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

Guidelines for Midwives

Notification of Case Attended

How to complete and submit Form 2 – Health (Notification by Midwives) Regulations 1994

health.wa.gov.au

Guidelines for Completing Notification of Case Attended for Birth
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Introduction

This is a reference guide for midwives to assist in completing reporting of health information listed on the Notification of Case Attended (NOCA) form. This form is also referred to as the Birth Notification, NOCA, Form 2 or MR15.

The NOCA Form provides a list of all health information to be provided when an infant is liveborn or stillborn in WA of at least 20 weeks gestation, or if gestation is unknown, with birthweight of at least 400 grams.

The NOCA form changed from a one page to a two page form for reporting births from 1st July 2014. This change enabled the font to be increased to a more readable level and to include new information.

Submitting this birth information is a requirement of the Health (Notifications by Midwives) Regulations 1994 published in the Government Gazette. Subsequent amendments to the NOCA (Form 2) are also published. The most recent amendment will be published in the Western Australian (WA) Government Gazette in 2016.

Midwives may submit this health information with the use of a data entry package like Stork, SJOG System, or the Ramsay System.

Non-maternity sites and Privately Practising Midwives use the paper NOCA form and can email, fax or post it to the Maternal and Child Health Unit which manages the collection for the WA Department of Health (DoH).

These guidelines provide context and definitions for data items to assist midwives in submitting this important health information accurately.

The Midwives' Notification System

The Midwives' Notification System (MNS) was introduced in WA in 1974. Information for all births occurring since 1980 have been included in the digital dataset.

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.

To contribute meaningfully in these ways the health information contained in the WA MNS must be complete and of a high quality.

Data contained in the MNS is provided by Midwives submitting data listed on the NOCA Form.

The Maternal and Child Health Unit (MCHU) at the WA Department of Health (DoH) is responsible for administering the MNS.

Instead of information being submitted on paper forms, more than 99% of births in WA now have information submitted using three software systems, Stork, the SJOG System, and the Ramsay System. When using these tools, do not complete the paper version of the NOCA Form. The paper version of Form 2 is only provided for use when computer systems are not available e.g. private practice homebirths and unexpected births at non-maternity sites.

Requests for information held in the MNS are encouraged. The release of information is governed by the Policies of the WA DoH.

Quality of MNS data

The quality of these data is determined and improved using a multi-step process. The following documents about the MNS validation process are available upon request to midwives and maternity services submitting MNS data:

- MNS – Validation Process Manual Administrators 2015 V1_11 FINAL.pdf
- MNS – Validation Process Manual Private Health 2015 V1_01 FINAL.pdf
- MNS – Validation Process Manual WA Health 2015 V1_01 FINAL.pdf
- MNS Validation Rules Quick Reference Guide 2015 for Private Health Users V1 FINAL.pdf
- MNS Validation Rules Quick Reference Guide 2015 for WA Health Users V1 FINAL.pdf

These documents describe in detail steps 3 to 4 of the following objectives:

1. Completeness and validity of data confirmed before submission by data providers (health services, midwives).
2. Data files received by MCHU are confirmed to be complete and in the correct format specified as file format “M7” to be used for submitting data for births occurring from 1st July 2016.
3. At time of loading data files, records that pass validation rules are accepted, records with errors are labelled as in “Error” and records with suspect data are flagged as a “Warning” and require checking and confirmation that data is correct.
4. “Error” and “Warning” records with errors are returned to data providers for correction.
5. Data in MNS are checked against data in the Hospital Morbidity Data System (HMDS) and any woman who had a birth procedure recorded in HMDS without a matching MNS record are found. A query requesting an MNS notification is sent to the maternity service.
6. MCHU checks MNS data for unusual changes in frequency of events or unusual combinations of data items (i.e. midwife recorded as only birth attendant for failed vacuum extraction). All issues are discussed with health services providing the data to determine correct information for the record.
7. Finally, approximately every five years a record audit is conducted. Recommendations from the audit are used to improve specifications, instructions and validation processes. A report of this audit is published enabling users of data to evaluate the reliability of the data supplied for their project.

Responsibility for Submission of Health Information

It is the responsibility of the midwife in attendance at the time of the birth to submit the birth information described on the NOCA Form. If no midwife was in attendance then the medical officer in attendance is responsible. If there is no midwife or medical officer in attendance when the birth occurs, the first midwife or medical officer to attend the woman is responsible for providing the birth information.

Completing the Paper Form

If a software system is not available for use, a 2-page paper NOCA Form must be completed.

- A twin birth requires one page 1 and two page 2s of the NOCA Form to be completed.
- Each of the pages must have enough information to ensure separated pages can be put back together with correct mother and baby matches.
- Complete birth information as soon after birth as practicable.
- Email, fax or post completed paper NOCA Form to MCHU within 48 hours of birth.
- Complete discharge information on NOCA Form for infant at time of discharge from birth service or on day of birth for a homebirth.
- Email, fax or post any updates recorded on the previously submitted paper NOCA Form to MCHU within seven days of discharge of infant/s.
- Ensure a copy of information provided on a NOCA Form to MCHU is available in mother's health service record.

When completing NOCA Form:

1. Ensure legibility by:
    - Using ballpoint pen
    - Print all text in BLOCK LETTERS
    - Limit abbreviations to those in common use
2. 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
    - A telephone number should always be provided to enable continuity of care by Child Health Services. If no contact number available please state on the form

- 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, leave boxes for days 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, please 'right adjust' your response
  e.g. birthweight of infant – 975 grams

0	9	7	5

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

☐ essential hypertension
☑ pre-existing diabetes mellitus
☐ asthma
☐ genital herpes
☑ other (specify) *RETINOPATHY*

_____

3. Ensure timely submission by forwarding the:
   - The NOCA Form to the MCHU within 48 hours of the birth (even if discharge information for infant not yet available).
   - Final copy of NOCA Form to the MCHU within 7 days of the infant being discharged from the service.

Reporting Using Software System

WA has three software systems in use to enable submission of information described on the 2-page paper NOCA Form.

Data must be provided for each infant of a multiple birth including the same maternal information.

Digital capture of information must include:

1. All data items as specified on the 2-page paper NOCA Form.
2. Submission of an electronic Birth Notification currently specified as “BN3” by email within 48 hours of the event, and
3. Submission of an electronic NOCA Extract currently specified as file format “M7”. This is a complete record that includes discharge information for each infant born. This file must be submitted as a batch file. It has been found to be efficient if a one month birth cohort is included in each batch file and this batch file to be provided within one month of the end of the birth month.

Documents describing the correct format of these digital records are found at: http://www.health.wa.gov.au/healthdata/statewide/midwives.cfm

1. Ensure completeness by:
   - including all data required in the format expected
   - providing a telephone number to enable continuity of care by Child Health Services. If no contact number available – add text to inform no telephone number available
   - providing multiple responses as applicable. Use ICD-10 codes to describe any “Other” conditions supplied
2. Ensure timely submission by emailing:
   - Birth Notification to RoyalStCHN@health.wa.gov.au within 48 hours of the birth
   - NOCA Extract “M7” via MyFT to Birthdata@health.wa.gov.au. These data to be submitted as a batch for the previous calendar month of births within 30 days of the end of the period being reported.

Description of Data

When preparing health information about births using a software system or the paper NOCA Form please refer to the following information outlining when, how and which data to report about births in WA.

Maternal Demographics

Must be completed once for each woman giving birth

	Data Item	Commenced	Description
1.	Last Name	1975	The legal family name of the woman giving birth. If an alias or assumed name is used, this should be indicated in brackets following the legal surname.
2.	First Name	1975	The legal first name of the woman giving birth. Anglicised versions of first names should not be provided.
3.	Second Name		The legal second name of the woman giving 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 woman giving birth at the time of her own birth. If the woman has never married, her 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 woman, including property name if appropriate. A Street address, not a post office box number or road mail box number, is required for child health services. A woman's permanent address should be reported if at the time of giving birth she is living at a temporary address until her and baby are well enough to return to rural home or until temporary visa expires and she and baby return to international home. Child health services may require the temporary address information to enable appropriate and immediate care. This data also assists in determining birth rates and conditions in the area in which the woman usually lives.
6.	Town or Suburb	1975	The Town or Suburb of the woman's address of usual residence
7.	State	1998	The State or Territory of the woman's Address of usual residence e.g. WA.
8.	Postcode	1975	The postcode for the Suburb of the woman's Address of usual residence. For international address report 8888
9.	Unit record number	1975	The hospital record number allocated to the woman giving birth. If number has less digits than the boxes provided 'right adjust' your 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 woman giving birth. Provide the date as an 8 digit response, i.e. ddmmyyyy.
11.	Height	1975	The height in whole centimetres of the woman giving 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 woman giving birth. If the woman has no weight recorded before 20 weeks gestation, report the self-reported weight at conception.

	Data Item	Commenced	Description
13.	Telephone number	1990	The home or contact telephone number of the woman giving birth. A contact telephone number is valuable to child health nurses. For women intending to reside temporarily at other than their usual address, please record best contact number.
14.	Interpreter required	Jul 2016	Flag for whether the woman requires an Interpreter to communicate with health care workers. If so, respond Yes, otherwise respond No. A response must be reported. If Yes, must have "Language requiring Interpreter" provided.
15.	Language requiring Interpreter	Jul 2016	The language that the woman 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	Name or licensee number of the health service reporting the woman's birth. If place of birth is a hospital then record the name or number of the hospital. For a planned homebirth occurring at home record Homebirth. For births designated "born before arrival" report the Establishment as the health service reporting the birth to the WA DoH and Report "Yes" for Born Before Arrival.
17.	Ward	1998	Location of birth within Establishment. e.g. Delivery Suite, Family Birth Centre, Kalamunda Birth Centre, CMP.
18.	Marital Status, Values available:	1975 Update 1998	Self reported marital state of the woman giving birth at the time she is giving birth. Not necessarily the legal marital status.
1	Never married		Woman was never married and has no defacto partner. Family Name may NOT be same as Maiden Name.
2	Widowed		Woman was married and husband died. She has no current husband or defacto partner. Family Name may NOT be same as Maiden Name.
3	Divorced		Woman was married and is now legally divorced. She has no current husband or defacto partner. Family Name may NOT be same as Maiden Name.
4	Separated		Woman was married and is now legally separated from her husband. She has no current defacto partner. Family Name may NOT be same as Maiden Name.
5	Married (inc. defacto)		Woman is legally married to current partner or has a defacto partner. Family Name may NOT be same as Maiden Name.
6	Unknown or not stated		Woman's marital status is unable to be determined or is not stated. Family Name may NOT be same as Maiden Name.

	Data Item	Commenced	Description
19.	Ethnic status, Values available:	1975 (Race) Update 1998, Jan 2013	Self reported ethnic origin of the woman giving birth. A woman who identifies herself 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		Woman 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-Dec2012	Woman 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		Woman 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)		Woman 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		Woman who self reports ethnic origin as African, which usually includes descendants of people from Africa i.e. Nigerian, Somalian etc
6	Polynesian		Woman 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		Woman who self reports ethnic origin as Maori, which usually includes people of New Zealand origin
8	Other		Woman 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	Woman who self reports ethnic origin as Aboriginal and not Torres Strait Islander
11	Torres Strait Islander, not Aboriginal	Jan 2013	Woman who self reports ethnic origin as Torres Strait Islander and not Aboriginal
12	Aboriginal and Torres Strait Islander	Jan 2013	Woman who self reports ethnic origin as both Aboriginal and Torres Strait Islander

Pregnancy Details

Must be completed once for each woman giving 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 woman 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 woman 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 woman 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 was any previous pregnancy 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. 98 should be reported if the woman giving birth has had no antenatal care prior to this birth event. 99 should be reported 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 a pregnant female. Antenatal care visits are attributed to the pregnant woman. In rural and remote locations where a midwife or doctor is not employed, registered Aboriginal health workers and registered nurses may perform this role within the scope of their training and skill license. 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 only, or those contacts that occurred during the pregnancy that related to other 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. Exception to this rule is made when 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 woman did not experience a menstrual period prior to this pregnancy report LMP as unknown. If the LMP is unknown, leave field blank and report LMP date as NOT CERTAIN for the next data item.
31.	LMP Date Certain	1979	Indication of whether the LMP date reported was a certain date. If LMP is unknown or not experienced report No**.**
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. Should not be left 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 Last Menstrual Period, 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.

	Data Item	Commenced	Description
34.	Influenza vaccination during pregnancy:	Jul 2016	The trimester of this pregnancy in which this woman received vaccination against influenza. A response must be reported.
01	Vaccinated during 1st trimester		Influenza vaccination received by woman in first trimester (between 1 and 14 weeks gestation) of this pregnancy.
02	Vaccinated during 2nd trimester		Influenza vaccination received by woman in second trimester (between 15 and 28 weeks gestation) of this pregnancy.
03	Vaccinated during 3rd trimester		Influenza vaccination received by woman in third trimester (after 28 weeks gestation) of this pregnancy.
04	Vaccinated in unknown trimester		Woman did receive influenza vaccination during pregnancy but gestation at time of vaccination is unable to be determined.
05	Not vaccinated		Woman did not receive influenza vaccination during this pregnancy.
99	Unknown if vaccinated		Not able to be determined if woman received influenza vaccination during this pregnancy.
35.	Pertussis vaccination during pregnancy:	Jul 2016	The trimester of this pregnancy in which this woman received vaccination against pertussis (whooping cough). A response must be reported.
01	Vaccinated during 1st trimester		Pertussis vaccination received by woman in first trimester (between 1 and 14 weeks gestation) of this pregnancy.
02	Vaccinated during 2nd trimester		Pertussis vaccination received by woman in second trimester (between 15 and 28 weeks gestation) of this pregnancy.
03	Vaccinated during 3rd trimester		Pertussis vaccination received by woman in third trimester (after 28 weeks gestation) of this pregnancy.
04	Vaccinated in unknown trimester		Woman did receive pertussis vaccination during pregnancy but gestation at time of vaccination is unable to be determined.
05	Not vaccinated		Woman did not receive pertussis vaccination during this pregnancy.
99	Unknown if vaccinated		Not able to be determined if woman 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 woman 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 woman has quit smoking at some point in the period being reported, report the number usually smoked daily prior to quitting. 000 is reported if the woman did not smoke during the period reported 998 is reported if the woman smoked less than 1 cigarette per day in the period reported. 999 is reported if the woman's tobacco smoking is unable to be determined.

	Data Item	Commenced	Description
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 woman after the first 20 weeks of pregnancy until birth. This information should be determined after the woman has given birth. If a woman has quit smoking at some point in the period being reported, report the number usually smoked daily prior to quitting. 000 is reported if the woman did not smoke during the period reported 998 is reported if the woman smoked less than 1 cigarette per day in the period reported. 999 is reported if the woman's tobacco smoking is unable to be determined.
38.	Complications of pregnancy Values available**:**	1975 Update 1979, 1993, 2014	A condition that has arisen during this pregnancy, the condition is associated with pregnancy and has complicated this pregnancy.
1	Threatened abortion (<20 weeks)		Vaginal bleeding with the uterus determined to be the source of bleeding before the 20th gestational week.
2	Threatened preterm labour (< 37 weeks)		Period of regular, 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 Gestational Hypertension. 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 (which stands for Haemolysis, Elevated Liver Enzymes, Low Platelet count and is a variant of preeclampsia) are to be included under this code for preeclampsia.
5	Antepartum haemorrhage (APH) – placenta praevia		Bleeding from the placenta positioned over or very near the internal cervical os.
6	Antepartum haemorrhage (APH) – placental abruption		Bleeding from placenta that has been totally or partially abruptly separated from the uterine wall before birth of the infant.

	Data Item	Commenced	Description
7	Antepartum haemorrhage (APH) – Other		Bleeding from the uterus where cause is other than placenta praevia or abruption i.e. 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. Gestational Diabetes diagnosed in a prior pregnancy is not recorded for this pregnancy. Pre-existing Diabetes is to be reported in the Current Medical Conditions area.
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 reported 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 preeclampsia. Followed by return of blood pressure to normal within 3 months post-partum - which feature would be unknown at time of reporting.
12	Pre-eclampsia superimposed on essential hypertension	Jul 2014	Where hypertension was diagnosed prior to pregnancy and woman diagnosed with Pre-eclampsia as defined above during pregnancy.
99	Other (Specify)	Jul 2014	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, 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.
39.	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 (e.g. Thalassaemia).
1	Essential hypertension		Diagnosis of condition as defined using the Australasian Hypertension in Pregnancy Consensus Statement (see above). Pre-Eclampsia and other conditions arising in Pregnancy are to be reported in the Complications of Pregnancy area.

	Data Item	Commenced	Description
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.
4	Genital herpes		A prior 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 resulted from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.
8	Other (specify)		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.
40.	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.

	Data Item	Commenced	Description
41.	Intended place of birth at onset of labour, Values available:	1998	The location type that the woman 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 the actual place of birth should be reported.
1	Hospital, excluding birth centre		Can include any hospital, but as it is an "intended" place of birth it is usually a hospital with a maternity service. This value is expected for women who gave birth without labouring i.e. elective caesarean section.
2	Birth centre, attached to hospital		A model of care that is usually provided by midwives from a dedicated unit that can be 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		A model of care that is usually provided by midwives from a dedicated unit that can be co-located on a hospital campus or outside the boundaries of a health service. Midwives are usually not part of a hospital staff and provide care in collaboration with General Practitioners and/or local health services.
4	Home		A birth planned to occur in a private home booked with a midwife or without a health professional in attendance. Should not be used to report unbooked pregnancies or pregnancies accidentally occurring at home or enroute to health service.
8	Other		A birth where there was no intended place of birth at onset of labour i.e. concealed or undiagnosed pregnancy, women with no antenatal care.

Labour Details

Must be completed once for each woman giving birth

	Data Item	Commenced	Description
42.	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 the three values available must be reported for each woman giving birth.
1	Spontaneous		Woman 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 Procedure may be reported as NONE or 1 or more values Induction Procedures must be reported as NONE Duration of 1st stage and 2nd stages of labour must be reported as being 1 minute or more.
2	Induced		Woman had a medical or surgical procedure aimed at inducing labour. Woman may have had a period of labour Rupture of membranes may have occurred before onset of labour, Artificial rupture of membranes before labour should be recorded as “Induced Labour”. Augmentation Procedure must be reported as NONE Induction Procedures must have at least one value reported and not have NONE reported If the induction procedures failed to induce onset of labour, then duration of 1st stage and 2nd stages of labour must be 00:00 and a Labour and Delivery complication of Other-failed induction should be recorded. A birth occurred of an infant of 20 weeks gestation or more. A failed induction occurs when an induction procedure, either medical and/or surgical, fails to establish labour. IN this event report: • Onset of labour as Induced • All methods of induction used • duration of labour as 00 hours and 00 minutes for both 1st and 2nd stage • Complication of Labour and Birth as 13-Other
3	No labour		Reported for a woman who had no labour induction procedure and no labour. Augmentation Procedure must be reported as NONE Induction Procedures must be reported as NONE Duration of 1st stage and 2nd stages of labour must be reported as 00:00. Method of birth must be reported as either Elective or Emergency Caesarean Section. A woman who did not labour after an Induction procedure must be reported as having Onset of Labour as Induced.

	Data Item	Commenced	Description
43.	Principal reason for Induction Values available:	Jul 2016	Report the one most important indication reported to be the main reason for inducing this woman's labour. Definitions for this data have been provided by AIHW at: http://meteor.aihw.gov.au/content/index.phtml/itemId/569595. A response must be reported if Onset of labour = Induction
1	Prolonged pregnancy		Most likely occurs when gestation is greater than or equal to 41 week.
2	Prelabour rupture of membranes		Report if preterm or term spontaneous rupture of membranes if it occurred before labour commenced and rupture of membranes may be prolonged.
3	Diabetes		If reported as principal reason for induction, the woman's type of Diabetes must also be reported in Pregnancy Complications or Pre-Existing Medical Conditions for this reason to be considered valid.
4	Hypertensive disorders		If reported as principal reason for induction, the woman's type of Hypertension must be reported in Pregnancy Complications or Pre-Existing Medical Conditions for this reason to be considered valid.
5	Multiple pregnancy		The birth plurality must be greater than one for this reason to be considered valid.
6	Chorioamnionitis (includes suspected)		Report if stated to be reason for induction.
7	Cholestasis of pregnancy		Report if stated to be reason for induction.
8	Antepartum Haemorrhage		The woman's cause/type of Antepartum Haemorrhage must be reported in Pregnancy Complications for this reason to be considered valid.
9	Maternal age		May refer to high or low maternal age but most likely for a high maternal age.
10	Body Mass Index (BMI)		May refer to high or low maternal BMI. This woman's height and weight must be reported for this reason to be considered valid.
11	Maternal mental health indication		Must be a diagnosed mental health disorder or condition. The condition must also be reported in Pregnancy Complications or Pre-Existing Medical Conditions for this reason to be considered valid.
12	Previous adverse perinatal outcome		A woman who experienced a previous late unexplained stillbirth or other adverse perinatal outcome may wish to have labour induced.
19	Other maternal obstetric or medical indication		Includes 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.
20	Fetal compromise (includes suspected)		Includes oligohydramnios, reduced fetal movement, abnormal antenatal cardiotocography (CTG), abnormal Doppler, other abnormalities of fetal wellbeing (e.g. abnormal profile).
21	Fetal growth restriction (includes suspected)		It is not always possible to determine fetal growth restriction (also known as intra uterine growth restriction (IUGR)) until the baby is born therefore this code includes suspected fetal growth restriction.
22	Fetal macrosomia (includes suspected)		It is not always possible to confirm fetal macrosomia until the baby is born therefore this code includes suspected fetal macrosomia.

	Data Item	Commenced	Description
23	Fetal death		Report if stated to be reason for induction. Infant's birth status must be reported as "Antepartum Stillborn" in the birth record.
24	Fetal congenital anomaly		Report if stated to be reason for induction. Infant's congenital anomaly must be reported as "Birth defect" in the record.
80	Administrative or geographical indication		Includes scheduling like health provider's availability, ensuring availability of theatre, anaesthetist or other staffing reasons. This code could also be used where a pregnant woman is normally resident in a rural or remote area or an area without adequate birthing facilities and the need for induction is determined by such factors as the available facilities and the woman's ability and availability to travel to a centre with suitable facilities.
81	Maternal choice in the absence of any obstetric, medical, fetal, administrative or geographical indication		The woman has requested an induction and none of the other permissible values, including Code 89, apply. It is important to distinguish between a woman's choice, and other indications such as maternal medical/obstetric, fetal and administrative/geographical reasons for induction. Where the clinician determines that a diagnosed maternal mental health indication is the reason for the induction, Code 11 should be selected. Code 80 should also be considered for relevance.
89	Other indication not elsewhere classified		Includes other fetal indications such as fetal anaemia and isoimmunisation and any other indications not listed. Do not use this to indicate maternal choice, for this reason report "81".
44.	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. More than one method can be reported A response must be recorded
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
45.	Induction of Labour (before labour began), Values available:	1998 Update 2014	Medical or surgical procedure performed to commence contractions and dilatation of cervix. Should be reported for procedures done when membranes are ruptured but labour has not yet begun More than one method can be reported A response must be recorded
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

	Data Item	Commenced	Description
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 and progress in dilatation of cervix and improve application of the presenting part to the cervix
5	Dilatation device i.e. Foley Cath	Jul 2014	Mechanical cervical dilatation such as a cervical ripening balloon catheter, or Atard
8	Other		Any other intervention performed to begin uterine contractions, progress in dilatation of cervix and improve application of the presenting part to the cervix i.e. balloon catheter to cervix
46.	Analgesia (during labour)	1990 Update 2013	Pharmacological or other administration provided to relieve the pain of labour without inducing loss of consciousness A response must be recorded Multiple responses are permitted
1	None		No analgesia was administered during labour Must be reported if onset of labour was No Labour Usually reported if birth occurred before arrival, however an ambulance officer or health professional may have provided one of the items listed below prior to arrival at the reporting site.
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	Discontinued 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
47.	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 woman did not reach full dilatation of cervix prior to caesarean section. Onset of labour can be determined by report of woman/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 woman 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
48.	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.
49.	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.
50.	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.
51.	Midwife Signature		Required when completing a paper form, electronic data submission can provide a unique identifier for the midwife in this data field
52.	Date of providing information	1975 Update 1980	Date that form was completed by the Midwife named as responsible for reporting information.

	Data Item	Commenced	Description
53.	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
54.	Anaesthesia (during delivery)	1984 Update 1998	Pharmacological administration provided to relieve the sensation and pain of birth procedures, like manoeuvres, instruments or caesarean section. Excludes anaesthesia for perineal repair procedures. A response must be recorded Multiple responses are permitted
1	None		No anaesthesia was administered during birth. May be reported even when Analgesia has already been reported except where effects of epidural/spinal/caudal are still in effect or have been "topped up" for the birth. Usually reported if birth occurred before arrival, however an ambulance officer or health professional may have provided one of the items listed below prior to arrival at the reporting site.
2	Local anaesthesia to perineum		An anaesthetic agent is administered locally to perineum usually to reduce the pain/sensation of performing an episiotomy. Not to be reported when local anaesthesia is only administered after the birth for the purpose of perineal repair.
3	Pudendal		An anaesthetic agent is administered locally via the vaginal wall to pudendum usually to reduce the pain/sensation of the vaginal birth. Rarely used.
4	Epidural/caudal	2007	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 birth. And/or an epidural needle/catheter was inserted into the epidural space and medications 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 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 immediately before the birth procedure or were in effect during the birth to create 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	General		A procedure and medication administration

	Data Item	Commenced	Description
			immediately before the birth 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 immediately before the birth procedure or were in effect during the birth. The catheter is 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 at the time of the birth e.g. TENS, acupuncture, hypnotherapy.
55.	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, forceps.**
1	Precipitate delivery		Reporting of this condition is based on a 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. This cannot be the reason for an operative delivery.
2	Fetal distress		Reporting of this condition or fetal compromise is based on suspicion immediately before the birth or during labour. Suspicion may be 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. This may be the reason for operative delivery.
3	Prolapsed cord		Reporting of this event is determined by observing of umbilical cord in front of the fetus and beyond the internal os of the cervix. It may be suspected with sudden rupture of membranes with excessive amniotic fluid or sudden change in fetal heart rate but should not be reported unless clinically diagnosed. Cord presentation or vasa praevia are not to be reported as prolapsed cord but should be reported as 13-Other. Prolapsed cord is usually a reason for operative delivery.

	Data Item	Commenced	Description
4	Cord tight around the neck		Reporting of this event is determined by requirement to clamp and cut the cord prior to delivering the shoulders/trunk of the infant. It may be suspected with sudden change in fetal heart rate during descent. This is not a reason for operative delivery.
5	Cephalopelvic disproportion		Reporting of this condition is determined by labour or delivery delays, complications or additional procedures resulting from a fetal head that is large in comparison with the maternal pelvic passage. It may be suspected with failure for fetal presenting part to enter the pelvic brim, delayed or obstructed descent in labour, failure of fetal head to rotate while descending through pelvis. This is 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. This is not a reason for operative delivery.
7	Retained placenta – manual removal	1998	Reporting of this event is determined by the procedure of manual removal of placenta being performed either in the delivery room or in the operating theatre. This is not a reason for operative delivery.
8	Persistent occipito posterior	1998	Reporting of this condition is determined by a posterior fetal presentation, where the back of the fetus's head is against the maternal spine, that delays the progress of labour or descent of the fetus. The fetus may not be delivered in the occipito posterior position. This may be a reason for operative delivery.
9	Shoulder dystocia	1998	Reporting of this condition is determined by difficulty and delay in delivering the fetal shoulders. It may be suspected by failure of fetal head to restitute after delivery, burrowing of the fetal chin or difficulty in delivering the anterior shoulder. This should only be reported if there is delay and difficulty in delivering the anterior shoulder which included procedures to manage shoulder dystocia. This is usually not a reason for operative delivery.
10	Failure to progress <= 3cm	1998	Reporting of this condition is determined by cervical dilatation being only 3cm or less despite an appropriate labour which has given the woman sufficient time to have cervix further dilated. This should only be reported if the reason for lack of dilatation is a failure to progress in labour despite good labour. This is a reason for operative delivery (caesarean section). This should not be reported if the reason for caesarean section is fetal distress or other condition that interrupts a normal labour process before a failure to progress can be determined.

	Data Item	Commenced	Description
11	Failure to progress > 3cm	1998	Reporting of this condition is determined by cervical dilatation being more than 3cm but failure to achieve 10cm or delivery before the expected time and despite an appropriate labour which has given the woman sufficient time to have cervix further dilated. This should only be reported if the reason for lack of dilatation is a failure to progress in labour despite good labour. This is a reason for operative delivery (caesarean section). This should not be reported if the reason for caesarean section is fetal distress or other condition that interrupts a normal labour process before a failure to progress can be determined.
12	Previous caesarean section	1998	Reporting of this condition is determined by a history of caesarean section and this being the reason for an operative delivery like elective repeat caesarean section. For women attempting VBAC this should not be reported as it is not the reason for any subsequent operative delivery and the history of caesarean section is already captured in the Pregnancy section of the form. This should only be reported if the decision for caesarean section is determined by this history and no trial of VBAC was desired. This is usually only reported as a primary reason for caesarean section. For women attempting VBAC the reason for decision to perform caesarean section should be reported like fetal distress, failure to progress or other.
13	Other (Specify)		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.*
56.	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 woman.
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.

	Data Item	Commenced	Description
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.
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.

	Data Item	Commenced	Description
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. Also report as a Complication of Labour and Delivery - Other (O61.9).
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		Woman 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		Woman 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		Woman 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		Woman 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		Woman 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.
20	Maternal choice in the absence of any obstetric, medical, surgical, psychological indications		A CS was performed when the woman 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.

	Data Item	Commenced	Description
57.	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
58.	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.

	Data Item	Commenced	Description
59.	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.
60.	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.
61.	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.
62.	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
63.	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.
64.	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.
65.	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.
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.

	Data Item	Commenced	Description
66.	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 woman 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.
67.	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.
68.	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.

	Data Item	Commenced	Description
69.	Gender	1975	The biological distinction between male and female. Must be reported for each infant.
1	Male		Reported if the infant is recognised as being a boy
2	Female		Reported if the infant is recognised as being a girl
3	Indeterminate		Reported if the infant is unable to be recognised as being a boy or girl
70.	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. Must be reported for each infant.
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.
71.	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
72.	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.
73.	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.

	Data Item	Commenced	Description
74.	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 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.
75.	Resuscitation Values available:	1979 Update 1993, Jul 2014	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 the most intensive method and only one item for each infant. Methods are provided in ascending order of invasiveness.
1	None		Reported if the infant required no resuscitation or was stillborn.
2	Suction only		Reported if suction of airway (nose and/or mouth) with or without guedel airway was the most intensive resuscitation administered.
3	Oxygen therapy only		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	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	Reported if the infant was given external cardiac massage and ventilation via mask or endotracheal tube.
8	Other		Reported if the infant was given medications like Narcan, Adrenaline etc

	Data Item	Commenced	Description
76.	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.
77.	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.
78.	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.

	Data Item	Commenced	Description
79.	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.
80.	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
81.	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
82.	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.

	Data Item	Commenced	Description
83.	Transferred to: (Specify establishment code)	1979	Report name or establishment code of the hospital to which the infant was transferred. 0103 = Princess Margaret Hospital 0104 = King Edward Memorial Hospital for Women 0106 = Fiona Stanley Hospital 2102 = Gaol Bandyup 0900 = Home 0912 = Died 0921 = Foster Home 0985 = Interstate hospital
84.	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 001. 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.
85.	Coder ID	1998 Deactivated Jun 2014	HE number of person completing data entry for the birth record.
86.	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.
87.	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.

ICD-10 Codes for reporting OTHER conditions

For some time conditions reported as “Other” have been stored in the Midwives Notification System in data fields of 10 characters using ICD-10 codes. Text that is not a recognised ICD-10 code is not accepted as valid data.

The core purpose and design of ICD-10 codes means that they do not always correlate well with the intended meaning of the “Other” condition reported to the Midwives Notification System.

To assist with design of computer systems that supply these data and to enable translation of the ICD-10 codes stored in this context, a “most commonly used” list of ICD-10 codes is available for each of the four affected data fields:

- 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).

The document, ICD10AM codes for MNS 2016 V1.xlsx contains the list of codes described above.

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