

Perinatal National Minimum Data Set

National Health Data Dictionary, Version 12

National Health Data Committee

2003

Australian Institute of Health and Welfare
Canberra

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Introduction

A National Minimum Data Set (NMDS) is a core set of data elements agreed by the National Health Information Management Group for mandatory collection and reporting at a national level. One NMDS may include data elements that are also included in another NMDS. A NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

The *National Health Data Dictionary* contains definitions of data elements that are included in NMDS collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilateral agreements between the Commonwealth and State/Territory governments about funding and delivery of health services).

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Perinatal NMDS

Admin. status:	CURRENT	1/07/2000	Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET		
Start date:	1 July 1997		
End date:			
Latest evaluation date:			
Scope:	The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400g birth weight.		
Statistical units:			
Collection methodology:			
National reporting arrangements:	State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.		
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year		
Data elements included:	Actual place of birth, version 1 Birth order, version 2 [∇] Birth plurality, version 1 Country of birth, version 3 [∇] Date of birth, version 4 [∇] Establishment identifier, version 4 [∇] First day of last menstrual period, version 1 Gestational age, version 1 Indigenous status, version 4 [∇] Infant weight - neonate, stillborn, version 3 Method of birth, version 1 Onset of labour, version 2 Person identifier, version 1 [∇] Separation date, version 5 Sex, version 3 [∇] Status of the baby, version 1		
Supporting data elements and data element concepts:	Birthweight, version 1 Establishment number, version 4 Establishment sector, version 3 Establishment number, version 4		

◆ new in NMDS this version

∇ modified this version

Supporting data elements and data element concepts: (continued)

Establishment sector, version 3
 Gestational age, version 1
 Live birth, version 1
 Neonatal death, version 1
 Neonate, version 1
 Perinatal period, version 1
 Region code, version 2
 State/Territory identifier, version 3
 Stillbirth (foetal death), version 1

Data elements in common with other NMDSs:

See Appendix D

Scope links with other NMDSs:

Source organisation:

National Health Information Management Group

Comments:

Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

Data elements included

Actual place of birth

Identifying and Definitional Attributes

Knowledgebase ID: 000003 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/96

Definition: The actual place where the birth occurred.

Context: Perinatal statistics:
Used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals, an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Hospital
2	Birth centre, attached to hospital
3	Birth centre, free-standing
4	Home
8	Other
9	Not stated

Guide for use: This is to be recorded for each baby the mother delivers from this pregnancy.

Verification rules:

Collection methods:

Related metadata: is a qualifier of Intended place of birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Other setting

Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

Birth order

Identifying and Definitional Attributes

Knowledgebase ID:	000019	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The sequential order of each baby of a multiple birth.		

Context: Required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight, and a higher perinatal death rate.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Singleton or first of a multiple birth
	2	Second of a multiple birth
	3	Third of a multiple birth
	4	Fourth of a multiple birth
	5	Fifth of a multiple birth
	6	Sixth of a multiple birth
	8	Other
	9	Not stated

Guide for use: Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).

Verification rules:

Collection methods: This data should be collected routinely for persons aged 28 days or less.

Related metadata: supersedes previous data element Birth order vers 1
is a qualifier of the data element Birth plurality vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:

NMDS - Perinatal

DSS - Health care client identification

Start date

End date

01/07/1997

01/01/2003

Comments:

Birth plurality

Identifying and Definitional Attributes

Knowledgebase ID:	000020	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.		
Context:	Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.		

Relational and Representational Attributes

Datatype:	Numeric																
Representational form:	Code																
Representational layout:	N																
Minimum size:	1																
Maximum size:	1																
Data domain:	<table> <tr><td>1</td><td>Singleton</td></tr> <tr><td>2</td><td>Twins</td></tr> <tr><td>3</td><td>Triplets</td></tr> <tr><td>4</td><td>Quadruplets</td></tr> <tr><td>5</td><td>Quintuplets</td></tr> <tr><td>6</td><td>Sextuplets</td></tr> <tr><td>8</td><td>Other</td></tr> <tr><td>9</td><td>Not stated</td></tr> </table>	1	Singleton	2	Twins	3	Triplets	4	Quadruplets	5	Quintuplets	6	Sextuplets	8	Other	9	Not stated
1	Singleton																
2	Twins																
3	Triplets																
4	Quadruplets																
5	Quintuplets																
6	Sextuplets																
8	Other																
9	Not stated																

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of foetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or foetuses weighing 400 grams or more, are taken into account in determining plurality. Foetuses aborted before 20 completed weeks or foetuses compressed in the placenta at 20 or more weeks are excluded.

Verification rules:

Related metadata: is qualified by the data element Birth order vers 2

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

National Minimum Data Set

Perinatal

Data Set Specifications:

NMDS - Perinatal

DSS - Health care client identification

Start date

01/07/1997

01/01/2003

End date

Comments:

Country of birth

Identifying and Definitional Attributes

Knowledgebase ID: 000035 **Version No:** 3

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: The country in which the person was born.

Context: Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of possible data items. The item provides a link between the Census of Population and Housing, other Australian Bureau of Statistics' (ABS) statistical collections and regional data collections. Country of birth may be used in conjunction with other data elements such as Period of residence in Australia, etc., to derive more sophisticated measures of access to services by different population sub-groups and may help in identifying population sub-group(s) that may be at increased risk of cardiovascular disease.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no. 1269.0 (1998).

Guide for use: A country, even if it comprises other discrete political entities such as 'states', is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Country of birth vers 2

Administrative Attributes

Source document: ABS Catalogue No. 1269.0 (1998)

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Demographic characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2000	
NMDS - Admitted patient mental health care	01/07/2000	
NMDS - Perinatal	01/07/2001	
NMDS - Community mental health care	01/07/2001	
NMDS - Admitted patient palliative care	01/07/2001	
NMDS - Alcohol and other drug treatment services	01/07/2001	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments: The Standard Australian Classification of Countries (SACC) (ABS 1269.0 1998) supersedes the Australian Standard Classification of Countries for Social Statistics (ASCCSS) which was reported in version 9 of the NHDD.

Date of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000036	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The date of birth of the person.		
Context:	Required to derive age at a point of time for clinical or administrative use. Used for demographic analyses, for analysis by age and for use to derive a diagnosis related group (admitted patients). NMDS - Perinatal: Requires the collection of the date of birth for the mother and the baby(s).		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8

Data domain: Valid date

Guide for use: If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.

Verification rules: This field must not be null.
National Minimum Data Sets:
For the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Collection methods: It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.
NMDS - Perinatal:
Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.

Related metadata: supersedes previous data element Date of birth vers 3
is used in the derivation of Diagnosis related group vers 1
is qualified by Estimated date flag vers 1
is used in the calculation of Length of stay (antenatal) vers 1
is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Health labour force	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Any new information collections should allow for 0000YYYY. (Refer Standards Australia, AS5017 Health care client identification).

Do not use punctuation (slashes or hyphens) or spaces.

In cases where all components of the date of birth are not known or where an estimate is arrived at from age, use 00 for day and 00 for month and estimate year of birth according to the person's approximate age. As soon as known or on re-presentation, always update the Date of Birth (DOB) field. The use of the Estimated date flag is also to be used to signify that an estimate is being made.

Establishment identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000050	Version No:	4
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.		

Context:

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	NNA(N)NNNNN
Minimum size:	9
Maximum size:	9

Data domain:	Concatenation of: State/Territory identifier (character position 1) Establishment sector (character position 2) Region code (character positions 3-4) Establishment number (character positions 5-9)
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Guide for use:

Verification rules:

Collection methods:

Related metadata:	supersedes previous data element Establishment identifier vers 3 is composed of Establishment number vers 4 is composed of Establishment sector vers 3 relates to the data element Person identifier vers 1 relates to the data element Person identifier type - health care vers 1 is composed of Region code vers 2 is composed of State/Territory identifier vers 3
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Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee
Information model link:	
NHIM	Organisation characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Community mental health establishments	01/07/2003	
NMDS - Elective surgery waiting times	01/07/2003	
NMDS - Emergency department waiting times	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Public hospital establishments	01/07/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Establishment identifier should be able to distinguish between all health care establishments nationally.

NMDS - Admitted patient care:

A residential establishment is considered to be separately administered if managed as an independent institution for which there are financial, budgetary and activity statistics. For example, if establishment-level data for components of an area health service are not available separately at a central authority, this is not grounds for treating such components as a single establishment unless such data are not available at any level in the health care system.

This item is now being used to identify hospital contracted care. The use of this item will lead to reduced duplication in reporting patient activity and will enable linkage of services to one episode of care.

First day of the last menstrual period

Identifying and Definitional Attributes

Knowledgebase ID:	000056	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	Date of the first day of the mother's last menstrual period (LMP).		
Context:	Perinatal statistics:		

The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates or 99999999 if first day is unknown
Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Verification rules:	
Collection methods:	
Related metadata:	is used in the calculation of Gestational age vers 1

Administrative Attributes

Source document:		
Source organisation:	National Perinatal Data Development Committee	
Information model link:	NHIM Physical wellbeing	
Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	

Comments:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID:	000060	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The estimated gestational age of the baby in completed weeks as determined by clinical assessment.		
Context:	Perinatal statistics: The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Number representing the number of completed weeks 99 Not stated/unknown.
Guide for use:	This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy. Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.
Verification rules:	
Collection methods:	
Related metadata:	is calculated using First day of the last menstrual period vers 1 relates to the data element concept Gestational age vers 1

Administrative Attributes

Source document:	International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992	
Source organisation:	National Perinatal Data Development Committee	
Information model link:	NHIM Physical wellbeing	
Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	
Comments:		

Indigenous status

Identifying and Definitional Attributes

Knowledgebase ID: 000001 **Version No:** 4

Metadata type: Data Element

Admin. status: Current
01/07/03

Definition: Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition. See Comments for the Commonwealth definition.

Context: Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area.

The purpose of this data element is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgements about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated/inadequately described

Guide for use: This data element is based on the Australian Bureau of Statistics' (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS web site as indicated below in the Source document section.

The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin

- both Aboriginal and Torres Strait Islander origin

Non-indigenous:

- neither Aboriginal nor Torres Strait Islander origin

Not stated/inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- primarily when importing data from other data collections that do not contain mappable data
- where an answer was refused
- where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Verification rules:

Collection methods:

The standard question for Indigenous status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen-based data capture systems. An additional response category:

Yes, both Aboriginal and Torres Strait Islander.....

may be included if this better suits the data collection practices of the agency concerned.

Related metadata: supersedes previous data element Indigenous status vers 3

Administrative Attributes

Source document: Available on the ABS web site. From the ABS Home page (www.abs.gov.au) select: About Statistics/About Statistical Collections (Concepts & Classifications) /Other ABS Statistical Standards/Standards for Social Labour and Demographic Variables/Cultural Diversity Variables/Indigenous Status.

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments: The following definition, commonly known as 'The Commonwealth Definition' was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth Definition:

- descent
- self-identification
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Infant weight, neonate, stillborn

Identifying and Definitional Attributes

Knowledgebase ID:	000010	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	The first weight of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.		

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants. This item is required to generate Australian national diagnosis related groups.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNN
Minimum size:	4
Maximum size:	4

Data domain: Measured weight in grams

Guide for use: For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000 g and age is less than 365 days.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies, this field must be consistent with diagnoses and procedure codes for valid grouping.

Collection methods:

Related metadata: is used in the derivation of Diagnosis related group vers 1
supersedes previous data element Stillborn, live born baby, infant weight vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

NMDS - Admitted patient care

NMDS - Perinatal

Start date

End date

01/07/1997

01/07/1997

Comments:

Method of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000093	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The method of complete expulsion or extraction from its mother of a product of conception.		
Context:	Perinatal statistics: The method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.		

Relational and Representational Attributes

Datatype:	Numeric														
Representational form:	Code														
Representational layout:	N														
Minimum size:	1														
Maximum size:	1														
Data domain:	<table> <tr><td>1</td><td>Spontaneous vaginal</td></tr> <tr><td>2</td><td>Forceps (assisted vaginal birth)</td></tr> <tr><td>3</td><td>Vaginal breech</td></tr> <tr><td>4</td><td>Caesarean section</td></tr> <tr><td>5</td><td>Vacuum extraction</td></tr> <tr><td>8</td><td>Other</td></tr> <tr><td>9</td><td>Not stated</td></tr> </table>	1	Spontaneous vaginal	2	Forceps (assisted vaginal birth)	3	Vaginal breech	4	Caesarean section	5	Vacuum extraction	8	Other	9	Not stated
1	Spontaneous vaginal														
2	Forceps (assisted vaginal birth)														
3	Vaginal breech														
4	Caesarean section														
5	Vacuum extraction														
8	Other														
9	Not stated														

Guide for use: In a vaginal breech with forceps to the after coming head, code as vaginal breech.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Presentation at birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:

NMDS - Perinatal

Start date

End date

01/07/1997

Comments:

Onset of labour

Identifying and Definitional Attributes

Knowledgebase ID:	000113	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	Manner in which labour started.		
Context:	Perinatal care: How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Spontaneous 2 Induced 3 No labour 4 Not stated

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

Verification rules: 'No labour' can only be associated with caesarean section.

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

Related metadata: is used in conjunction with Method of birth vers 1
supersedes previous data element Onset of labour vers 1
is used in conjunction with Type of labour induction vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/2000	

Comments:

Person identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000127	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	Person identifier unique within an establishment or agency.	
Context:	This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.	

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AN(20)
Minimum size:	6
Maximum size:	20
Data domain:	Valid person identification number.
Guide for use:	Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.
Verification rules:	Field cannot be blank.
Collection methods:	
Related metadata:	relates to the data element Establishment identifier vers 4 is qualified by Person identifier type – health care vers 1

Administrative Attributes

Source document:	AS5017 Health care client identification (with adaptation)
Source organisation:	National minimum data set working parties
Information model link:	

NHIM Recipient role

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2000	
NMDS – Admitted patient mental health care	01/07/2000	
NMDS – Perinatal	01/07/1997	
NMDS – Community mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	
NMDS – Alcohol and other drug treatment services	01/07/2000	
NMDS – Non-admitted patient emergency department care	01/07/2003	
DSS – Cardiovascular disease (clinical)	01/01/2003	
DSS – Health care client identification	01/01/2003	

Comments:

Separation date

Identifying and Definitional Attributes

Knowledgebase ID:	000043	Version No:	5
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/99		
Definition:	Date on which an admitted patient completes an episode of care.		
Context:	Required to identify the period in which an admitted patient hospital stay or episode occurred, and for derivation of length of stay.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	
Verification rules:	For the provision of State and Territory hospital data to Commonwealth agencies this field must: <ul style="list-style-type: none"> - be <= last day of financial year - be >= first day of financial year - be >= Admission date.
Collection methods:	
Related metadata:	supersedes previous data element Discharge date vers 4 is used in the calculation of Length of stay (including leave days) vers 1 is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:			
NHIM	Exit/leave from service event		
Data Set Specifications:		Start date	End date
NMDS - Admitted patient care		01/07/1999	
NMDS - Admitted patient mental health care		01/07/1999	
NMDS - Perinatal		01/07/1999	
NMDS - Admitted patient palliative care		01/07/1999	

Comments:

There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Sex

Identifying and Definitional Attributes

Knowledgebase ID:	000149	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The sex of the person.		
Context:	Required for analyses of service utilisation, needs for services and epidemiological studies.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	N		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Male	
	2	Female	
	3	Indeterminate	
	9	Not stated/inadequately described	
Guide for use:	An indeterminate sex category may be necessary for situations such as the classification of perinatal statistics when it is not possible for the sex to be determined.		
Verification rules:	Code 3 Indeterminate should be queried for people aged 90 days (3 months) or greater. For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnosis and procedure codes, for records grouped in Major diagnostic categories 12, 13 and 14, for valid grouping. For other Major diagnostic categories, sex conflicts should be queried.		

Collection methods: Code 9 is not to be an allowable option when data is being collected ie it is not to be a tick box on any collection forms or computer screens. Systems are to take account of any null values that may occur on the primary collection form. It is suggested that the following format be used for data collection:

What is your (the person's) sex?

___ Male ___ Female

The term 'sex' refers to the biological differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females – masculinity and femininity.

The Australian Bureau of Statistics advises that the correct terminology for this data element is sex.

Information collection for transsexuals and people with transgender issues should be treated in the same manner.

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

Related metadata: is used in the derivation of Diagnosis related group vers 1 supersedes previous data element Sex vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments: This item enables standardisation of the collection of information relating to sex (to include indeterminate), gender, people with transgender issues and transsexuals.

In collection systems (ie on forms and computer screens) Male and Female may be mapped to M and F respectively for collection purposes; however, they should be stored within information systems as the codes 1 and 2 respectively.

State/Territory of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000155	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	The State/Territory in which the birth occurred.	
Context:	NMDS - Perinatal: To enable analyses by State/Territory of delivery.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	New South Wales
	2	Victoria
	3	Queensland
	4	South Australia
	5	Western Australia
	6	Tasmania
	7	Northern Territory
	8	Australian Capital Territory
	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Other setting

Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	
DSS - Health care client identification	01/01/2003	

Comments:

Status of the baby

Identifying and Definitional Attributes

Knowledgebase ID: 000159 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/96

Definition: Status of the baby at birth.

Context: Perinatal statistics:
Essential to analyse outcome of pregnancy.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Live birth
2	Stillbirth (foetal death)
9	Not stated

Guide for use: Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (World Health Organization (WHO) 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Verification rules:

Collection methods:

Related metadata:

- is qualified by Apgar score at 1 minute vers 1
- relates to the data element concept Live birth vers 1
- is used in conjunction with Resuscitation of baby vers 2
- relates to the data element concept Stillbirth (foetal death) vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

NMDS - Perinatal

Start date

End date

01/07/1997

Comments:

Supporting data elements and data element concepts

Birthweight

Identifying and Definitional Attributes

Knowledgebase ID: 000021 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/96

Definition: The first weight of the foetus or baby obtained after birth. The World Health Organization further defines the following categories:

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

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications: **Start date** **End date**

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Establishment number

Identifying and Definitional Attributes

Knowledgebase ID:	000377	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	An identifier for an establishment, unique within the State or Territory.		
Context:	All health services.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Identification number
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5
Data domain:	Valid establishment number
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	is a composite part of Establishment identifier vers 4 supersedes previous data element Establishment number vers 3

Administrative Attributes

Source document:			
Source organisation:			
Information model link:	NHIM Organisation characteristic		
Data Set Specifications:		Start date	End date
	DSS - Health care client identification	01/01/2003	

Comments:	This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times. Establishment number should be a unique code for the health care establishment used in that State/Territory or uniquely at a national level.
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Establishment sector

Identifying and Definitional Attributes

Knowledgebase ID:	000379	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	A section of the health care industry with which a health care establishment can identify.		

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	1 Public
	2 Private

Guide for use:

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4
supersedes previous data element Establishment sector vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisational setting

Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Comments:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID: 000059 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/96

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

The World Health Organization identifies the following categories:

- Pre-term: less than 37 completed weeks (less than 259 days) of gestation
- Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation
- Post-term: 42 completed weeks or more (294 days or more) of gestation.

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Gestational age vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

Data Set Specifications: **Start date** **End date**

Comments:

Live birth

Identifying and Definitional Attributes

Knowledgebase ID: 000083 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/94

Definition: A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Status of the baby vers 1

Administrative Attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, Vol. 1, WHO 1992

Source organisation: National Health Data Committee
National Perinatal Data Development Committee
National Perinatal Data Advisory Committee

Information model link:

NHIM Birth event

Data Set Specifications: **Start date** **End date**

Comments:

Neonatal death

Identifying and Definitional Attributes

Knowledgebase ID:	000101	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/96	
Definition:	The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.	
Context:	Perinatal.	

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Status of the baby vers 1

Administrative Attributes

Source document:	International Classification of Diseases, Tenth Revision – WHO, 1992	
Source organisation:	National Perinatal Data Development Committee	
Information model link:	NHIM Death event	
Data Set Specifications:	Start date	End date

Comments:	Age at death during the first day of life (day zero) should be recorded in units of completed minutes or hours of life. For the second (day one), third (day two) and through 27 completed days of life, age at death should be recorded in days (WHO 1992).
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Neonate

Identifying and Definitional Attributes

Knowledgebase ID: 000103 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/95

Definition: A live birth who is less than 28 days old.

Context: Perinatal.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document: International Classification of Diseases and Related Health Problems, Tenth Revision – WHO, 1992

Source organisation: National Health Data Committee, National Perinatal Data Development Committee National Perinatal Data Advisory Committee

Information model link:

NHIM Person characteristic

Data Set Specifications: **Start date** **End date**

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

Perinatal period

Identifying and Definitional Attributes

Knowledgebase ID:	000124	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/96		
Definition:	The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.		
Context:	Perinatal.		

Relational and Representational Attributes

Datatype:
Representational form:
Representational layout:
Minimum size:
Maximum size:
Data domain:
Guide for use:
Verification rules:
Collection methods:
Related metadata:

Administrative Attributes

Source document:		
Source organisation:	National Perinatal Data Development Committee	
Information model link:		
NHIM	Physical wellbeing	
Data Set Specifications:		
	Start date	End date

Comments:	<p>This definition of perinatal period differs from that recommended by the World Health Organization (WHO). In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (WHO 1992) the perinatal period is defined as commencing 'at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth'.</p> <p>At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.</p> <p>To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.</p>
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Region code

Identifying and Definitional Attributes

Knowledgebase ID:	000378	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	An identifier for location of health services in a defined geographic or administrative area.		
Context:	All health services.		

Relational and Representational Attributes

Datatype:	Alphanumeric		
Representational form:	Code		
Representational layout:	AN		
Minimum size:	1		
Maximum size:	2		
Data domain:	Any valid region code created by a jurisdiction.		
Guide for use:	Domain values are specified by individual States/Territories. Regions may also be known as Areas or Districts.		
Verification rules:			
Collection methods:			
Related metadata:	is a composite part of Establishment identifier vers 4		

Administrative Attributes

Source document:			
Source organisation:			
Information model link:			
NHIM	Organisation characteristic		
Data Set Specifications:		Start date	End date
DSS - Health care client identification		01/01/2003	

Comments:

State/Territory identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000380	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	An identifier for Australian State or Territory.		
Context:	Public health care.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	N		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	New South Wales	
	2	Victoria	
	3	Queensland	
	4	South Australia	
	5	Western Australia	
	6	Tasmania	
	7	Northern Territory	
	8	Australian Capital Territory	
	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)	

Guide for use:

Verification rules:

Collection methods:

Related metadata:	relates to the data element Address type vers 1
	relates to the data element Australian postcode vers 1
	relates to the data element Postal delivery point identifier vers 1
	is a composite part of Establishment identifier vers 4
	supersedes previous data element State identifier vers 2
	relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document: Adapted from Australian Standard Geographic Classification, Australian Bureau of Statistics, Catalogue No. 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

Data Set Specifications:

DSS - Health care client identification

Start date

End date

01/01/2003

Comments:

Stillbirth (foetal death)

Identifying and Definitional Attributes

Knowledgebase ID:	000160	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/96		
Definition:	<p>A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight.</p> <p>The death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.</p>		
Context:	Perinatal.		

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	

Administrative Attributes

Source document:			
Source organisation:	National Perinatal Data Development Committee		
Information model link:	NHIM Death event		
Data Set Specifications:	Start date	End date	

Comments:	<p>The World health Organization definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.</p> <p>Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.</p>
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