Perinatal Services BC
An agency of the Provincial Health Services Authority

Application for Data for Research Purposes from Perinatal Services BC
BCPDR Data Fields Checklist

Project Title		*Applies Subpopulation (s)*	

Date Range	yyyy/mm/dd	to	yyyy/mm/dd
Other date range criteria:			

BC Perinatal Data Registry (BCPDR) (April 1, 2000 to March 31, 2015)

The BC Perinatal Data Registry (BCPDR) captures maternal, fetal, and neonatal data for an estimated 99% of all births that occur in BC. The BCPDR captures data for both the mother (Delivery episode, Postpartum Transfer/Readmissions ≤42 days) and the baby (Baby Newborn episode, Baby Transfer/Readmissions ≤28 days). The available BCPDR data fields are separated into these four suites below.
For detailed abstraction guidelines and questions about the definitions for specific fields in the BCPDR, please refer to the applicable version(s) of the BCPDR Reference Manual, located at: http://www.perinatalservicesbc.ca/health-professionals/data-surveillance/perinatal-data-registry. You can also refer to the Frequently Asked Questions at: http://www.perinatalservicesbc.ca/Documents/Data-Surveillance/PDR/DataRequests/DAR_FAQ.pdf

For all projects requesting PSBC data, you must specify how you want to apply the following inclusion/exclusion criteria. Also, please ensure that your cohort definition (page 18 of the DAR) clearly addresses the inclusion/exclusion criteria:

- **Unlinked records**: Whether only linked mother/baby records should be included in the extract, or if all mothers and babies meeting the cohort definition should be included even if they are not linked. Please specify:
- **Live/Stillbirths**: Whether live births and stillbirths are requested. Please specify:
- **Late terminations of pregnancy**: Note that pregnancies involving a late Therapeutic Abortion (TA) delivered at >=20 weeks gestational age or that result in the delivery of a fetus/product of conception >=500 grams may be captured in the Mother Delivery Episode and/or Baby Newborn Episode records. Please indicate which of the following three options is requested: (1) Records involving TAs should be removed from the cohort(s), (2) Records involving TAs should be included in the cohort(s) but do not need to be identified. TA records may be abstracted as either stillbirths or neonatal deaths, or (3) Identified TA records required. Please specify (**Note that a research rationale describing why identified TA records are required must be supplied before it will be considered for release**):

Mother Delivery Episode of Care Information (April 1, 2000 to March 31, 2015)

Delivery records include deliveries in acute care facilities and deliveries at home attended by registered midwives.

NOTE: Until March 31, 2014, a woman who delivered at home with a registered midwife who was admitted to acute care within 24 hours of delivery will have the acute care admission as her Delivery record (total record count=1). Effective April 1, 2014, a woman who delivered at home with a registered midwife and who was admitted to acute care within 24 hours of delivery will have a home Delivery record and a subsequent Postpartum acute care record (total record count=2).

☐	Place of Mother's usual residence – HA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Authority (HA) of mother's usual residence as determined by resident postal code.	
☐	Place of Mother's usual residence – HSDA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Service Delivery Area (HSDA) of mother's usual residence as determined by resident postal code.	

☐	Place of Mother's usual residence – LHA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Local Health Area (LHA) of usual mother's residence as determined by resident postal code.	
☐	Place of Mother's usual residence – FSA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The first three characters of mother's resident postal code (i.e., Forward Sortation Area).	
☐	Baby sequence	Sequence of baby in the current pregnancy.	
☐	Number of births	Total number of babies delivered in the current pregnancy.	
☐	Mother's date of birth – Year		
☐	Mother's date of birth – Month		
☐	Mother's date of birth – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**		
☐	Mother age at delivery **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Mother's age (in years) calculated at date of delivery.	
☐ **OR** ☐	Place of delivery – Institution number **– Replaced by project-specific identification number** Place of delivery – Institution number **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Location where mother received care.	
☐ **OR** ☐	Institution from **– Replaced by project-specific identification number** Institution from **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution from which mother arrived to the current episode of care.	
☐	Mother transferred in	A flag (i.e., Yes, Null) to indicate the mother was transferred in from another acute care institution for the delivery episode of care.	
☐ **OR** ☐	Institution to **– Replaced by project-specific identification number** Institution to **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution to which mother was transferred from the current episode of care.	
☐	Mother transferred out	A flag (i.e., Yes, Null) to indicate the mother was transferred out to another institution after delivery.	
☐	Mother transferred up	A flag (i.e., Yes, Null) to indicate the mother with delivery episode was transferred directly from delivery hospital to a hospital with a higher level of care.	
☐	Admission date – Year	Year mother was admitted for the current episode of care.	

☐	Admission date – Month	Month mother was admitted for the current episode of care.	
☐	Admission date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day mother was admitted for the current episode of care.	
☐	Admission time	Time mother was admitted for the current episode of care.	
☐	Discharge date – Year	Year mother was discharged from the current episode of care.	
☐	Discharge date – Month	Month mother was discharged from the current episode of care.	
☐	Discharge date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day mother was discharged from the current episode of care.	
☐	Discharge time	Time mother was discharged from the current episode of care.	
☐	Fiscal year	The fiscal year during which the mother was discharged (i.e., Apr 1 to Mar 31).	
☐	Total length of stay	Total length of stay (in hours) for the delivery hospitalization. Note: Always null for deliveries at home.	
☐	Antepartum length of stay	Time, in hours, between admission to delivery episode and delivery of the first baby. Note: Always null for deliveries at home.	
☐	Postpartum length of stay	Time, in hours, between delivery of the placenta and discharge from the episode of care. Note: Always null for deliveries at home.	
Past Obstetric History			
☐	Gravida	Total number of prior plus current pregnancies.	
☐	Parity	Indicates whether woman has previously delivered a pregnancy that reached 20 weeks gestation or 500 grams birth weight (i.e., multiparous, nulliparous, unknown).	
☐	Number of previous term deliveries	Total number of previous pregnancies delivered at ≥ 37 completed weeks gestation.	
☐	Number of previous preterm deliveries	Total number of previous pregnancies delivered between 20 to 36 completed weeks gestation.	
☐	Number of living children	Total number of children the mother has given birth to, who are currently living.	
☐	Number of previous spontaneous abortions	Total number of previous natural or spontaneous losses in pregnancy < 20 completed weeks and < 500 grams.	
☐	Number of previous cesarean sections	Total number of previous pregnancies resulting in a cesarean delivery ≥ 20 completed weeks gestation.	
☐	Number of previous vaginal deliveries	Total number of previous pregnancies resulting in a vaginal delivery ≥ 20 completed weeks gestation.	
☐	Prior neonatal death	A flag (i.e., Yes, Null) to indicate mother had at least one prior live born infant, who died within the first 28 days of life.	
☐	Prior stillbirth	A flag (i.e., Yes, Null) to indicate mother had at least one	

		prior stillbirth or intrauterine death documented.	
☐	Prior low birthweight baby	A flag (i.e., Yes, Null) to indicate mother had at least one prior low birth weight baby (< 2,500 g) at ≥ 20 weeks gestation.	
☐	Prior macrosomic baby	A flag (i.e., Yes, Null) to indicate mother had at least one prior macrosomic baby (birth weight > 4,000g).	
☐	Rh isoimmunization (past pregnancy)	A flag (i.e., Yes, Null) to indicate mother had a previous pregnancy in which isoimmunization occurred.	
☐	Major congenital anomalies (past pregnancy)	A flag (i.e., Yes, Null) to indicate mother had at least one previous pregnancy in which the baby or fetus displayed a major congenital anomaly.	
☐	History of mental illness – Any	A flag (i.e., Yes, Null) to indicate any history of mental illness (depression, previous postpartum depression, anxiety, bipolar disorder, other, or unknown type) prior to or during the current pregnancy.	2008/09 onwards
☐	History of mental illness – Anxiety	A flag (i.e., Yes, Null) to indicate mother has documented history of anxiety.	2008/09 onwards
☐	History of mental illness – Depression	A flag (i.e., Yes, Null) to indicate mother has documented history of depression.	2008/09 onwards
☐	History of mental illness – Bipolar	A flag (i.e., Yes, Null) to indicate mother has documented history of bipolar disorder.	2008/09 onwards
☐	History of mental illness – Postpartum depression (past pregnancy)	A flag (i.e., Yes, Null) to indicate mother has documented history of postpartum depression.	2008/09 onwards
☐	History of mental illness – Other	A flag (i.e., Yes, Null) to indicate mother has documented history of other mental illness.	2008/09 onwards
☐	History of mental illness – Unknown	A flag (i.e., Yes, Null) to indicate mother has documented history of mental illness, type unspecified.	2008/09 onwards
Current Pregnancy			
☐	First contact with physician/midwife date – Year	Year of mother's first contact with a physician/midwife for this pregnancy.	
☐	First contact with physician/midwife date – Month	Month of mother's first contact with a physician/midwife for this pregnancy.	
☐	First contact with physician/midwife date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of mother's first contact with a physician/midwife for this pregnancy.	
☐	Number of antenatal visits	Total number of antenatal visits with the primary care provider.	
☐	Total antenatal hospital admissions (prior to delivery admission)	Total prior inpatient hospital admissions, to any facility, for any reason, during the current pregnancy (excluding current delivery admission).	
☐	Pre-pregnancy weight	Mother's weight (in kilograms) before pregnancy or ≤ 11 weeks completed gestation. Note: Approx. 21% missing.	
☐	Admission weight	Mother's weight (kg) at the time of admission for delivery, or the last weight documented ≤ 7 days prior to delivery. Note: Approx. 29% missing.	

☐	Weight gain in pregnancy	Mother's weight gain (in kilograms) during the pregnancy. Note: Approx. 39% missing.	
☐	Height	Mother's height (in cm). Note: Approx. 20% missing.	
☐	Body Mass Index (BMI)	Body Mass Index number of the mother, based on pre-pregnancy weight. Note: Approx. 30% missing.	
☐	Body Mass Index (BMI) group	Body mass index category of the mother, based on pre-pregnancy weight (e.g., underweight, normal, overweight).	
☐	Lone Parent	A flag (i.e., Yes, No, Unknown) to indicate lone parent status.	2000/01-2007/08
☐	Blood type	Classification of mother's blood type (e.g., A+, AB-).	
☐	Last Normal Menstrual Period (LNMP) date – Year	Year of LNMP. Note: Approx. 24% missing.	
☐	Last Normal Menstrual Period (LNMP) date – Month	Month of LNMP. Note: Approx. 24% missing.	
☐	Last Normal Menstrual Period (LNMP) date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of LNMP. Note: Approx. 24% missing.	
☐	First ultrasound date – Year	Year of first ultrasound (< 20 weeks). Note: Approx. 28% missing.	
☐	First ultrasound date – Month	Month of first ultrasound (< 20 weeks). Note: Approx. 28% missing.	
☐	First ultrasound date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of first ultrasound (< 20 weeks). Note: Approx. 28% missing.	
☐	Gestational age at first ultrasound – completed weeks	Gestational age, in weeks, when the first ultrasound (<20 weeks) was performed.	
☐	Gestational age at first ultrasound – days	Gestational age, in days, when the first ultrasound (<20 weeks) was performed.	2008/09 onwards
☒	Gestational age at delivery (by LNMP)	Gestational age at delivery in completed weeks (calculated by Last Normal Menstrual Period; LNMP). Note: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☒	Gestational age at delivery (by first ultrasound date)	Gestational age at delivery in completed weeks (calculated by first ultrasound date). Note: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☒	Gestational age at delivery (by algorithm)	Gestational age at delivery in completed weeks, calculated by algorithm incorporating LNMP, first ultrasound, newborn examination, and maternal chart. Note 1: Algorithms updated in 2013. Note 2: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☐	Rh immunoglobulin given, earliest date antepartum – Year	Year of the first antepartum injection of Rh immunoglobulin administered to an Rh-negative mother during the current pregnancy.	
☐	Rh immunoglobulin given, earliest date antepartum – Month	Month of the first antepartum injection of Rh immunoglobulin administered to an Rh-negative mother during the current pregnancy.	

☐	Rh immunoglobulin given, earliest date antepartum – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the first antepartum injection of Rh immunoglobulin administered to an Rh-negative mother during the current pregnancy.	
☐	Hemoglobin level third trimester	Lowest hemoglobin value for the third trimester.	
☐	Bleeding (<20 weeks)	A flag (i.e., Yes, Null) to indicate mother had antepartum bleeding in pregnancy < 20 weeks gestation.	
☐	Antepartum hemorrhage (≥20 weeks)	A flag (i.e., Yes, Null) to indicate mother had antepartum hemorrhage or bleeding in pregnancy ≥ 20 weeks gestation, including bleeding from cervical polyps.	
☐	Pregnancy induced hypertension	A flag (i.e., Yes, Null) to indicate care provider diagnosed mother with gestational hypertension during the current pregnancy.	
☐	Proteinuria	A flag (i.e., Yes, Null) to indicate care provider diagnosed proteinuria.	
☐	Rh blood antibodies	A flag (i.e., Yes, Null) to indicate mother developed or showed signs of Rh (anti-D) antibodies in her blood in the current pregnancy.	
☐	Other blood antibodies	A flag (i.e., Yes, Null) to indicate mother developed or showed signs of antibodies in her blood, other than Rh antibodies, in the current pregnancy.	
☐	Intrauterine growth restriction (IUGR) identified as risk during antenatal period	A flag (i.e., Yes, Null) to indicate health care provider identified intrauterine growth restriction (IUGR) during the antenatal period.	
☐	Diabetes (any)	A flag (i.e., Yes, Null) to indicate pre-existing or gestational diabetes.	
☐	Gestational diabetes (insulin dependent)	A flag (i.e., Yes, Null) to indicate gestational diabetes (insulin dependent).	
☐	Gestational diabetes (non-insulin dependent)	A flag (i.e., Yes, Null) to indicate gestational diabetes (non-insulin dependent).	
☐	Diabetes mellitus (insulin dependent)	A flag (i.e., Yes, Null) to indicate pre-existing diabetes mellitus Type 1 or Type 2, insulin used.	
☐	Diabetes mellitus (non-insulin dependent)	A flag (i.e., Yes, Null) to indicate pre-existing diabetes mellitus Type 1 or Type 2, insulin not used.	
☐	Abnormal glucose factor	A flag (i.e., Yes, Null) to indicate care provider diagnosed Abnormal Glucose Factor in pregnancy.	2000/01-2010/11
☐	Hypertension (≥ 140/90)	A flag (i.e., Yes, Null) to indicate mother had a blood pressure reading of ≥ 140/90 on two consecutive readings during the pregnancy, prior to labour. NOTE: This variable alone is insufficient to identify women diagnosed with hypertension.	
☐	Antihypertensive drugs	A flag (i.e., Yes, Null) to indicate mother received antihypertensive drugs during her pregnancy (antepartum period only).	
☐	Hypertensive chronic renal disease	A flag (i.e., Yes, Null) to indicate mother had hypertension associated with chronic renal disease in the current pregnancy.	

☐ Hypertension due to other causes	A flag (i.e., Yes, Null) to indicate mother had hypertension as a result of another cause during pregnancy, labour, or the postpartum period.	
☐ Drug use during pregnancy identified as a risk	A flag (i.e., Yes, Null) to indicate care provider lists mother's use of drugs (prescription, non-prescription, illicit) as a risk factor in this pregnancy.	2000/01-2007/08
☐ Substance use during pregnancy – Any	A flag (i.e., Yes, Null) to indicate mother used any of the following substances at any time during the current pregnancy: Heroin/opioids, cocaine, methadone, solvents, or marijuana; OR care provider lists use of prescription, 'other', or unknown other drug as a risk to the pregnancy.	2008/09 onwards
☐ Substance use during pregnancy – Heroin/opioids	A flag (i.e., Yes, Null) to indicate heroin/opioid use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Cocaine	A flag (i.e., Yes, Null) to indicate cocaine use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Methadone	A flag (i.e., Yes, Null) to indicate methadone use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Solvents	A flag (i.e., Yes, Null) to indicate solvent use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Prescription drugs	A flag (i.e., Yes, Null) to indicate use of a prescription drug is noted as a risk in the pregnancy.	2008/09 onwards
☐ Substance use during pregnancy – Marijuana	A flag (i.e., Yes, Null) to indicate marijuana use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Other	A flag (i.e., Yes, Null) to indicate other substance use during pregnancy, including before woman knew she was pregnant.	2008/09 onwards
☐ Substance use during pregnancy – Unknown	A flag (i.e., Yes, Null) to indicate care provider lists mother's use of an unspecified drug as a risk at any time during current pregnancy.	2008/09 onwards
☐ No selected risks	A flag (i.e., Yes, Null) to indicate the mother did not have any of the specific risk factors collected in the PDR identified in the current pregnancy, past pregnancies, or in the mother's medical history.	
☐ Alcohol during pregnancy identified as a risk	A flag (i.e., Yes, Null) to indicate care provider lists mother's use of alcohol as a risk factor in this pregnancy.	
☐ T-ACE score	Final value of T-ACE questionnaire. Note: >99% null values.	2000/01-2007/08
☐ TWEAK score	Final value of TWEAK questionnaire. Note: >96% null values	2008/09 onwards
☐ Average number of alcoholic drinks per week	Average number of alcoholic drinks consumed per week by mother during current pregnancy.	2008/09 onwards
☐ Binge drinking	Mother consumed ≥ 4 alcoholic drinks at one time during the current pregnancy.	2008/09 onwards
☐ Smoking during current pregnancy	Mother smoked tobacco products during pregnancy.	

☐	Cigarettes per day	Number of documented cigarettes smoked per day during pregnancy.	
☐	Exposure to second hand smoke	Mother was regularly exposed to indoor smoke any time during the current pregnancy, either at home or work.	2008/09 onwards
☐	HIV test done during pregnancy	HIV testing was performed during this pregnancy.	2004/05 onwards
☐	Maternal serum screening offered during current pregnancy	Indicates whether maternal serum screening offered during current pregnancy (i.e., Yes, No, Unknown).	2004/05 onwards
☐	Group B strep test done during current pregnancy	Mother had Group B Strep (GBS) testing done during current pregnancy (i.e., Yes, No, Unknown).	2004/05 onwards
☐	Group B strep testing results	Indicates Group B strep testing results (i.e., positive, negative, unknown).	2004/05 onwards
☐	HBsAg testing	Indicates Hepatitis B surface antigen (HBsAg) testing was performed at any time during the current pregnancy, prior to delivery (i.e., Yes, No, Unknown).	2008/09 onwards
☐	HBsAg testing results	Indicates HBsAg testing results (i.e., positive, negative, unknown).	2008/09 onwards
☐	In vitro fertilization used for current pregnancy	Indicates mother had in-vitro fertilization to achieve the current pregnancy. (i.e., Yes, No, Unknown).	2008/09 onwards
☐	School years completed	Total number of school years completed by the mother. Note: Approx. 80% Null values.	2004/05 onwards
Labour and delivery			
☐	Cervical dilation on admission	Measurement of cervical dilation, in centimeters, taken within the first hour of admission for the delivery episode.	
☐	Cervical dilation prior to cesarean	Last recorded measurement of cervical dilation during active labour, in centimeters, prior to cesarean delivery.	2008/09 onwards
☐	Rupture of membranes date – Year	Year of artificial/spontaneous rupture of the amniotic sac.	
☐	Rupture of membranes date – Month	Month of artificial/spontaneous rupture of the amniotic sac.	
☐	Rupture of membranes date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of artificial/spontaneous rupture of the amniotic sac.	
☐	Rupture of membranes time	Time of artificial/spontaneous rupture of the amniotic sac (i.e., HH:MM:00.0000000).	
☐	Length of time from rupture of membranes to first stage of labour (hours)	Hours between rupture of membranes and beginning of first stage of labour. Based on first infant delivered.	
☐	Start of first stage of labour date – Year	Year when there was onset of regular uterine contractions and cervical dilation.	
☐	Start of first stage of labour date – Month	Month when there was onset of regular uterine contractions and cervical dilation.	
☐	Start of first stage of labour date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day when there was onset of regular uterine contractions and cervical dilation.	
☐	Start of first stage of labour time	Time when there was onset of regular uterine contractions and cervical dilation (i.e., HH:MM:00.0000000).	

☐	Length of the first stage of labour	Duration of first stage of labour (rupture of membranes to full cervical dilation), in hours.	
☐	Start of second stage of labour date – Year	Year there was full cervical dilation and delivery of the newborn commenced.	
☐	Start of second stage of labour date – Month	Month there was full cervical dilation and delivery of the newborn commenced.	
☐	Start of second stage of labour date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day there was full cervical dilation and delivery of the newborn commenced.	
☐	Start of second stage of labour time	Time there was full cervical dilation and delivery of the newborn commenced (i.e., HH:MM:00.0000000).	
☐	Length of the second stage of labour	Duration of second stage of labour (full cervical dilation to delivery of infant), in hours.	
☐	Baby delivery date – Year	Year baby was delivered.	
☐	Baby delivery date – Month	Month baby was delivered.	
☐	Baby delivery date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day baby was delivered.	
☐	Baby delivery time	Time baby was delivered (i.e., HH:MM:00.0000000).	
☐	Placenta delivery date – Year	Year of placenta delivery date.	
☐	Placenta delivery date – Month	Month of placenta delivery date.	
☐	Placenta delivery date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of placenta delivery date.	
☐	Placenta delivery time	Hour placenta was delivered (i.e., HH:MM:00.0000000).	
☐	Length of third stage of labour	Duration of third stage of labour (delivery of infant to delivery of placenta), in hours.	
☐	Length of time from rupture of membranes to first baby delivery time	Time between rupture of membranes and delivery, in hours.	
☐	Fetal surveillance during labour	Fetal surveillance during labour (i.e., external electronic fetal monitoring, internal electronic fetal monitoring, external and internal electronic monitoring, no labour, no electronic monitoring).	2000/01-2003/04
		Fetal surveillance during labour (i.e., auscultation only, auscultation and external electronic fetal monitoring, external electronic fetal monitoring only, internal electronic fetal monitoring only, auscultation and internal electronic fetal monitoring, external and internal electronic fetal monitoring, all, no labour, none).	2004/05-onwards
☐	Labour initiation – spontaneous	A flag (i.e., Yes, Null) to indicate onset of regular contractions and progressive dilation of the cervix occurred without instrumental or medicinal assistance.	

☐	Labour initiation – induced	A flag (i.e., Yes, Null) to indicate instrumental or medicinal assistance was used to initiate labour.	
☐	Labour initiation – none	A flag (i.e., Yes, Null) to indicate woman did not labour.	
☐	Labour initiation – unknown	A flag (i.e., Yes, Null) to indicate unknown how labour commenced.	
☐	Labour type	Indicates labour type (i.e., spontaneous, induced, no labour, unknown)	
☐	Labour induction – Artificial rupture of membranes (ARM)	A flag (i.e., Yes, Null) to indicate labour was induced using artificial rupture of membranes.	
☐	Labour induction – Oxytocin	A flag (i.e., Yes, Null) to indicate labour was induced using oxytocin.	
☐	Labour induction – Prostaglandin	A flag (i.e., Yes, Null) to indicate labour was induced using prostaglandin.	
☐	Labour induction – Other agent	A flag (i.e., Yes, Null) to indicate labour was induced using another method.	
☐	Primary indication for induction	Indicates the primary indication that an external agent was used to initiate labour (i.e., post-term, prelabour ROM, fetal compromise, other maternal condition, logistics, fetal demise, other, unknown, not applicable). Note that the following options were added in 2008/09: Hypertension in pregnancy, antepartum hemorrhage, chorioamnionitis, diabetes.	
☐	Labour augmentation	A flag (i.e., Yes, Null) to indicate labour was augmented.	
☐	Method of labour augmentation – Artificial rupture of membranes (ARM)	A flag (i.e., Yes, Null) to indicate labour was augmented using artificial rupture of membranes.	
☐	Method of labour augmentation – Oxytocin	A flag (i.e., Yes, Null) to indicate labour was augmented using oxytocin.	
☐	Method of labour augmentation – Other agent	A flag (i.e., Yes, Null) to indicate labour was augmented using another method.	
☐	Method of labour augmentation – Prostaglandin	A flag (i.e., Yes, Null) to indicate labour was augmented using prostaglandin.	2000/01-2007/08
☐	Anesthesia/analgesia during labour – None	A flag (i.e., Yes, Null) to indicate no anesthetic or analgesic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Entonox (nitronox)	A flag (i.e., Yes, Null) to indicate entonox (nitronox) anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Local	A flag (i.e., Yes, Null) to indicate local anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Pudendal	A flag (i.e., Yes, Null) to indicate pudendal anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Epidural	A flag (i.e., Yes, Null) to indicate epidural anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Spinal	A flag (i.e., Yes, Null) to indicate spinal anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – General	A flag (i.e., Yes, Null) to indicate general anesthetic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Narcotics	A flag (i.e., Yes, Null) to indicate mother received narcotics during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Other	A flag (i.e., Yes, Null) to indicate other anesthetic or analgesic was given during labour (first, second or third stage).	
☐	Anesthesia/analgesia during labour – Unknown	A flag (i.e., Yes, Null) to indicate type of anesthetic or analgesic administered during labour (first, second or third stage) is unknown.	

☐ Mode of delivery	Method of extraction/delivery of newborn from the mother (i.e., cesarean section, vaginal)	
☐ Mode of delivery – detailed	Expanded classification of method of extraction/delivery of newborn from the mother (i.e., emergency primary, emergency repeat, elective primary, elective repeat, forceps and vacuum, forceps, vacuum, other instrument, spontaneous).	
☐ Cesarean section type	Type of cesarean section (i.e., primary elective, primary emergent, repeat elective, repeat emergent).	
☐ Cesarean section incision	Type of cesarean section incision.	
☐ Primary indication for cesarean delivery	Primary/principal reason (indication) for cesarean delivery (i.e., breech, dystocia/CPD, non-reassuring fetal heart rate pattern, repeat cesarean, abruptio placenta, placenta previa, other, malposition/malpresentation, active herpes. Note that the following option was added in 2008/09: VBAC declined or maternal request)	
☐ Vaginal birth after cesarean (VBAC) eligible	Mother is eligible to deliver this pregnancy by VBAC.	
☐ Vaginal birth after cesarean (VBAC) attempted	Whether woman attempted a VBAC in this pregnancy.	
☐ Vaginal birth after cesarean (VBAC) successful	Woman had a successful VBAC in this pregnancy.	
☐ Deliverer provider type	The health care provider (or person) who physically delivers the baby. Note: not necessarily the same as the provider who was seen for antenatal care.	
☐ Baby position in labour	Position of baby's head relative to the birth canal during labour.	
☐ Baby position at delivery	Position of baby's head relative to the birth canal at delivery.	
☐ Baby presentation in labour	Part of the baby's body that is presenting in reference to the birth canal during labour.	
☐ Baby presentation at delivery	Part of baby's body that is presenting in reference to the birth canal at the time of delivery.	
☐ Obstetric trauma	A flag (i.e., Yes, Null) to indicate woman experienced obstetric trauma during the current delivery episode.	
☐ Perineal trauma – Intact perineum	A flag (i.e., Yes, Null) to indicate perineum/vagina/cervix was intact.	
☐ Perineal trauma – Unknown	A flag (i.e., Yes, Null) to indicate condition of the perineum/vagina/cervix is unknown.	
☐ Perineal trauma – Episiotomy	A flag (i.e., Yes, Null) to indicate an episiotomy was done.	
☐ Perineal trauma – Episiotomy type	Type of episiotomy performed (i.e., median, mediolateral).	
☐ Perineal trauma – Laceration	Tear and/or rupture occurred to the vagina or perineum during delivery, excluding abrasions.	
☐ Perineal trauma – Laceration degree	Highest degree of laceration sustained during delivery (i.e., 1-4).	
☐ Perineal trauma – Cervical tear	A flag (i.e., Yes, Null) to indicate mother experienced cervical injury during delivery.	
☐ Perineal trauma – Other tear	A flag (i.e., Yes, Null) to indicate another type of tear or laceration to the perineum was sustained during delivery.	
Other Episode of Care Information		
☐ Blood transfusion given	A flag (i.e., Yes, Null) to indicate mother received whole or packed red blood cells during this admission.	
☐ Blood transfusion units – Number of units transfused antepartum	Total number of units of whole or packed red blood cells the mother received during the antepartum period of this pregnancy.	

☐	Blood transfusion units – Number of units transfused intrapartum	Total number of units of whole or packed red blood cells the mother received during the intrapartum period of this pregnancy.	
☐	Blood transfusion units – Number of units transfused postpartum	Total number of units of whole or packed red blood cells the mother received during the postpartum period of this pregnancy.	
☐	Blood transfusion units – Total number of units transfused	Total number of units of whole or packed red blood cells the mother received during this pregnancy.	
☐	Eligible for postpartum Rh immunoglobulin	Mother is eligible to receive Rh Immunoglobulin postpartum (i.e., Yes, No, Unknown).	
☐	Date postpartum Rh immunoglobulin – Year	Year of the postpartum injection of Rh immunoglobulin during the delivery episode.	
☐	Date postpartum Rh immunoglobulin – Month	Month of the postpartum injection of Rh immunoglobulin during the delivery episode.	
☐	Date postpartum Rh immunoglobulin – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the postpartum injection of Rh immunoglobulin during the delivery episode.	
☐	Drugs received during delivery admission – Antihypertensives	A flag (i.e., Yes, Null) to indicate mother received antihypertensive medication during the delivery episode of care.	
☐	Drugs received during delivery admission – Steroids for lung maturation	A flag (i.e., Yes, Null) to indicate mother received steroid medication during the inpatient delivery episode of care, or for transport.	
☐	Drugs received during delivery admission – Other drugs for lung maturation	A flag (i.e., Yes, Null) to indicate other medications were administered to mother for fetal lung maturation during the inpatient delivery episode of care, or for transport.	
☐	Drugs received during delivery admission – Antibiotics	A flag (i.e., Yes, Null) to indicate mother received antibiotics during the delivery episode of care.	
☐	Drugs received during delivery admission – CS prophylactic antibiotics	A flag (i.e., Yes, Null) to indicate mother received prophylactic antibiotics one hour before or after c/section delivery (inclusive of intra-operative antibiotics).	2008/09 onwards
☐	Drugs received during delivery admission – Tocolytics	A flag (i.e., Yes, Null) to indicate mother received medication to suppress premature labour during the inpatient delivery episode of care or transport.	
☐	Health care provider(s) service	Provider's specialty service number.	
☐	Health care provider(s) type	Health care provider's role in the care of the mother during episode of care.	
☐	Midwife involved in maternal or neonatal care	Midwife involved in the care of the mother or neonate. Midwife does not necessarily deliver the baby (i.e., midwife, no midwife).	
☐	Midwife cases only - Intended place of delivery	Midwife Cases - Where mother plans to deliver (i.e., hospital, home, unknown).	
☐	Midwife cases only - Actual place of delivery	Midwife Cases - Where mother actually delivers (i.e., hospital, home, other).	
Post delivery information (delivery episode)			
☐	HELLP Syndrome	A flag (i.e., Yes, Null) to indicate mother was diagnosed with HELLP Syndrome.	2008/09-onwards
☐	Acute Fatty Liver	A flag (i.e., Yes, Null) to indicate mother diagnosed with acute fatty liver during current pregnancy or postpartum period.	2008/09-onwards
☐	Liver hematoma	A flag (i.e., Yes, Null) to indicate mother diagnosed with liver hematoma during current pregnancy or postpartum period.	2008/09-onwards

☐	Postpartum Special Care Unit Days	Number of days mother spent in any Special Care Unit (ICU, CCU, etc.).	2008/09-onwards
☐	Postpartum hemoglobin date – Year	Year of mother's lowest postpartum hemoglobin result during episode of care.	2008/09-onwards
☐	Postpartum hemoglobin date – Month	Month of mother's lowest postpartum hemoglobin result during episode of care.	2008/09-onwards
☐	Postpartum hemoglobin date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of mother's lowest postpartum hemoglobin result during episode of care.	2008/09-onwards
☐	Postpartum hemoglobin value	Value of postpartum hemoglobin test result during episode of care.	2008/09-onwards
☐	Postpartum infection	Mother had an infection during the postpartum period (i.e., Yes, No, Unknown).	2008/09-onwards
☐	Postpartum wound infection	A flag (i.e., Yes, Null) to indicate mother had a postpartum wound infection.	2008/09-onwards
☐	Postpartum wound infection – Type	Specific location of the mother's postpartum wound infection.	2008/09-onwards
☐	Postpartum wound infection – Severity	Degree of the mother's postpartum wound infection.	2008/09-onwards
☐	Postpartum urinary tract infection – Type	Type of postpartum urinary tract infection	2008/09-onwards
☐	Postpartum urinary tract infection agent – Infectious agent 1	Most significant infectious agent causing positive maternal urine culture results during the postpartum period.	2008/09-onwards
☐	Postpartum urinary tract infection agent – Infectious agent 2	Other infectious agent causing positive maternal urine culture results during the postpartum period.	2008/09-onwards
☐	Postpartum positive blood culture	A flag (i.e., Yes, Null) to indicate mother's blood culture test results are positive.	2008/09-onwards
☐	Postpartum positive blood culture agent – Infectious Agent 1	Most significant infectious agent causing positive maternal blood culture results during the postpartum period.	2008/09-onwards
☐	Postpartum positive blood culture agent – Infectious Agent 2	Other infectious agent causing positive maternal blood culture results during the postpartum period.	2008/09-onwards
☐	Postpartum positive other culture	A flag (i.e., Yes, Null) to indicate lab culture results were positive (other than urine or blood).	2008/09-onwards
☐	Postpartum positive other culture agent – Infectious agent 1	Most significant infectious agent from other maternal positive culture results during the postpartum period.	2008/09-onwards
☐	Postpartum positive other culture agent – Infectious agent 2	Other infectious agent from other maternal positive culture results during the postpartum period.	2008/09-onwards
☐	Main Patient Service	Categorizes mothers according to related diseases, conditions and treatments.	
Diagnosis and procedures			
☐	Diagnosis Prefix	Alphanumeric character to further define a diagnosis code.	
☐	Diagnosis Code **– Please list the Diagnostic Codes (ICD-9 and/or ICD-10-CA) that you are requesting:**	Medical diagnostic code reflecting the diagnosis or condition of mother while in hospital. Note: International Classification of Diseases - ICD 9 - Assigned from April 1, 2000 to March 31, 2004. ICD-10-CA - Assigned starting with April 1, 2004 discharges using ICD-10-CA v2003, v2006, v2009, or v2012 (as applicable).	
☐	Diagnosis Type	Diagnosis type corresponding with the diagnosis codes (e.g., most responsible diagnosis, pre-admit comorbidity, secondary diagnosis, etc.)	
☐	Procedure Code **– Please list the Procedure Codes (CCP and/or CCI) that you are requesting:**	Code(s) for procedures performed during the episode of care. Note: Canadian Classification of Diagnostic,	

		Therapeutic and Surgical Procedures (CCP) - Assigned from April 1, 2000 to March 31, 2004 discharges. Canadian Classification of Health Interventions (CCI) - Assigned starting with April 1, 2004 discharges using CCI v2003, v2006, v2009, or v2012 (as applicable).	
☐	Procedure status	Procedure status attribute.	2004/05-onwards
☐	Procedure location	Procedure anatomical location.	2004/05-onwards
☐	Procedure extent	Procedure extent.	2004/05-onwards
☐	Procedure Date – Year	Year of the procedure.	
☐	Procedure Date – Month	Month of the procedure.	
☐	Procedure Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the procedure.	
☐	Procedure doctor service	The procedure provider service.	
☐	Anesthetic agent for procedure	Type of anesthesia used for the procedure (e.g., local, epidural, spinal, etc…).	
Mother Postpartum Transfer/Readmission Episode of Care Information (patient discharges from April 1, 2008 to March 31, 2015)			
☐	Place of Mother's usual residence – HA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Authority (HA) of mother's usual residence as determined by resident postal code.	
☐	Place of Mother's usual residence – HSDA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Service Delivery Area (HSDA) of mother's usual residence as determined by resident postal code.	
☐	Place of Mother's usual residence – LHA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Local Health Area (LHA) of usual mother's residence as determined by resident postal code.	
☐	Place of Mother's usual residence – FSA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The first three characters of mother's resident postal code (i.e., Forward Sortation Area).	
☐	Mother's date of birth – Year		
☐	Mother's date of birth – Month		
☐	Mother's date of birth – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**		
☐ ☐	Place of postpartum admission From **– Replaced by project-specific identification number** **OR** Place of postpartum admission **– Research rationale describing why this field is required must be**	Location where mother received care.	

	supplied before it will be considered for release:		
☐	Institution From **– Replaced by project-specific identification number** **OR** Institution From **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution from which mother arrived to the current episode of care.	
☐	Mother transferred in	A flag (i.e., Yes, Null) to indicate mother was transferred in from another acute care institution for the current episode of care.	
☐	Institution To **– Replaced by project-specific identification number** **OR** Institution To **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution to which mother was transferred from the current episode of care.	
☐	Mother transferred out	A flag (i.e., Yes, Null) to indicate mother was transferred out to another institution from the current episode of care.	
☐	Admission Date – Year	Year mother was admitted for the current episode of care.	
☐	Admission Date – Month	Month mother was admitted for the current episode of care.	
☐	Admission Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day mother was admitted for the current episode of care.	
☐	Admission Time	Time mother was admitted for the current episode of care (i.e., HH:MM:00.0000000).	
☐	Discharge Date – Year	Year mother was discharged from the current episode of care.	
☐	Discharge Date – Month	Month mother was discharged from the current episode of care.	
☐	Discharge Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day mother was discharged from the current episode of care.	
☐	Discharge Time	Time mother was discharged from the current episode of care (i.e., HH:MM:00.0000000).	
☐	Fiscal year	The fiscal year during which the mother was discharged (i.e., Apr 1 to Mar 31).	
☐	Total Length of Stay (hours)	Length of stay of admission expressed in hours.	
☐	Delivery date – Year	Year the woman delivered.	
☐	Delivery date – Month	Month the woman delivered.	
☐	Delivery date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day the woman delivered.	
☐	Place of delivery **– Replaced by project-specific identification number** **OR**	Institution where the mother delivered.	

☐	Place of delivery **– Research rationale describing why this field is required must be supplied before it will be considered for release:**		
Other episode of care information			
☐	Blood transfusion given	A flag (i.e., Yes, Null) to indicate mother received whole or packed red blood cells during this admission.	
☐	Blood transfusion units – Number of units transfused postpartum	Total number of units of whole or packed red blood cells the mother received during the episode of care.	
☐	Health care provider(s) service	Provider's specialty service number.	
☐	Health care provider(s) type	Health care provider's role in the care of the mother during episode of care (e.g., most responsible, resident/intern, allied health etc.)	
Post delivery information			
☐	HELLP Syndrome	A flag (i.e., Yes, Null) to indicate mother was diagnosed with HELLP Syndrome	
☐	Acute Fatty Liver	A flag (i.e., Yes, Null) to indicate mother diagnosed with acute fatty liver during current pregnancy or postpartum period.	
☐	Liver hematoma	A flag (i.e., Yes, Null) to indicate mother diagnosed with liver hematoma during current pregnancy or postpartum period.	
☐	Postpartum Special Care Unit Days	Number of days mother spent in any Special Care Unit (ICU, CCU, etc.).	
☐	Postpartum hemoglobin date – Year	Year of mother's lowest postpartum hemoglobin result during episode of care.	
☐	Postpartum hemoglobin date – Month	Month of mother's lowest postpartum hemoglobin result during episode of care.	
☐	Postpartum hemoglobin date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of mother's lowest postpartum hemoglobin result during episode of care.	
☐	Postpartum hemoglobin value	Value of postpartum hemoglobin test result during episode of care.	
☐	Postpartum infection	Mother had an infection during the episode of care (i.e., Yes, No, Unknown).	
☐	Postpartum wound infection	A flag (i.e., Yes, Null) to indicate mother had a postpartum wound infection.	
☐	Postpartum wound infection – Type	Specific location of the mother's postpartum wound infection.	
☐	Postpartum wound infection – Severity	Degree of the mother's postpartum wound infection.	
☐	Postpartum urinary tract infection – Type	Type of postpartum urinary tract infection	
☐	Postpartum urinary tract infection agent – Infectious agent 1	Most significant infectious agent causing positive maternal urine culture results during the episode of care.	
☐	Postpartum urinary tract infection agent – Infectious agent 2	Other infectious agent causing positive maternal urine culture results during the episode of care.	
☐	Postpartum positive blood culture	A flag (i.e., Yes, Null) to indicate mother's blood culture test results are positive.	
☐	Postpartum positive blood culture agent – Infectious Agent 1	Most significant infectious agent causing positive maternal blood culture results during the episode of care.	
☐	Postpartum positive blood culture agent – Infectious Agent 2	Other infectious agent causing positive maternal blood culture results during the episode of care.	

☐	Postpartum positive other culture	A flag (i.e., Yes, Null) to indicate lab culture results were positive (other than urine or blood).	
☐	Postpartum positive other culture agent – Infectious agent 1	Most significant infectious agent from other maternal positive culture results during the episode of care.	
☐	Postpartum positive other culture agent – Infectious agent 2	Other infectious agent from other maternal positive culture results during the episode of care.	
☐	Main Patient Service	Categorizes mothers according to related diseases, conditions and treatments.	
Diagnoses and procedures			
☐	Diagnosis Prefix	Alphanumeric character to further define a diagnosis code.	
☐	Diagnosis Code **– Please list the Diagnostic Codes (ICD-10-CA) that you are requesting:**	Medical diagnostic code reflecting the diagnosis or condition of mother while in hospital. Note: ICD-10-CA - Assigned starting with April 1, 2008 discharges using ICD-10-CA v2006, v2009, or v2012 (as applicable).	
☐	Diagnosis Type	Diagnosis type corresponding with the diagnosis codes (e.g., most responsible diagnosis, pre-admit comorbidity, secondary diagnosis, etc…)	
☐	Procedure Code **– Please list the Procedure Codes (CCI) that you are requesting:**	Code(s) for procedures performed during the episode of care. Note: Canadian Classification of Health Interventions (CCI) - Assigned starting April 1, 2008 discharges using CCI v2006, v2009, or v2012 (as applicable).	
☐	Procedure status	Procedure status attribute	
☐	Procedure location	Procedure anatomical location	
☐	Procedure extent	Procedure extent	
☐	Procedure Date – Year	Year of the procedure.	
☐	Procedure Date – Month	Month of the procedure.	
☐	Procedure Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the procedure.	
☐	Procedure doctor service	The procedure provider service.	
☐	Anesthetic agent for procedure	Type of anesthesia used for the procedure (e.g., general, spinal, epidural, etc.).	
Baby Newborn Episode of Care Information (April 1, 2000 to March 31, 2015)			
Baby Newborn records include births in acute care facilities and births at home attended by registered midwives. NOTE: Until March 31, 2014, a baby born at home under the care of a registered midwife who was admitted to acute care within 24 hours of birth will have the acute care admission as the Baby Newborn record (total record count=1). Effective April 1, 2014, a baby born at home with a registered midwife and who was admitted to acute care within 24 hours of birth will have a Baby Newborn record at home and a subsequent Baby Transfer/Readmission acute care record (total record count=2).			
☐	Place of baby's usual residence – HA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Authority (HA) of baby's usual residence as determined by resident postal code	
☐	Place of baby's usual residence – HSDA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Service Delivery Area (HSDA) of baby's usual residence as determined by resident postal code.	

☐	Place of baby's usual residence – LHA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Local Health Area (LHA) of usual baby's residence as determined by resident postal code.	
☐	Place of baby's usual residence – FSA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The first three characters of baby's resident postal code (i.e., Forward Sortation Area).	
☐	Baby Sequence	The incremental sequence number of babies born from the *current* pregnancy (e.g. twin A = sequence 1, twin B = sequence 2).	
☐	Number of births	The total number of babies delivered from the current pregnancy.	
☐	Baby Date of Birth – Year	Year baby was born.	
☐	Baby Date of Birth – Month	Month baby was born.	
☐	Baby Date of Birth – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day baby was born.	
☐	Sex	Biological sex of the newborn.	
Current admission information			
☐ ☐	Place of birth **– Replaced by project-specific identification number** **OR** Place of birth **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Location where baby received care.	
☐ ☐	Institution To **– Replaced by project-specific identification number** **OR** Institution To **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution to which baby was transferred from the current episode of care.	
☐	Transfer up (to higher level of care)	A flag (i.e., Yes, Null) to indicate newborn transferred to a hospital with a higher level of care directly from the birth episode.	
☐	Admission Date – Year	Year baby was admitted to the current episode of care.	
☐	Admission Date – Month	Month baby was admitted to the current episode of care.	
☐	Admission Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day baby was admitted to the current episode of care.	
☐	Admission Time	Time baby was admitted to current episode of care (i.e., HH:MM:00.0000000).	
☐	Discharge Date – Year	Year baby was discharged from the current episode of care.	
☐	Discharge Date – Month	Month baby was discharged from the current episode of care.	
☐	Discharge Date – Day **– Research rationale describing why this field is required must be**	Day baby was discharged from the current episode of care.	

	supplied before it will be considered for release:		
☐	Discharge Time	Time baby was discharged from the current episode of care (i.e., HH:MM:00.0000000).	
☐	Fiscal Year	The fiscal year during which the baby was discharged (i.e., Apr 1 to Mar 31).	
☐	Length of Stay (Hours)	Baby's length of stay for admission expressed in hours. Note: Always null for home births.	
☐	Neonatal Intensive Care Unit days (Level II)	Total number of days baby was in Neonatal Intensive Care Unit Level II. Note: Changes over time to calculation method. Also, documented data quality issues from 2010/11 onwards.	2004/05 onwards
☐	Neonatal Intensive Care Unit days (Level III)	Total number of days baby was in Neonatal Intensive Care Unit Level III. Note: Changes over time to calculation method. Also, documented data quality issues from 2010/11 onwards.	2004/05 onwards
☐	Admission weight	Admission weight in grams.	
☐	Discharge weight	Baby's weight (in grams) at discharge.	
☒	Gestational age at birth by newborn exam	Baby's gestational age (in completed weeks) based on care provider's physical assessment and neuromuscular assessment of the newborn at birth. Note: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☒	Gestational age at birth from maternal chart	Baby's gestational age (in completed weeks) documented by the care provider before delivery, determined by maternal last menstrual period and/or ultrasound. Note: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☒	Gestational age at birth, in completed weeks – calculated by algorithm incorporating LNMP, first U/S, newborn examination, and maternal chart	Gestational age at birth, in completed weeks – calculated by algorithm incorporating LNMP, first U/S, newborn examination, and maternal chart. Note: Checked automatically because this field should always be requested when delivery or newborn records requested.	
☐	Birth length	Length of baby at birth (in centimeters).	
☐	Birth head circumference	Head circumference of baby at birth (in centimeters).	
☐	Birth Type	Identifies birth type for births at or after 20 weeks gestation or weighing at least 500 grams (i.e., stillbirth, live birth).	
☐	Stillbirth timing	The stage in labour when the stillbirth occurred (e.g., stillbirth after onset of labour, stillbirth prior to onset of labour).	
☐	Vitamin K	Newborn received vitamin K (i.e., Yes, No, Unknown).	2000/01-2007/08
☐	Eye prophylaxis given	Baby received erythromycin or other eye prophylaxis (i.e., Yes, No, Unknown).	2000/01-2007/08
☐	Breastfeeding at discharge	Indicates if mother is breastfeeding the baby at discharge (i.e., Yes, No, Unknown).	2000/01-2003/04
☐	Newborn feeding	The type of feeding given to the newborn during the entire hospital stay, including discharge (e.g., Exclusive breast milk, breast milk and formula, formula, etc.).	2004/05-onwards
☐	Breastfeeding initiation	Time frame during which breastfeeding first commenced/attempted following delivery, regardless of whether the baby latched.	2008/09-onwards
☐	Health care provider(s) service	Provider's specialty service number.	

☐ Health care provider(s) type	Health care provider's role in the care of the baby during episode of care (e.g., most responsible, resident/intern, allied health etc.)	
☐ Discharged to	Where the baby was discharged to, or the status of the baby at the time of discharge (e.g., adoption, death/stillbirth, foster home, home, other hospital, unknown).	
☐ 1st temperature within 1st hour after birth	Value of first temperature taken within the first hour of birth (in Celsius to 1 decimal place).	2008/09-onwards
☐ Surfactant Given	A flag (i.e., Yes, Null) to indicate surfactant administered during hospital admission.	2008/09-onwards
☐ Antibiotics Given	A flag (i.e., Yes, Null) to indicate antibiotics were administered during hospital admission.	2008/09-onwards
Birth information		
☐ Apgar 1 minute	Apgar score at 1 minute.	
☐ Apgar 5 minutes	Apgar score at 5 minutes.	
☐ Apgar 10 minutes	Apgar score at 10 minutes.	
☐ Meconium thick	A flag (i.e., Yes, Null) to indicate meconium described as thick or particulate at birth.	2000/01-2003/04
☐ Meconium	A flag (i.e., Yes, Null) to indicate presence of thick or thin meconium at any time during the intrapartum period, including delivery.	2004/05-onwards
☐ Drugs for resuscitation / stabilization	Administration of medication to the newborn for resuscitative/stabilization purposes during the birth episode (i.e., Yes, No, Unknown).	
☐ Suction – Perineum	A flag (i.e., Yes, Null) to indicate baby is suctioned at the perineum upon delivery of the head.	2000/01-2007/08
☐ Suction – Oropharynx	A flag (i.e., Yes, Null) to indicate clearing of the newborn's airway at the level of the oropharynx.	
☐ Suction – Trachea	A flag (i.e., Yes, Null) to indicate clearing of the newborn's airway at the level of the trachea.	
☐ Suction – Unspecified	A flag (i.e., Yes, Null) to indicate clearing of the newborn's airway at an unspecified level.	
☐ Oxygen for resuscitation	A flag (i.e., Yes, Null) to indicate baby received oxygen for immediate resuscitation.	
☐ Oxygen for resuscitation – Age started	Age in minutes when oxygen for resuscitation started.	
☐ Oxygen for resuscitation – Age stopped	Age in minutes when oxygen for resuscitation ended.	
☐ Total length of time oxygen given for resuscitation	Total minutes baby received oxygen for immediate resuscitation.	
☐ IPPV mask given for resuscitation	A flag (i.e., Yes, Null) to indicate newborn received intermittent positive pressure ventilation (IPPV) for immediate resuscitation via mask.	
☐ IPPV mask given for resuscitation – Age started	Age in minutes when intermittent positive pressure ventilation (IPPV) by mask started.	
☐ IPPV mask given for resuscitation – Age stopped	Age in minutes when intermittent positive pressure ventilation (IPPV) by mask for resuscitation ended.	
☐ Total length of time IPPV mask given for resuscitation	Total minutes baby received intermittent positive pressure ventilation (IPPV) by mask for immediate resuscitation.	
☐ IPPV ETT given for resuscitation	A flag (i.e., Yes, Null) to indicate newborn received intermittent positive pressure ventilation (IPPV) for immediate resuscitation via endotracheal tube (ETT).	

☐	IPPV ETT given for resuscitation – Age started	Age in minutes when intermittent positive pressure ventilation (IPPV) by endotracheal tube (ETT) started.	
☐	IPPV ETT given for resuscitation – Age stopped	Age in minutes when intermittent positive pressure ventilation (IPPV) by endotracheal tube (ETT) for resuscitation ended	
☐	Total length of time IPPV ETT given for resuscitation	Total minutes baby received intermittent positive pressure ventilation (IPPV) by endotracheal tube (ETT) for immediate resuscitation.	
☐	Chest compressions given for resuscitation	A flag (i.e., Yes, Null) to indicate baby received chest compressions for immediate resuscitation.	
☐	Chest compressions given for resuscitation – Age Started	Age in minutes when chest compressions for resuscitation started	
☐	Chest compressions given for resuscitation – Age Stopped	Age in minutes when chest compressions for resuscitation ended	
☐	Total length of time compressions given for resuscitation	Total minutes baby received chest compressions for immediate resuscitation.	
☐	Total ventilator days	Total number of days (in whole numbers) baby was on a ventilator.	
☐	Total CPAP days	Total number of days (in whole numbers) baby was on Continuous Positive Airway Pressure (CPAP).	2008/09-onwards
☐	Total oxygen days	Total number of days (in whole numbers) baby received continuous oxygen therapy or nasal prongs.	
☐	Total TPN days	Total number of days (in whole numbers) the baby received any total parenteral nutrition (TPN).	
☐	Cord arterial gases pH	pH value of cord arterial blood gases, obtained from the umbilical artery.	
☐	Cord arterial gases base excess/deficit	Base excess (+) or deficit (-) value of the cord arterial blood gases, obtained from the umbilical artery.	
☐	Positive Blood Culture	A flag (i.e., Yes, Null) to indicate baby's blood culture test results were positive.	2008/09-onwards
☐	Positive blood culture agent – Infectious Agent 1	Most significant infectious agent causing positive blood culture results in the baby.	2008/09-onwards
☐	Positive blood culture agent – Infectious Agent 2	Other infectious agent causing positive blood culture results in the baby.	2008/09-onwards
☐	Positive urine culture	A flag (i.e., Yes, Null) to indicate baby's urine culture test results were positive.	2008/09-onwards
☐	Positive urine culture – Infectious Agent 1	Most significant infectious agent causing positive urine culture results in the baby.	2008/09-onwards
☐	Positive urine culture – Infectious Agent 2	Other infectious agent causing positive urine culture results in the baby.	2008/09-onwards
☐	Positive other culture	A flag (i.e., Yes, Null) to indicate lab culture test results were positive for the baby (other than blood and urine).	2008/09-onwards
☐	Positive other culture – Infectious Agent 1	Most significant infectious agent causing other positive culture results in the baby, other than blood and urine.	2008/09-onwards
☐	Positive other culture – Infectious Agent 2	Other infectious agent causing other positive culture results in the baby, other than blood and urine.	2008/09-onwards
☐	Main Patient Service	Categorizes babies according to related diseases, conditions and treatments.	
Diagnosis and procedures			
☐	Diagnosis prefix	Alphanumeric character to further define a diagnosis code.	
☐	Diagnosis Code **– Please list the Diagnostic Codes (ICD-9 and/or ICD-10-CA) that you are requesting:**	Medical diagnostic code reflecting the diagnosis or condition of mother while in hospital. Note: International Classification of Diseases - ICD 9 - Assigned from April 1, 2000 to March 31, 2004. ICD-10-CA - Assigned starting	

		with April 1, 2004 using ICD-10-CA v2003, v2006, v2009, or v2012 (as applicable).	
☐	Diagnosis Type	Diagnosis type corresponding with the diagnosis codes (e.g., most responsible diagnosis, pre-admit comorbidity, secondary diagnosis, etc…)	
☐	Procedure Code **– Please list the Procedure Codes (CCP and/or CCI) that you are requesting:**	Code(s) for procedures performed during the episode of care. Note: Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures - Assigned from April 1, 2000 to March 31, 2004. Canadian Classification of Health Interventions (CCI) - Assigned effective April 1, 2004 using CCI v2003, v2006, v2009, or v2012 (as applicable).	
☐	Procedure status	Procedure status attribute	2004/05-onwards
☐	Procedure location	Procedure anatomical location	2004/05-onwards
☐	Procedure extent	Procedure extent	2004/05-onwards
☐	Procedure Date – Year	Year of the procedure.	
☐	Procedure Date – Month	Month of the procedure.	
☐	Procedure Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the procedure.	
☐	Procedure doctor service	The procedure provider service.	
☐	Anesthetic agent for procedure	Type of anesthesia used for the procedure (e.g., local, epidural, spinal etc.).	
Baby Transfer/Readmission Episode of Care Information (April 1, 2000 to March 31, 2015)			
☐	Place of baby's usual residence – HA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Authority (HA) of baby's usual residence as determined by resident postal code	
☐	Place of baby's usual residence – HSDA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Health Service Delivery Area (HSDA) of baby's usual residence as determined by resident postal code.	
☐	Place of baby's usual residence – LHA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The Local Health Area (LHA) of usual baby's residence as determined by resident postal code.	
☐	Place of baby's usual residence – FSA **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	The first three characters of baby's resident postal code (i.e., Forward Sortation Area).	

☐ Baby Sequence	The incremental sequence number of babies born from the *current* pregnancy (e.g. twin A = sequence 1, twin B = sequence 2).	
☐ Number of births	The total number of babies delivered from the current pregnancy.	
☐ Sex	Biological sex of the newborn.	
☐ Place of admission **– Replaced by project-specific identification number** **OR** ☐ Place of admission **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Location where baby received care	
☐ Institution from **– Replaced by project-specific identification number** **OR** ☐ Institution from **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution from which baby was admitted to the current episode of care.	
☐ Institution To **– Replaced by project-specific identification number** **OR** ☐ Institution To **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Institution to which baby was transferred from the current episode of care.	
☐ Admission Date – Year	Year baby was admitted to the current episode of care.	
☐ Admission Date – Month	Month baby was admitted to the current episode of care.	
☐ Admission Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day baby was admitted to the current episode of care.	
☐ Admission Time	Time baby was admitted to current episode of care (i.e., HH:MM:00.0000000).	
☐ Discharge Date – Year	Year baby was discharged from the current episode of care.	
☐ Discharge Date – Month	Month baby was discharged from the current episode of care.	
☐ Discharge Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day baby was discharged from the current episode of care.	
☐ Discharge Time	Time baby was discharged from the current episode of care (i.e., HH:MM:00.0000000).	
☐ Fiscal Year	The fiscal year during which the baby was discharged (i.e., Apr 1 to Mar 31).	
☐ Length of Stay (Hours)	Baby's length of stay for admission expressed in hours.	
☐ Neonatal Intensive Care Unit days (Level II)	Total number of days baby was in Neonatal Intensive Care Unit Level II. Note: Changes over time to calculation method. Also, documented data quality issues from 2010/11 onwards.	2004/05-onwards
☐ Neonatal Intensive Care Unit days (Level III)	Total number of days baby was in Neonatal Intensive Care Unit Level III. Note: Changes over time to calculation	2004/05-onwards

		method. Also, documented data quality issues from 2010/11 onwards.	
☐	Admission weight	Admission weight in grams.	
☐	Discharge weight	Baby's weight (in grams) at discharge.	
☐	Discharged to	Where the baby was discharged to, or the status of the baby at the time of discharge (i.e., adoption, death/stillbirth, foster home, home, other hospital, unknown).	
☐	Health care provider(s) service	Provider's specialty service number.	
☐	Health care provider(s) type	Health care provider's role in the care of the baby during episode of care (e.g., most responsible, resident/intern, allied health).	
☐	1st temperature within 1st hour after birth	Value of first temperature taken within the first hour of birth (in Celsius to 1 decimal place).	2008/09-onwards
☐	Surfactant Given	A flag (i.e., Yes, Null) to indicate surfactant administered during hospital admission.	2008/09-onwards
☐	Antibiotics Given	A flag (i.e., Yes, Null) to indicate antibiotics were administered during hospital admission.	2008/09-onwards
☐	Total ventilator days	Total number of days (in whole numbers) baby was on a ventilator.	
☐	Total CPAP days	Total number of days (in whole numbers) baby was on Continuous Positive Airway Pressure (CPAP).	2008/09-onwards
☐	Total oxygen days	Total number of days (in whole numbers) baby received continuous oxygen therapy or nasal prongs.	
☐	Total TPN days	Total number of days (in whole numbers) the baby received any total parenteral nutrition (TPN).	
☐	Positive Blood Culture	A flag (i.e., Yes, Null) to indicate baby's blood culture test results were positive.	2008/09-onwards
☐	Positive blood culture agent – Infectious Agent 1	Most significant infectious agent causing positive blood culture results in the baby.	2008/09-onwards
☐	Positive blood culture agent – Infectious Agent 2	Other infectious agent causing positive blood culture results in the baby.	2008/09-onwards
☐	Positive urine culture	A flag (i.e., Yes, Null) to indicate baby's urine culture test results were positive.	2008/09-onwards
☐	Positive urine culture – Infectious Agent 1	Most significant infectious agent causing positive urine culture results in the baby.	2008/09-onwards
☐	Positive urine culture – Infectious Agent 2	Other infectious agent causing positive urine culture results in the baby.	2008/09-onwards
☐	Positive other culture	Lab culture test results were positive for the baby (other than blood and urine).	2008/09-onwards
☐	Positive other culture – Infectious Agent 1	Most significant infectious agent causing other positive culture results in the baby, other than blood and urine.	2008/09-onwards
☐	Positive other culture – Infectious Agent 2	Other infectious agent causing other positive culture results in the baby, other than blood and urine.	2008/09-onwards
☐	Main Patient Service	Categorizes babies according to related diseases, conditions and treatments.	
Diagnoses and procedures			
☐	Diagnosis prefix	Alphanumeric character to further define a diagnosis code.	
☐	Diagnosis Code **– Please list the Diagnostic Codes (ICD-9 and/or ICD-10-CA) that you are requesting:**	Medical diagnostic code reflecting the diagnosis or condition of mother while in hospital. Note: International Classification of Diseases - ICD 9 - Assigned from April 1, 2000 to March 31, 2004. ICD-10-CA - Assigned effective April 1, 2004 using ICD-10-CA v2003, v2006, v2009, or v2012 (as applicable).	

☐	Diagnosis Type	Diagnosis type corresponding with the diagnosis codes (e.g., most responsible diagnosis, pre-admit comorbidity, secondary diagnosis, etc…)	
☐	Procedure Code **– Please list the Procedure Codes (CCP and/or CCI) that you are requesting:**	Code(s) for procedures performed during the episode of care. Note: Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures - Assigned from April 1, 2000 to March 31, 2004. Canadian Classification of Health Interventions (CCI) - Assigned effective April 1, 2004 using CCI v2003, v2006, v2009, or v2012 (as applicable).	
☐	Procedure status	Procedure status attribute	2004/05 onwards
☐	Procedure location	Procedure anatomical location	2004/05 onwards
☐	Procedure extent	Procedure extent	2004/05 onwards
☐	Procedure Date – Year	Year of the procedure.	
☐	Procedure Date – Month	Month of the procedure.	
☐	Procedure Date – Day **– Research rationale describing why this field is required must be supplied before it will be considered for release:**	Day of the procedure.	
☐	Procedure doctor service	The procedure provider service.	
☐	Anesthetic agent for procedure	Type of anesthesia used for the procedure (e.g., local, epidural, spinal etc.).	