at some point in the period being reported, report the number usually smoked daily prior to quitting. Report 000 if the person did not smoke during the period reported Report 998 if the person smoked less than one cigarette per day in the period reported. Report 999 if the person's tobacco smoking is unable to be determined.
38.	Frequency of drinking an alcoholic drink on a typical day in the first 20 weeks of pregnancy.	Jul 2019 Updated Jul 2019	The self-reported frequency of drinking alcoholic drinks by the pregnant person. If a person has ceased drinking alcohol at some point in the period being reported, report the frequency prior to ceasing.
01	Never		The person did not drink alcohol.
02	Monthly		The person drank alcohol monthly at the most frequent
03	2 to 4 times a month		The person drank alcohol 2 to 4 times per month (fortnightly or weekly) at the most frequent
04	2 to 3 times a week		The person drank alcohol 2 to 3 times per week at the most frequent

	Data Item	Commenced	Description
05	4 or more times a week		The person drank alcohol 4 or more times per week at the most frequent
99	Unknown		The frequency the person drank alcohol is not known.
39.	Frequency of drinking an alcoholic drink on a typical day after 20 weeks of pregnancy.	Jul 2017 Updated Jul 2019	The self-reported frequency of drinking alcoholic drinks by the pregnant person. If a person has ceased drinking alcohol at some point in the period being reported, report the frequency prior to ceasing.
01	Never		The person did not drink alcohol.
02	Monthly		The person drank alcohol monthly at the most frequent
03	2 to 4 times a month		The person drank alcohol 2 to 4 times per month (fortnightly or weekly) at the most frequent
04	2 to 3 times a week		The person drank alcohol 2 to 3 times per week at the most frequent
05	4 or more times a week		The person drank alcohol 4 or more times per week at the most frequent
99	Unknown		The frequency the person drank alcohol is not known.
40.	Number of standard alcoholic drinks on a typical day in the first 20 weeks of pregnancy	Jul 2017 Updated Jul 2019	The self-reported number of standard alcoholic drinks drunk on a typical day. Report 00 if the frequency of drinking is reported as 01 Never. A value must be reported.
41.	Number of standard alcohol drinks on a typical day after 20 weeks of pregnancy	Jul 2017 Updated Jul 2019	The self-reported number of standard alcoholic drinks drunk on a typical day. Report 00 if the frequency of drinking is reported as 01 Never. A value must be reported.
42.	Was screening for depression/anxiety conducted?	Jul 2017	Indication of whether the pregnant person was screened for depression or anxiety where screening used a recognised tool or method.
1	Yes		The person was screened for depression/anxiety with a recognised tool or method during this pregnancy
2	Not offered		The person was not offered screening for depression/anxiety with a recognised tool or method during this pregnancy
3	Declined		The person was offered screening for depression/anxiety with a recognised tool or method during this pregnancy but she declined to complete screening.
9	Unknown		It is unable to be determined if the person was screened for depression/anxiety with a recognised tool or method during this pregnancy.
43.	Was additional follow-up indicated for perinatal mental health risk factors?	Jul 2017	Indication of whether the pregnant person required follow-up beyond usual antenatal care regardless of whether she accepted it.
1	Yes		The person required additional follow-up for perinatal mental health risk factors during this pregnancy. Regardless of whether screening was conducted.
2	No		As a result of screening or history the person did not require additional follow-up for perinatal mental health risk factors during this pregnancy.
7	Not applicable		The person was not screened and there was no known history where additional follow-up was considered necessary during this pregnancy.
9	Unknown		It was unable to be determined if the person required additional follow-up during this pregnancy.

	Data Item	Commenced	Description
44.	Complications of pregnancy Values available;	1975 Update 1979, 1993, 2014	A condition that arose during this pregnancy, the condition is associated with this pregnancy and has complicated this pregnancy.
1	Threatened abortion (<20 weeks)		Vaginal bleeding occurred during this pregnancy and the uterus was determined to be the source of bleeding before the 20th gestational week.
2	Threatened preterm labour (< 37 weeks)		Period of regular and painful uterine contractions not resulting in birth between 20+0 and 36+6 weeks.
3	Urinary Tract Infection		Diagnosed infection of urinary tract occurring during pregnancy with diagnosis confirmed by culture of bacteria in urine with or without treatment.
4	Pre-Eclampsia		Diagnosis of condition arising after 20 weeks gestation as defined using the Australasian Hypertension in Pregnancy Consensus Statement. *The following text added to guidelines for data from Jul 2014:* Preeclampsia is a multi-system disorder unique to human pregnancy characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis. A diagnosis of preeclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following: renal involvement, haematological involvement, liver involvement, neurological involvement, pulmonary oedema, fetal growth restriction, placental abruption. Women with HELLP syndrome (Haemolysis, Elevated Liver Enzymes, Low Platelet count) are to be reported as having Pre-Eclampsia.
5	Antepartum haemorrhage (APH) – placenta praevia		Bleeding from the placenta which is positioned over, or very near, the internal cervical os.
6	Antepartum haemorrhage (APH) – placental abruption		Bleeding from placenta, when the placenta has been totally, or partially, abruptly separated from the uterine wall before birth of the infant.
7	Antepartum haemorrhage (APH) – Other		Bleeding from the uterus where cause is other than placenta praevia or placental abruption. For example trauma, unknown cause.
8	Pre-labour rupture of membranes		Rupture of membranes at any gestation and at any time before the onset of labour.
9	Gestational Diabetes		Condition arising during this pregnancy diagnosed as defined using the Australasian Diabetes in Pregnancy Consensus Statement. Pre-existing diabetes such as Type 1 or Type 2 is to be reported as a Current Medical Condition. Do not report both gestational diabetes when either Type 1 or Type 2 diabetes is reported. Gestational Diabetes diagnosed in a prior pregnancy is not to be notified for this pregnancy.

	Data Item	Commenced	Description
10	Other (Specify)	**Deactivated Jun 2014**	Report any other conditions arising in pregnancy that affect the outcome of the pregnancy. Such conditions could include Eclampsia, Pre-Eclampsia Superimposed on Essential or Chronic Hypertension, intrauterine growth restriction, intrauterine death, oligohydramnios, polyhydramnios, anaemia, hyperemesis gravidarum. Report condition as text or ICD-10 code. If no Other condition to report leave blank. Do not report NIL, N/A etc. Pre-Eclampsia Superimposed on Essential Hypertension and Eclampsia was reported as OTHER pregnancy complication until Jun 2014. Essential Hypertension and Secondary Hypertension to be notified in the Current Medical Conditions area.
11	Gestational Hypertension	Jul 2014	Condition arising as new onset of hypertension after 20 weeks gestation without any maternal or fetal features of Pre-Eclampsia. The definition includes a return to normal blood pressure that must occur within 3 months post-partum. This feature would be unknown at time of notification.
12	Pre-eclampsia superimposed on essential hypertension	Jul 2014	Hypertension was diagnosed prior to pregnancy and person was diagnosed with Pre-eclampsia (as defined above) during pregnancy.
99	Other (Specify)	Deactivated Jul 2017	Report any other conditions arising in pregnancy that affect the outcome of the pregnancy. Such conditions could include Eclampsia, intrauterine growth restriction, intrauterine death, oligohydramnios, polyhydramnios, anemia, hyperemesis gravidarum. Report condition as text or ICD-10 code. If no Other condition to report leave blank. Do not report NIL, N/A etc.
	Other pregnancy complications	Jul 2017	Using codes between 013 and 098, multiple other conditions can be reported by reference to this list.
45.	Medical Conditions, Values available:	1975 Update 1979, 2014	A condition that was diagnosed before the pregnancy that may affect care or outcome of this pregnancy. Includes maternal congenital abnormality or carrier trait like Thalassaemia.
1	Essential hypertension		Diagnosis of condition as defined using the Australasian Hypertension in Pregnancy Consensus Statement. Pre-Eclampsia and other conditions arising during pregnancy are to be notified as Complications of Pregnancy.
2	Pre-Existing diabetes mellitus	Deactivated Jun 2014	Diagnosis of condition arising prior to this pregnancy as defined using the Australasian Diabetes in Pregnancy Consensus Statement. Gestational Diabetes in this pregnancy is to be reported in the Pregnancy Complications area.
3	Asthma		A diagnosis of asthma that requires medication during pregnancy or admission to hospital for management during pregnancy.
4	Genital herpes		A diagnosis of genital herpes with or without lesions during pregnancy or at time of labour.
5	Type 1 Diabetes	Jul 2014	Diagnosis of Type 1 Diabetes prior to this pregnancy. Type 1 Diabetes is defined as beta-cell destruction usually leading to absolute insulin deficiency.
6	Type 2 Diabetes	Jul 2014	Diagnosis of Type 2 Diabetes prior to this pregnancy. Type 2 Diabetes is defined as a common major form of diabetes which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

	Data Item	Commenced	Description
8	Other (specify)	Deactivated July 2017	Report any other conditions. Such conditions could include Epilepsy, Malignant *Neoplasms,* Renal disease, Thyroid disease. Report condition as text or ICD-10 code. If no other condition to report leave blank. Do not report NIL, N/A etc.
	Pre-existing medical conditions	Jul 2017	Using codes between 010 and 099, multiple other conditions can be reported using this list.
46.	Procedures/treatments, Values available:	1993	Any procedures or treatments relevant to this pregnancy. Fertility treatments to be reported include all assisted reproductive technology.
1	Fertility treatments (include drugs)		Fertility procedures include any Assisted Reproductive Technology treatments such as In-Vitro-Fertilisation (IVF), Frozen Embryo Transfer (FET), Gamete Intrafallopian Transfer (GIFT), Artificial Insemination (AI), any use of donor, micro-manipulation, Intrauterine Insemination (IUI), tubal transfer, etc. Fertility drugs include Cetrotide, Clomid, Gonal-F, Pregnyl, Puregon, Synarel, etc.
2	Cervical suture		Includes cervical stitch or cervical cerclage or lower uterine cerclage inserted during pregnancy
3	CVS/Placental biopsy		Chorionic villus sampling (CVS) and placental biopsy conducted for this pregnancy.
4	Amniocentesis		Any diagnostic or therapeutic amniocentesis procedure conducted for this pregnancy at any gestation.
5	Ultrasound		Any ultrasound conducted for fetal examination during this pregnancy at any gestation.
6	CTG antepartum		Any formal cardiotocograph (CTG) performed in the antenatal period to assess fetal wellbeing or to record uterine activity determined not to be labour.
7	CTG intrapartum		Any formal cardiotocograph (CTG) performed during a labour event to assess fetal wellbeing and record uterine activity determined to be labour.
47.	Intended place of birth at onset of labour, Values available:	1998	The location type that the person was booked to, or expected to give birth at, at the time she commenced the labour that resulted in the birth. Does not include labour where no birth occurs i.e. threatened preterm labour. For women who do not labour before giving birth, then provide actual place of birth.
1	Hospital, excluding birth centre		Person intended to give birth at a licensed hospital. Includes any hospital, but as it is an “intended” place of birth it is expected to be a hospital with a maternity service. Report this value for person who gave birth without labour i.e. elective caesarean section.
2	Birth centre, attached to hospital		Person intended to give birth at a designated birth centre which was co-located and integrated to some degree with a maternity service within a licensed hospital. A designated birth centre usually includes a shared ethos for care provided from a building that is freestanding on a hospital campus or in a part of the hospital building. Midwives are part of the hospital staff and provide care in collaboration with hospital medical officers and/or General Practitioners.
3	Birth centre, free standing		Person intended to give birth at a designated birth centre which was NOT co-located and integrated to some degree with a maternity service within a licensed hospital. A designated birth centre usually includes a shared ethos for care provided from a building that is freestanding on a hospital campus or in a part of the hospital building. Midwives provide care in collaboration with General Practitioners or local health services.

	Data Item	Commenced	Description
4	Home		Person intended to give birth in a private home, usually her own. A registered midwife was planned to be in attendance. Do NOT report "Home" if person was planning to give birth at home without a registered midwife in attendance. Do NOT report "Home" if person unexpectedly gave birth at home or enroute to a maternity service.
8	Other		Person had no plan for an intended place of birth (e.g. concealed or undiagnosed pregnancy) or planned to give birth at home without a registered midwife (freebirth).
48.	Was screening for family violence conducted?	Jul 2021	Indication of whether the pregnant person was screened for family violence where screening used a validated screening tool such as the Humiliation, Afraid, Rape, Kick (HARK) tool. Report 9 if unknown if screening was conducted.
1	Yes		The person was screened for family violence with a validated screening tool during this pregnancy.
2	Not offered		The person was not offered screening for family violence with a validated screening tool during this pregnancy.
3	Declined		The person was offered screening for family violence with a validated screening tool during this pregnancy, but she declined to complete screening.
9	Not stated / inadequately described.		It is unable to be determined if the person was screened for family violence with a validated screening tool during this pregnancy.
49.	Primary maternity model of care	Jul 2021	The ID number of the primary maternity model of care that provided the longest duration of antenatal care for the person during this pregnancy. IDs are generated from the AIHW Maternity Models of Care Classification System (MaCCS). The ID numbers below are to be notified when no model of care can be associated with a pregnancy.
	Interstate		Report value 988888 if the longest duration of antenatal care received by the person was provided in another Australian state or territory.
	Overseas		Report value 988899 if the longest duration of antenatal care received by the person was provided outside of Australia.
	Not applicable		Report value 999997 if the person did not receive any antenatal care during this pregnancy.
	Not stated / inadequately described		Report value 999999 if the person received pregnancy care during this pregnancy but it was unable to be determined which maternity model of care provided the longest duration of antenatal care.
50.	Maternity model of care at the onset of labour or non-labour caesarean	Jul 2021	The ID number of the maternity model of care that provided care for the person at the time labour commenced or caesarean section was performed without labour occurring. IDs are generated from the AIHW Maternity Models of Care Classification System (MaCCS).
	Not applicable		Report value 999997 if the person belonged to no maternity model of care at the time labour commenced e.g. no antenatal care. Not to be used for a person who had no labour before birth by caesarean section.
	Not stated / inadequately described		Report value 999999 if the person belonged to a maternity model of care at the time labour commenced but the actual model of care was unable to be determined. Not to be used for a person who had no labour before birth by caesarean section.

	Data Item	Commenced	Description
51.	Syphilis screening at first antenatal contact (before 28 weeks gestation)?	Jul 2023	Indication of whether person was screened at the first pregnancy assessment performed by a health practitioner, and the screening occurred before 28 weeks gestation.
1	Yes		There is written evidence of a syphilis test being conducted or the person is certain she was screened. A result is not required to be known to respond Yes.
2	Not offered		There is no evidence of screening having been conducted and the person is certain she was not offered screening. Or the pregnancy ended before 28 weeks.
3	Declined		The person is certain she declined syphilis screening when it was offered or there is written evidence that screening was offered and declined by the person.
8	Unknown		There is no evidence of the test being conducted or a result received, and the person is not aware that she was screened for syphilis.
9	Not stated		Only for use by Department of health staff when paper notification form submitted. No response provided for this question.
52.	Syphilis screening conducted between 28 and 35 weeks?	Jul 2023	Indication of whether women was screened between 28 and 35 weeks gestation. It may be the first or a subsequent screening performed.
1	Yes		There is written evidence of a syphilis test being conducted or the person is certain she was screened. A result is not required to be known to respond Yes.
2	Not offered		There is no evidence of screening having been conducted and the person is certain she was not offered screening. Or the pregnancy ended before testing could be performed between 28 and 35 weeks.
3	Declined		The person is certain she declined syphilis screening when it was offered or there is written evidence that screening was offered and declined by the person.
8	Unknown		There is no evidence of the test being conducted or a result received, and the person is not aware that she was screened for syphilis.
9	Not stated		Only for use by Department of health staff when paper notification form submitted. No response provided for this question.
53.	Syphilis screening conducted between 36 weeks and birth?	Jul 2023	Indication of whether women was screened from 36 weeks gestation and before birth.
1	Yes		There is written evidence of a syphilis test being conducted or the person is certain she was screened. A result is not required to be known to respond Yes.
2	Not offered		There is no evidence of screening having been conducted and the person is certain she was not offered screening. Or the pregnancy ended before testing could be performed from 36 weeks to before the birth occurred.
3	Declined		The person is certain she declined syphilis screening when it was offered or there is written evidence that screening was offered and declined by the person.
8	Unknown		There is no evidence of the test being conducted or a result received, and the person is not aware that she was screened for syphilis.
9	Not stated		Only for use by Department of health staff when paper notification form submitted. No response provided for this question.

Labour Details

Must be completed once for the person who gave birth

	Data Item	Commenced	Description
54.	Onset of Labour Values available:	1979 Update 1988	Labour is defined as regular, painful contractions of the uterus resulting in dilation of the cervix. One of three values must be reported.
1	Spontaneous		Person had a period of labour resulting in the birth of an infant of 20 weeks gestation or more. Labour commenced naturally without any medical or surgical induction procedures. Rupture of membranes may have occurred before onset of labour. Artificial rupture of membranes before labour should be recorded as “Induced Labour”. Artificial rupture of membranes performed to increase strength, duration and/or frequency of contractions during a labour that began spontaneously should be recorded as an Augmentation of Labour. Augmentation procedures may be reported as NONE or one or more values Duration of 1st stage of labour must be 1 minute or more.
2	Induced		Person had a medical or surgical procedure aimed at inducing labour. Rupture of membranes may have occurred spontaneously before onset of labour. Labour may not commence. One or more induction methods must be reported. A failed induction occurs when an induction procedure, either medical and/or surgical, fails to establish labour. If labour did not commence before decision for caesarean section, then duration of 1st and 2nd stages of labour must be 00:00. A complication of “failed induction” must be reported. A successful induction occurs when one or more induction procedures were followed by a period of labour.
3	No labour		Person did not commence labouring and had no attempted induction of labour. Augmentation methods are reported as 01-None Induction procedures are reported as 01-None Duration of 1st and 2nd stages of labour are reported as 00:00. Method of birth is reported as elective or emergency caesarean section.
55.	Principal reason for Induction Values available:	Jul 2016	Report the one most important indication for inducing labour for this person. Definitions for this data have been provided by AIHW at: http://meteor.aihw.gov.au/content/index.phtml/itemId/569595. A value must be reported if Onset of labour = Induction
1	Prolonged pregnancy		Reason for induction is that pregnancy is prolonged and gestation is 41 completed weeks or more. Gestational age must be reported as 41+0 or greater.
2	Prelabour rupture of membranes		Labour was induced because the amniotic membranes ruptured and labour did not commence spontaneously. Gestation may be preterm, or rupture of membranes may be prolonged.
3	Diabetes		Labour was induced because of maternal diabetes where Gestational Diabetes is reported as a pregnancy complication or Diabetes Type 1 or Type 2 is reported as a pre-existing medical condition.

	Data Item	Commenced	Description
4	Hypertensive disorders		Labour was induced because of maternal diabetes where Gestational Hypertension or Pre-Eclampsia is reported as a pregnancy complication or Essential Hypertension, Secondary Hypertension, or Pre-Eclampsia superimposed on Essential Hypertension is reported as a pre-existing medical condition.
5	Multiple pregnancy		Labour was induced because there is more than one fetus in pregnancy.
6	Chorioamnionitis (includes suspected)		Labour was induced because an infection of the amniotic membranes was suspected or diagnosed.
7	Cholestasis of pregnancy		Labour was induced because maternal cholestasis of pregnancy was diagnosed and reported as a pregnancy complication.
8	Antepartum Haemorrhage		Labour was induced because antepartum haemorrhage occurred and was reported as a pregnancy complication.
9	Maternal age		Labour was induced because of maternal age. May be young or old.
10	Body Mass Index (BMI)		Labour was induced because of a low or high maternal Body Mass Index (BMI). Maternal height and weight must be reported.
11	Maternal mental health indication		Labour was induced because of a diagnosed mental health disorder or condition reported as a pregnancy complication or pre-existing medical condition.
12	Previous adverse perinatal outcome		Labour was induced because the person had experienced a late unexplained stillbirth or other adverse perinatal outcome in a previous pregnancy.
19	Other maternal obstetric or medical indication		Labour was induced because the person was diagnosed with another condition like renal disease, abnormal liver function tests, cardiac disease, deep vein thrombosis (DVT), antiphospholipid syndrome, chronic back pain, dental infections, gestational thrombocytopenia, Lupus, hip dysplasia, history of pulmonary embolism etc. The condition must also be reported as a pregnancy complication or pre-existing medical condition.
20	Fetal compromise (includes suspected)		Labour was induced because the pregnancy was diagnosed with complications like oligohydramnios, reduced fetal movement, abnormal antenatal cardiotocography (CTG), abnormal Doppler, other abnormalities of fetal wellbeing.
21	Fetal growth restriction (includes suspected)		Labour was induced because fetal growth restriction (also known as intra uterine growth restriction (IUGR)) was suspected or diagnosed in pregnancy.
22	Fetal macrosomia (includes suspected)		Labour was induced because fetal macrosomia was suspected or diagnosed in pregnancy.
23	Fetal death		Labour was induced because fetal death was diagnosed. Birth status must be reported as “stillborn – antepartum”.
24	Fetal congenital anomaly		Labour was induced because a congenital anomaly was diagnosed in the fetus. Birth defect must include a description of each congenital anomaly suspected or diagnosed.

	Data Item	Commenced	Description
80	Administrative or geographical indication		Labour was induced because of an administrative or geographical indication. An administrative indication may be health provider's availability, availability of operating theatre, anaesthetist, or other staffing reasons. A geographical indication may be person normally resident in a rural or remote area, or in an area without adequate birthing facilities and travel to, and accommodation near, birth site must be scheduled.
81	Maternal choice in the absence of any obstetric, medical, fetal, administrative or geographical indication		Labour was induced because of person's wishes and no other reason specified in this list applied for this person or her pregnancy.
82	Late term pregnancy	July 2021	Reason for induction is that pregnancy is considered "prolonged" but gestation had not reached 41 completed weeks. Gestational age must be reported as 40+0 to 40+6.
89	Other indication not elsewhere classified		Reason for induction is any other fetal indications such as fetal anaemia, isoimmunisation, or other indications not specified. Do not report this value if induction was performed at person's request. For this reason report value "81".
56.	Augmentation (labour has begun), Values available:	1990	Medical or surgical procedure performed to increase strength, duration and/or frequency of contractions during a labour that began spontaneously. One or more methods must be reported. Report 01-None, if labour not augmented.
1	None		No method of augmentation of labour was administered. Must be reported if onset of labour was Induced or No Labour
2	Oxytocin		Medication administration involving intravenous oxytocic to increase strength or frequency of contractions
3	Prostaglandins		Medication administration involving vaginal or rectal prostaglandins to increase strength or frequency of contractions
4	Artificial rupture of membranes		Surgical rupture of membranes performed to increase strength or frequency of contractions, or to improve application of the presenting part to the cervix. Do not report as augmentation if performed solely to monitor liquor or fetal wellbeing.
8	Other		Any other intervention performed to increase strength, duration, or frequency of contractions.
57.	Induction of Labour (before labour began), Values available:	1998 Update 2014	Medical or surgical procedure performed to commence contractions and dilatation of cervix. Labour may not result after induction procedures performed. One or more methods must be reported. Report 01-None, if labour induction methods not performed.
1	None		No method of induction was administered. Must be reported if onset of labour was Spontaneous or No Labour.
2	Oxytocin		Medication administration involving intravenous oxytocic to begin uterine contractions and progress in dilatation of cervix.
3	Prostaglandins		Medication administration involving vaginal or rectal prostaglandins to begin uterine contractions and progress in dilatation of cervix.
4	Artificial rupture of membranes		Surgical rupture of membranes performed to begin uterine contractions, dilate cervix, and improve application of the presenting part to the cervix.

	Data Item	Commenced	Description
5	Dilatation device i.e. Foley Catheter	Jul 2014	Mechanical cervical dilatation such as a cervical ripening balloon catheter or Atard.
6	Antiprogestogen i.e. mifepristone	Jul 2019	Medication administration to cause dilatation of the cervix and increase the sensitivity of the myometrium to the action of prostaglandins.
8	Other		Any other intervention performed to begin uterine contractions, dilate cervix, and improve application of the presenting part to the cervix
58.	Analgesia (during labour)	1990 Update 2013	Pharmacological or other administration provided to relieve the pain of labour without inducing loss of consciousness One or more responses must be recorded
1	None		No analgesia was administered during labour or no labour occurred. Must be reported if onset of labour was No Labour or duration of 1st and 2nd stage of labour = 00:00. Usually reported for births before arrival (BBA) at birth site but record all analgesia administered by ambulance officer or other health professional prior to arrival.
2	Nitrous Oxide		A gas mixture of Nitrogen and Oxygen was administered during labour with the intention of reducing the sensation of pain in labour.
3	Intra-Muscular Narcotics	Deactivated Dec 2012	A narcotic like morphine or pethidine was administered intramuscularly during labour with the intention of reducing the sensation of pain in labour. Excludes narcotics administered intravenously, orally, epidurally or spinally.
4	Epidural/caudal		A medication was administered via needle to the caudal portion of the spine with the intention of creating a sensory block in the pelvic region during labour. And/or an epidural needle/catheter was inserted into the epidural space and medications administered during labour with the intention of creating a pain block approximately below the site of the epidural insertion point. If a spinal and an epidural are used in combination please report Option 7 below and not this option.
5	Spinal		A needle/catheter was introduced into the spinal cord and medications administered into the spinal fluid during labour with the intention of creating a sensory block below the site of the spinal insertion point. If a spinal and an epidural are used in combination please report Option 7 below and not this option.
6	Systemic Opioids	Jan 2013	A narcotic like morphine or pethidine was administered intramuscularly, intravenously, epidurally or spinally with the intention of reducing the sensation of pain in labour. Excludes narcotics administered orally.
7	Combined spinal/epidural	2007	A needle/catheter was introduced into the spinal cord and medications administered into the spinal fluid during labour. The catheter was withdrawn to the epidural space to enable further administration of anaesthesia/analgesia. The spinal component gives a rapid onset of a predictable block. The indwelling epidural catheter provides long lasting analgesia and ability to titrate future doses.
8	Other		Any other medication or treatment was administered with the intention of reducing the sensation of pain in labour e.g. TENS, acupuncture, hypnotherapy.

	Data Item	Commenced	Description
59.	Duration of labour	1975	The time period between onset of labour (as defined above) and birth of final infant of pregnancy. Excludes time taken for delivery of placenta and membranes. A response must be recorded.
1	1st Stage (hour & min)	1998	The time period in hours and minutes between onset of labour (as defined above) and full dilatation of the cervix. Full dilatation may be determined by digital or visual examination like fetal head on view. Time of birth of first infant should be used instead of full dilatation if person did not reach full dilatation of cervix prior to caesarean section. Onset of labour can be determined by report of person/support person, it does not need to be determined by a health professional to be used for reporting onset of first stage of labour. Must be reported as 00:00 if onset of labour is No Labour or Induction of Labour followed by caesarean section without a period of established labour. Must be reported as 50:00 if unable to even estimate a period of first stage of labour. Example of data entry: 5 hours and 25 minutes 0 5 2 5
2	2nd Stage (hour & min)	1998	The time period in hours and minutes between full dilatation of the cervix and delivery of the final infant of pregnancy. Must be reported as 00:00 if onset of labour is No Labour or Induction of Labour followed by caesarean section without a period of established labour. Must be reported as 00:00 if person did not reach full dilatation of cervix prior to caesarean section. Must be reported as 49:59 if unable to even estimate a period of second stage of labour. Example of data entry: 1 hour and 5 minutes 0 1 0 5
60.	Postnatal blood loss in mLs	Jul 2014	The total volume of blood loss both measured and estimated in the period from birth to 24 hours postpartum. Reported in millilitres (mLs) and can be rounded to nearest 50mLs. It is understood that lochia in an amount considered to be "normal" following completion of third stage will not be included in this total.
61.	Number of babies born (admin purposes only)	Jul 2014	Total number of infants born this pregnancy when pregnancy gestation was 20 weeks or more. Reported on first page of the Form2 and ensures that the correct number of second pages of Form2 are collated with the mother's details. For example, a twin birth will have a Form2 of 3 pages.
62.	Midwife Name	1975 Update 1980	First Name and Last Name of the Midwife responsible for reporting the events of the birth, usually the midwife completing the report. Name must be PRINTED.
63.	Midwife Signature		Required when completing a paper form, electronic data submission can provide a unique identifier for the midwife in this data field
64.	Date of providing information	1975 Update 1980	Date that form was completed by the Midwife named as responsible for reporting information.
65.	Midwife Registration Number	1975	Number assigned by the Australian Health Practitioner Regulation Authority (AHPRA) when adding the Midwife named to the Register of midwives licensed to practice in Australia. NMW1234567890 Formerly, the Nurses and Midwives Board of Western Australia registration number. If a medical officer is completing this form an AHPRA number must also be provided i.e. MED1234567890.

Delivery details

Must be completed once for each infant born of the pregnancy.

	Data Item	Commenced	Description
66.	Anaesthesia (during delivery)	1984 Update 1998	Pharmacological administration provided to the person who gave birth to relieve the sensation and pain of birth procedures, like manoeuvres, instruments or caesarean section used at the birth of this infant. Excludes anaesthesia for perineal repair procedures. A response must be recorded. Multiple responses are permitted.
1	None		No anaesthesia was administered to the person who gave birth during the birth of this infant. May be reported when Analgesia methods reported. Anaesthesia should be reported if anaesthetic effects occurred from analgesia provided in labour e.g. epidural/spinal/caudal “top ups”.
2	Local anaesthesia to perineum		An anaesthetic agent is administered locally to perineum of the person who gave birth usually to reduce the pain/sensation of performing an episiotomy. Do not use to report local anaesthesia administered after the birth for perineal repair.
3	Pudendal		An anaesthetic agent is administered locally to the person who gave birth via the vaginal wall to pudendum usually to reduce the pain/sensation of the vaginal birth of this infant. Rarely used.
4	Epidural/caudal	2007	A medication was administered to the person who gave birth via needle to the caudal portion of the spine with the intention of creating a sensory block in the pelvic region during birth. And/or an epidural needle/catheter was inserted into the epidural space and medications were administered for the birth procedure or were in effect during the birth to create a pain and/or sensation block approximately below the site of the epidural insertion point. If a spinal and an epidural are used in combination report as item 7-Combined Spinal/Epidural.
5	Spinal		For the person who gave birth, a needle/catheter was introduced into the spinal cord and medications administered into the spinal fluid immediately before the birth procedure or were in effect during the birth of this infant to create a sensory block below the site of the spinal insertion point. If a spinal and an epidural are used in combination report as item 7-Combined Spinal/Epidural.
6	General		A procedure and medication administration to the person who gave birth immediately before the birth of this infant and intended to induce unconsciousness and lack of pain sensation.
7	Combined Spinal/Epidural		A needle/catheter was introduced into the spinal cord and medications administered into the spinal fluid of the person who gave birth immediately before the birth procedure or were in effect during the birth of this infant. The catheter is withdrawn to the epidural space to enable further administration of anaesthesia/analgesia. The spinal component gives a rapid onset and predictable block. The indwelling epidural catheter provides long lasting analgesia and ability to titrate future doses.
8	Other		Any other medication or treatment was administered to the person who gave birth with the intention of reducing the sensation of pain at the time of the birth of this infant e.g. TENS, acupuncture, hypnotherapy, sterile water injection.

	Data Item	Commenced	Description
67.	Complications of labour and delivery (includes the **reason** for instrumental delivery):	1979 Update 1993, 1998, 2014	A condition that was diagnosed during labour or immediately before caesarean section that complicated labour or delivery and may have affected care or outcome of this delivery. More than one option may be reported. **Must include the primary reason for successful and/or unsuccessful vacuum extraction or forceps.**
1	Precipitate delivery		Rapid delivery that occurred usually with a combined period for 1st and 2nd stage of less than 3 hours or a 2nd stage of less than 10 minutes. Usual preparations could not be made for the birth, and the infant and/or mother may have been deleteriously affected by the delivery. Cannot be the reason for an operative delivery.
2	Fetal distress		Fetal distress or fetal compromise suspected or diagnosed after induction or during labour. Diagnosis is based on fresh meconium in liquor during the first stage of labour and/or abnormalities of the fetal heart rate as determined through auscultation, CTG, or ultrasound. May be the reason for operative delivery.
3	Prolapsed cord		Diagnosis of prolapsed cord through observation of umbilical cord in front of the fetus and beyond the internal os of the cervix. May be suspected with sudden rupture of membranes with excessive amniotic fluid or sudden change in fetal heart rate. Cord presentation or vasa praevia are not prolapsed cord. Prolapsed cord is usually a reason for operative delivery.
4	Cord tight around the neck		Clamping and cutting of the umbilical cord prior to delivering the shoulders/trunk of the infant. May be required if there is a sudden change in fetal heart rate during descent. Not a reason for operative delivery.
5	Cephalopelvic disproportion		Diagnosis of fetal head being larger than the maternal pelvic passage. Indicated when failure of fetal presenting part to enter the pelvic brim, delayed or obstructed labour, failure of fetal head to descend in pelvis or to rotate while descending through pelvis. Often a reason for operative delivery.
6	PPH (>=500mLs)	1995 Deactivated Jun 2014	Reporting of this condition is determined by blood loss of 500 mLs or more in third stage and following delivery as determined by observation and measurement. Not a reason for operative delivery.
7	Retained placenta – manual removal	1998	Manual removal of placenta was performed in the delivery room or in the operating theatre. Not a reason for operative delivery.
8	Persistent occipito posterior	1998	Posterior fetal presentation with the back of the fetus's head against the maternal spine. Causes delay in progress of labour or descent of the fetus. The fetus may not be delivered in the occipito posterior position. May be a reason for operative delivery.
9	Shoulder dystocia	1998	Delay and difficulty in delivery of the fetal anterior shoulder. Required manipulation and accepted procedures to manage shoulder dystocia. Suspected when failure of fetal head to restitute after delivery, burrowing of the fetal chin or difficulty in delivering the anterior shoulder. Not usually a reason for operative delivery.
10	Failure to progress <= 3cm	1998	Cervical dilatation was 3cm or less at time of decision for caesarean delivery. Despite appropriate labour and sufficient time for cervix to be further dilated. Is a reason for operative delivery (caesarean section). Not to be reported if reason for caesarean section was fetal distress or other condition unrelated to labour failing to progress.

	Data Item	Commenced	Description
11	Failure to progress > 3cm	1998	Cervical dilatation was between 4 and 9 cm at time of decision for caesarean section. Despite appropriate labour and sufficient time for cervix to be further dilated. Is a reason for operative delivery (caesarean section). Not to be reported if reason for caesarean section was fetal distress or other condition unrelated to labour failing to progress.
12	Previous caesarean section	1998	Person had previous birth by caesarean section. History of caesarean section is also captured in the Pregnancy section of the form.
13	Other (Specify)	Deactivated July 2017	Examples include prolonged labour (labour >24 hours), prolonged rupture of membranes (>24 hours), maternal distress, Eclampsia, cord presentation, vasa praevia, placenta praevia etc. Provide ICD-10 code for condition or write condition on paper form. *When "Other (specify)" has been selected, describe the condition in either 'free text' or ICD code' (if known) otherwise leave 'blank' and don't select "Other (specify)" at all.*
	Labour and birth complications	Jul 2017	Using codes between 020-100, multiple other conditions can be reported by reference to this list.
68.	Principal reason for Caesarean Section Values available:	Jul 2014	Only report the one most important and driving reason that stipulates the timing and urgency of the caesarean section that was conducted for this person.
1	Fetal compromise		Diagnosis of suspected or actual fetal compromise and intra uterine growth restriction requiring delivery by CS. Unlikely to be reported for an Elective (Category 4) CS. Also report as Complication of Labour and Delivery.
2	Suspected fetal microsomal		Diagnosis of suspected fetal microsomal as clinically defined. May be reported for CS of any urgency.
3	Malpresentation		Diagnosis of any presentation other than vertex that would require birth by CS e.g. breech, compound, transverse etc. May be reported for CS of any urgency. Fetal presentation cannot be vertex for all infants born from pregnancy.
4	Lack of progress <= 3cm		Includes in coordinate uterine action, delayed or prolonged labour. Cannot be reported for an Elective (Category 4) CS. Cannot be reported where Onset of Labour = No Labour. If Induction resulted in no coordinated labour, then report value 13 below as reason for CS. Also report as Complication of Labour and Delivery.
5	Lack of progress in the 1st stage, 4cm to < 10 cm		Includes delayed or prolonged labour. Cannot be reported for an Elective (Category 4) CS. Cannot be reported where Onset of Labour = No Labour. If Induction resulted in no coordinated labour, then report value 13 below as reason for CS. Also report as Complication of Labour and Delivery.
6	Lack of progress in the 2nd stage		Cannot be reported for an Elective (or Category 4) CS. Cannot be reported where Onset of Labour = No Labour. Also report as Complication of Labour and Delivery.
7	Placenta praevia		Ultrasound or clinical evidence that the edge of the placenta covers the internal cervical os, or encroaches into the lower segment less than 2 cm away from the internal cervical os. May be reported for CS of any urgency. Also report as a Complication of Pregnancy.
8	Placental abruption		Ultrasound or clinical evidence antenatally of abruption of the placenta prior to onset or during labour. Probably not reported for an Elective (Category 4) CS. Also report as a Complication of Pregnancy.

	Data Item	Commenced	Description
9	Vasa praevia		Ultrasound or visual evidence of exposed fetal blood vessels running across the fetal membrane below or at the level of the fetal presenting part in the lower segment of the uterus. May be reported for CS of any urgency. Also report as a Complication of Labour and Delivery - Other (O69.4).
10	Antepartum/intrapartum haemorrhage		Antenatal or intrapartum vaginal bleeding that leads to the immediate delivery of the baby by caesarean section. Not reported for an Elective (Category 4) CS. Do not report this value if a more specific cause of the antepartum/intrapartum haemorrhage is known. For example, where there is a vasa praevia and haemorrhage, report value 09 “Vasa praevia”.
11	Multiple pregnancy		Includes twin and higher order multiple pregnancies.
12	Unsuccessful attempt at assisted delivery		Includes where the decision for CS occurred following attempt at vaginal delivery with vacuum and/or forceps without success. Not reported for an Elective (Category 4) CS.
13	Unsuccessful induction		Includes where the decision for CS occurred following an attempt to induce labour using medical, surgical or mechanical means failed to achieve regular uterine contractions with cervical dilatation. Not reported for an Elective (Category 4) CS.
14	Cord prolapse		Diagnosis of the prolapse of the umbilical cord into or beyond the cervix that requires immediate delivery of the baby by caesarean section. Not reported for an Elective (Category 4) CS. Also report as a Complication of Labour and Delivery.
15	Previous caesarean section		Person has history of CS for previous births. Only reported as principal reason for CS when no VBAC is attempted. Only reported for an Elective (Category 4) CS unless onset of labour or rupture of membranes changes time of CS from the time scheduled. Also report as a Complication of Labour and Delivery.
16	Previous shoulder dystocia		Person had a previous birth complicated by shoulder dystocia and where CS birth was planned to avoid the same adverse outcome. Only reported for an Elective (Category 4) CS unless onset of labour or rupture of membranes changes time of CS from the time scheduled.
17	Previous perineal trauma/4th degree tear		Person had a previous birth complicated by severe perineal trauma and where CS birth was planned to avoid the same adverse outcome. Only reported for an Elective (Category 4) CS unless onset of labour or rupture of membranes changes time of CS from the time scheduled.
18	Previous adverse fetal/neonatal outcome		Person had a previous birth complicated by an adverse outcome for baby and where CS birth was planned to avoid the same adverse outcome affecting the infant of this pregnancy. Only reported for an Elective (Category 4) CS unless onset of labour or rupture of membranes changes time of CS from the time scheduled.
19	Other obstetric, medical, surgical, psychological indications		Person had an obstetric, medical, surgical, psychological condition not described in values above that required a CS birth. May be reported for CS of any urgency.

	Data Item	Commenced	Description
20	Maternal choice in the absence of obstetric, medical, surgical, or psychological indication		A CS was performed when the person had no condition described in values above and no other obstetric, medical, surgical, psychological condition that required a CS birth. May be reported for CS of any urgency.
69.	Perineal status	1993 Update 1998, 2013	The status of the perineum following the birth of all infants. From Jan 2013, may report more than one option.
1	Intact		There is no episiotomy and the perineum and vagina has no trauma that could be considered a 1st degree tear or worse.
2	1st degree tear/vaginal tear		There is no episiotomy and the trauma that occurred during delivery was determined as a perineal laceration, rupture or tear (involving) fourchette, labia, skin, vagina or vulva.
3	2nd degree tear		The trauma that occurred during delivery was determined as a perineal laceration, rupture or tear that involved pelvic floor, perineal muscles or vaginal muscles.
4	3rd degree tear		The trauma that occurred during delivery was determined as a perineal laceration, rupture or tear that involved the anal sphincter and/or rectovaginal septum.
5	Episiotomy		An episiotomy was performed during delivery that did or did not extend beyond the incision performed. An extension of the episiotomy should be reported by selecting both Episiotomy and one of the other options i.e. 2nd degree tear.
6	Episiotomy plus tear	1998 Deactivated Jan 2013	An episiotomy was performed during delivery that extended beyond the incision performed.
7	4th degree tear		The trauma that occurred during delivery was determined as a perineal laceration, rupture or tear that involved the anal mucosa and/or rectal mucosa.
8	Other		The perineal trauma that occurred during delivery was determined as none of the above but significant i.e. hematoma, clitoral tear, female mutilation management etc.

Baby Details

Must be completed for each infant born of the pregnancy

	Data Item	Commenced	Description
70.	Aboriginal status of infant	1975 to 1979 Jan 2012	Aboriginal status of the infant as reported by the parent or guardian. An infant cannot be identified as more than 1 of the listed descriptions. The term Aboriginal Status is used in preference to Indigenous Status as directed by the WA Policy.
1	Aboriginal but not TSI		Infant is of Aboriginal origin but not Torres Strait Islander.
2	TSI but not Aboriginal		Infant is of Torres Strait Islander origin but not Aboriginal. Rare in WA
3	Aboriginal and TSI		Infant is of Aboriginal AND Torres Strait Islander origin. Rare in WA
4	Other		Infant is not of Aboriginal OR Torres Strait Islander origin.
71.	Adoption	1975 Deactivated Jun 2014	A flag that infant will be placed for adoption. In later years this is determined by the possibility that infant will be placed for adoption or foster care. This flag informs that the infant will not live at the mother's address and that information linking the baby to the mother should be managed sensitively.
1	Yes		There is a possibility that infant will be placed in foster care or for formal adoption.
2	No		There is no possibility that infant will be placed in foster care or for formal adoption.
72.	Born before arrival	1998	A flag that infant was born unexpectedly at an unplanned and unprepared location with or without a health professional in attendance. This flag informs that the infant and mother were at risk of complications caused by lack of preparation, equipment or skilled care.
1	Yes		Infant was born unexpectedly at an unplanned and unprepared location with or without a health professional in attendance.
2	No		Infant was NOT born unexpectedly at an unplanned and unprepared location with or without a health professional in attendance.
73.	Birth date	1975	The date on which the infant was born in format ddmmyyyy If no witness was present to note the actual date, an estimated date is acceptable but must be reflected in all other documentation.
74.	Birth time (24hr clock)	1975	The time at which the infant was born in 24-hour format like 2359. If no witness was present to note the actual time, an estimated time is acceptable but must be reflected in all other documentation. For infants born at midnight please report 0000
75.	Plurality (number of babies this birth)	1975 Update 1979	The number of infants born from a pregnancy of 20 weeks gestation or more. A fetus that died before 20 weeks of pregnancy but was not delivered until at least 20 weeks gestation must be counted.
76.	Birth Order	1979	The number representing the order in which this infant was born. A singleton infant would be reported as 1 A twin pregnancy would be reported as Baby born first as 1, baby born 2nd as 2 etc.
77.	Presentation	1975	The presenting part of the fetus at the time of birth. Each infant can have only one recorded.
1	Vertex		Fetus delivered with occiput part of head presenting. One of many cephalic presentations.

	Data Item	Commenced	Description
2	Breech		The fetus is delivered with breech presenting with extended or flexed legs, or footling or knee presentation.
3	Face		The fetus is delivered with face presenting either mento anterior or posterior. One of a number of cephalic presentations.
4	Brow		The fetus is delivered with brow presenting, the largest circumference for a presenting part. One of a number of cephalic presentations.
8	Other		The fetus is delivered with any other presenting part mentioned above i.e. shoulder. Usually not one of the cephalic presentations.
78.	Method of birth	1979	The attempted or successful method of expulsion or extraction from its mother of a product of conception in a birth event. Each infant must have one Method of Birth recorded. Multiple options can be selected for each infant.
1	Spontaneous		The delivery of an infant achieved through maternal expulsive efforts. May occur following application of instruments that were not in use at the time of the birth. Includes births for infants of any presentation including breech where no traction or assistance is provided other than support.
2	Vacuum successful		Attachment of suction cap to the fetal scalp with traction applied to assist rotation and/or descent that achieved the purpose for application.
3	Vacuum unsuccessful		Attachment of suction cap to the fetal scalp with traction applied to assist rotation and/or descent that was not successfully applied or did not achieve the purpose for application. Must have Obstetrician or Medical Officer reported as an Accoucheur.
4	Forceps successful		Application of a pair of forceps to the fetal head with rotation or traction applied to assist rotation and/or descent that achieved the purpose for application. Application of a pair of forceps to the fetal head to assist delivery of the fetal head during a caesarean section or breech delivery that achieved the purpose for application. Must have Obstetrician or Medical Officer reported as an Accoucheur.
5	Forceps unsuccessful		Application of a pair of forceps to the fetal head with rotation or traction applied to assist rotation and/or descent that were not successfully applied or did not achieve the purpose for application. Application of a pair of forceps to the fetal head to assist delivery of the fetal head during a caesarean section or breech delivery that were not successfully applied or did not achieve the purpose for application. Must have Obstetrician or Medical Officer reported as an Accoucheur.
6	Breech (vaginal)		Manoeuvres are employed to vaginally deliver an infant with a breech presentation. This excludes spontaneous breech delivery.
7	Elective Caesarean		Caesarean Section includes classical and lower uterine incisions, hysterotomy and hysterectomy. Procedure performed at a time planned some days in advance and usually in business hours with no onset of labour, ruptured membranes or attempted induction of labour. Must have Obstetrician or Medical Officer reported as an Accoucheur.

	Data Item	Commenced	Description
8	Emergency Caesarean		Caesarean Section includes classical and lower uterine incisions, hysterotomy and hysterectomy. Procedure performed at short notice and usually within the last 24 hours for a complication occurring before or during labour. There may have been labour or ruptured membranes. Emergency caesarean must be reported if a person was booked for an elective caesarean who is admitted before booked date because of ruptured membranes or onset of labour and caesarean is performed before the time of the booked procedure. Must have Obstetrician or Medical Officer reported as an Accoucheur.
79.	Water Birth	Jul 2016	A flag that infant was born into water either as a planned water birth or unexpectedly while the mother was immersed. The mother was in a bath or pool at time of birth and the infant was born fully submerged in water. Must be reported for every infant.
1	Yes		Infant's head was immersed in water at the time of birth.
2	No		Infant's head was NOT immersed in water at the time of birth.
80.	Accoucheur(s)	1998	The professional status or other description of the birth attendant/s or supervisor of the attendant At least one item must be reported for each infant Possible to report multiple birth attendants
1	Obstetrician		Reported if the birth has been conducted or supervised by a medical practitioner who has been recognised as a specialist in the practice of obstetrics.
2	Other medical officer		Reported if the birth has been conducted or supervised by a medical practitioner who is not an Obstetrician. Does not include a medical practitioner providing anaesthetic or paediatric services.
3	Midwife		Reported if the birth has been conducted or supervised by a midwife who is currently registered as a midwife with the Australian Health Practitioners Regulation Authority (AHPRA).
4	Student		Reported if the birth has been conducted or attended by a student in midwifery or medicine at a recognised facility. This option is usually reported with other options like midwife.
5	Self/no attendant		Reported if the birth occurs without another person in attendance. This option is usually only reported when the birth occurs before arrival at the birth site.
8	Other		Reported if the birth has been assisted by a person other than one of those listed above. May include registered nurse who is not a student of midwifery, ambulance officer, partner, support person etc. This option is usually reported with other options like midwife or when the birth occurs in an ambulance or other unplanned birth site.
81.	Sex	1975	The biological distinction between male and female. Must be reported for each infant.
1	Male		Reported if the infant is recognised as male.
2	Female		Reported if the infant is recognised as female.
3	Indeterminate		Reported if the infant is unable to be recognised as either male or female.

	Data Item	Commenced	Description
82.	Status of baby at birth	1975	The status of being alive or not at the time of birth as determined by beating of the heart, pulsation of the umbilical cord, definite movement, and/or breathing.
1	Liveborn		Reported if the infant is recognised as having signs of life at the moment of birth
2	Stillborn (unspecified)		Reported if the infant is recognised as having NO signs of life at the moment of birth and was unable to be resuscitated. Whether fetal life expired before or during labour is unknown.
3	Antepartum stillborn	Jan 2010	Reported if the infant is recognised as having NO signs of life at the moment of birth and was unable to be resuscitated. Fetal life is known to have expired before the onset of labour.
4	Intrapartum stillborn	Jan 2010	Reported if the infant is recognised as having NO signs of life at the moment of birth and was unable to be resuscitated. Fetal life is known to have expired after the onset of labour.
83.	Infant weight (whole gram)	1975	First naked weight recorded for an infant following birth to the nearest five whole grams. Usually obtained within 1 to 2 hours of birth. Weights less than 1000 grams must be reported as right adjusted with leading 0's i.e. 0 9 7 5
84.	Length (whole cm)	1975	First measurement of the naked length of an infant following birth to the nearest whole centimetre. Obtained by measuring the shortest distance between the infant's heel and crown while infant is held in a military attitude. Usually obtained within hours of birth. Lengths that are midway between two whole numbers should be recorded as the higher number i.e. if 51.5 cm then report 52 cm.
85.	Head circumference (whole cm)	1990	First measurement of the circumference of the head of an infant following birth to the nearest whole centimetre. Obtained by placing a tape measure around the fetal head just above the ears and across the maximum point of the occiput posteriorly and above the brows anteriorly. Usually obtained within hours of birth. Measurements that are midway between two whole numbers should be recorded as the higher number i.e. if 33.5 cm then report 34 cm.
86.	Time to establish unassisted regular breathing (whole min)	1975 Update 1988	The duration in minutes to the nearest whole minute of time taken by the infant to establish and maintain spontaneous respirations. If duration is less than 1 minute report 01 minute. If duration is between 1 and 2 minutes report 02 minutes. If infant stillborn or dies without maintaining spontaneous respirations report 00 minutes If infant is ventilated and spontaneous respirations are not achieved during resuscitation i.e. some hours later then report 98. If infant is BBA and time to spontaneous respiration is not able to be estimated report 98.
87.	Resuscitation Values available:	1979 Update 1993, Jul 2014 Updated Jul 2019	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances. Must be reported for each infant. Report all methods of Resusitation.

	Data Item	Commenced	Description
1	None		Reported if the infant required no resuscitation or was stillborn.
2	Suction		Reported if suction of airway (nose and/or mouth) with or without guedel airway was the most intensive resuscitation administered.
3	Oxygen		Reported if oxygen was administered without manual ventilation or intubation and this was the most intensive resuscitation administered.
4	Continuous positive airway pressure (CPAP)	Added Jul 2014	Reported if the infant's airways were kept open by using air provided at a constant increased pressure and this was the most intensive resuscitation administered. If ventilation was provided with CPAP then report value 5 below.
5	Bag and mask (IPPV)	Changed from value 4 Jul 2014 Deactivated Jul 2019	Reported if the infant was manually ventilated with a bag and mask or a "neopuff" device without intubation and this was the most intensive resuscitation administered.
6	Endotracheal intubation	Changed from value 5 in Jul 2014	Reported if the infant was intubated with or without manual ventilation with no external cardiac massage and this was the most intensive resuscitation administered.
7	Ext. cardiac massage and ventilation	Changed from value 6 in Jul 2014 Deactivated Jul 2019	Reported if the infant was given external cardiac massage and ventilation via mask or endotracheal tube.
10	Intermittent positive pressure ventilation (IPPV)	Jul 2019	Reported if the infant was manually ventilated with a bag and mask or a "neopuff" device.
11	External Cardiac Compressions	Jul 2019	Report if the infant was given external cardiac compressions.
88	Other		Reported if the infant was given medications like Narcan, Adrenaline etc
88.	Apgar Score 1 minute	1990	The score determined at one minute of age by rating the infant's heart rate, respiratory effort, muscle tone, reflex irritability and colour. Each item is rated as 0, 1 or 2. The totals are added to obtain a score between 0 and 10. Must be reported for every infant born. If score is less than 10 then report the number right adjusted with a leading 0 like 07. If infant was stillborn 00 If infant was BBA and Apgar Score at 1 minute was not determined report 99.
89.	Apgar Score 5 minutes	1975	The score determined at five minutes of age by rating the infant's heart rate, respiratory effort, muscle tone, reflex irritability and colour. Each item is rated as 0, 1 or 2. The totals are added to obtain a score between 0 and 10. Must be reported for every infant born. If score is less than 10 then report the number right adjusted with a leading 0 like 07. If infant was stillborn 00 If infant was BBA and Apgar Score at 5 minutes was not determined report 99.

	Data Item	Commenced	Description
90.	Estimated gestation (whole weeks)	1984	The gestational age of the pregnancy as determined by dates and/or examination of the infant at birth and referring to the Dubowitz Score if needed. Gestational age determined by the expected delivery date should be confirmed by examination of the infant. Liveborn infants that have a physical appearance significantly different to the gestational age indicated by the expected due date should be reported by their physical appearance. Stillborn infants that have a physical appearance indicating a gestational age less than the pregnancy dates indicate must have gestational age reported by the pregnancy dates. Valid number is between 20 and 45 weeks. If gestation is 36 weeks and 5 days, report 36 weeks.
91.	Birth defects (specify)	1975	Report by describing in free text a birth defect or congenital anomaly that is suspected or confirmed at the time of completing this report. It may be the reason for induction or method of birth or other intervention. Alerts of suspected anomalies recorded here are provided to the WA Register of Development Anomalies so that a detailed report can be retrieved from medical staff. The Register follows up on any defect of developmental origin in either liveborn or stillborn babies like structural (e.g. spina bifida), genetic/and chromosomal (e.g. Down's Syndrome) and biochemical (e.g. glucose 6-phosphate dehydrogenase deficiency) anomalies. Most minor malformations are excluded unless they are disfiguring or require treatment. Leave field blank if there is nothing to report. Do not record NIL, N/A, NONE etc.
92.	Birth trauma (specify)	1975	Report by describing in free text the site and type of trauma occurring during the birth process. Examples include fractures, lacerations, haematomas, palsies. Leave field blank if there is nothing to report. Do not record NIL, N/A, NONE etc.

Baby Separation Details

Must be completed for each infant born of the pregnancy

	Data Item	Commenced	Description
93.	Separation date	1975	The date of the day where infant left the birth site through discharge, transfer or death. Must be recorded as format ddmmyyyy For homebirths report date of birth as separation date For stillborn infants report date of birth as separation date
94.	Mode of separation Values available:	1975	The outcome or destination after infant's stay at birth site as known on the day of discharge (separation).
1	Transferred		Reported if infant was transferred to hospital other than the place of birth or transferred to a service like a foster home or gaol.
8	Died		Reported if infant was stillborn or liveborn and died before separation from birth site.
9	Discharged home		Reported if infant left the birth site for a private home. Home need not be the permanent residence of the parent.
95.	Transferred to: (Specify establishment code)	1979 Updated Jul 2019	Report name or establishment code of the hospital to which the infant was transferred. 0104 = King Edward Memorial Hospital for Women 0106 = Fiona Stanley Hospital 0107 = Perth Children's Hospital 2102 = Gaol Bandyup 0900 = Home 0912 = Died 0921 = Foster Home 0985 = Interstate hospital
96.	Special Care (excludes Level 1; whole days only)	1979	Report the number of whole days an infant was admitted to the special care nursery (Level 2 or 3) at the birth site during their birth admission. Report days less than 3 digits as right adjusted with leading 0's i.e. report 12 days as 012. For infants that were admitted less than 24 hours report 000. For infants that were not admitted, report a blank. Do not report or include any time the infant was admitted to a special care nursery at a site other than the birth site. Do not report or include any time the infant was admitted to a Level 1 nursery.
97.	Coder ID	1998 Deactivated Jun 2014	HE number of person completing data entry for the birth record.
98.	Midwife Name	Jul 2014	First Name and Last Name of the Midwife responsible for reporting the events of the birth, usually the midwife completing the report. Name must be PRINTED. Added to this page of Form Jul 2014 to enable correct matching of pages of form.
99.	Date of providing information	Jul 2014	Date that form was completed by the Midwife named as responsible for reporting information. Added to this page of Form Jul 2014 to enable correct matching of pages of form.

Reporting OTHER conditions

Since July 2017 notifications by midwives use designated 3 digit codes to describe common “Other” conditions for Complications of Pregnancy, Pre-existing Medical Conditions and Complications of Labour and Delivery. These codes are proved in this list.

Previously, these were stored in the Midwives Notification System in data fields of 10 characters using ICD-10 codes.

This change occurred because the core purpose and design of ICD-10 codes does not correlate well with conditions notified by midwives as an “Other” condition .

Lists and descriptions of ICD-10 codes previously recommended for notification by midwives for the following data items are available upon request from birthdata@health.wa.gov.au.

- Complications of Pregnancy (arising during or because of this pregnancy)
- Pre-Existing Medical Conditions (diagnosed before this pregnancy and influencing care during this pregnancy). Do not include conditions that are historical i.e. had appendicitis treated before this pregnancy.
- Complications of Labour & Delivery (diagnosed during labour/delivery or influencing care during labour/delivery), and
- Birth Trauma (trauma to infant as a result of birth processes and procedures).

This document can be made available in alternative formats on request for a person with a disability.