Integrating the Healthcare Enterprise

IHE Quality, Research and Public Health Technical Framework Supplement

Birth and Fetal Death Reporting-Enhanced (BFDR-E)

Draft for Public Comment

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Please verify you have the most recent version of this document. See here for Trial Implementation and Final Text versions and here for Public Comment versions.

Foreword

This is a supplement to the IHE Quality, Research and Public Health Technical Framework V0.1. Each supplement undergoes a process of Public Comment and Trial Implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is published on June 6, 2014 for Public Comment. Comments are invited and may be submitted at http://www.ihe.net/QRPH_Public_Comments. In order to be considered in development of the Trial Implementation version of the supplement, comments must be received by July 5, 2014

This supplement describes changes to the existing technical framework documents.

"Boxed" instructions like the sample below indicate to the Volume Editor how to integrate the relevant section(s) into the relevant Technical Framework volume.

Amend section X.X by the following:

Where the amendment adds text, make the added text **bold underline**. Where the amendment removes text, make the removed text **~~bold strikethrough~~**. When entire new sections are added, introduce with editor's instructions to "add new text" or similar, which for readability are not bolded or underlined.

General information about IHE can be found at: http://ihe.net.

Information about the IHE IT Infrastructure domain can be found at: http://ihe.net/IHE_Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at: http://ihe.net/IHE_Process and http://ihe.net/Profiles.

The current version of the IHE IT Infrastructure Technical Framework can be found at: http://ihe.net/Resources/Technical_Frameworks.

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Introduction to this Supplement

This supplement is written for Trial Implementation. It is written as an addition to the Trial Implementation version of the Quality, Research and Public Health Technical Framework.

This supplement also references the following documents[1]. The reader should review these documents as needed:

1. PCC Technical Framework, Volume 1
2. PCC Technical Framework, Volume 2
3. PCC Technical Framework Supplement: CDA Content Modules
4. IT Infrastructure Technical Framework Volume 1
5. IT Infrastructure Technical Framework Volume 2
6. IT Infrastructure Technical Framework Volume 3
7. HL7 and other standards documents referenced in Volume 1 and Volume 2
8. Birth Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Live Birth
9. Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Report of Fetal Death

Vital Records birth certificates and fetal death reports include important demographic, medical and key information about the antepartum period, the labor and delivery process and the newborn/fetal death[2]. Much of the medical and health information collected for the birth certificate and fetal death report can be pre-populated with information already available in the Electronic Health Record (EHR). A responsible Health Care Provider (HCP) or designated representative must review and complete the information to ensure data quality for vital registration purposes. These data may then be used by public health agencies to track maternal and infant health to target interventions for at risk populations.

[1] The first six documents can be located on the IHE Website at http://www.ihe.net/Technical_Frameworks/. The remaining documents can be obtained from their respective publishers.

[2] In some countries the birth certificate contains just the patient demographics and the medical information is recorded in separate early childhood health certificates produced at different times.

Open Issues and Questions

290 Open Issue List:

Item Count	Issue Description	Status
1	HL7 Issue – OBX is optional in HL7 – we want it required. a. This will be brought through the formalization process in HL7 b. Once HL7 formalizes the OBX R then statements leading in to the section requirements in Volume 2 should be updated to indicate NO FURTHER constraints	Review during Volume 2 development A DSTU Comment needs to be added against the VRBFDR DSTU 2013OCT 1. Fix type-o in ADT^A04 and ADT^A08 OBX to [{OBX}] 2. Fix cardinality to [1..*] 3. All observation types in Table 53 SHALL be recorded Check with Mead on how to make this further constraint. These constraints will be added to the Volume 2 message for QRPH BFDR Message.
2	LDS specification needs to be updated to allow for Intake and Output to represent coded observations	Review during Volume 3 development – check if this is still relevant. We may not need to address this. May be resolved by using ProblemObservation to gather breastfeeding observation. May be closed.
3	TEMPLATE OPEN ISSUE: The template does not really support the need to specify the mappings for the form receiver message exporter, form receiver CDA exporter, and the Pre-population requirements for the Form Manager. These have been reflected together as sub-sections to 6.3.1.D.4 Data Element Requirement Mappings.	This issue needs to be documented as an IHE TS template issue. Clear guidance doesn't exist within the template on where to add this type of mapping from a specific form to a standard input document or from a specific form to a standard output document.
4	Template Issue: Where should the list of data elements be specified in this new template? In the past, they were included in X.6 Content Module in some profiles. We have tentatively included a new section X.7 Data Requirements until this issue has been resolved.	Pending addition to template
5	Should there be only one option, the LDS-VR Option' – this had been considered but we want to be able to offer a lower participation threshold where possible – the pre-pop Option may need to be renamed, but it supports the LDS or the LDS-VR document.	Use of LDS will continue to be permitted until more vendors can produce LDS-VR documents.
6	Do we need a new transaction for each new type of outbound message? Is there are more generalized way to do this (like PCD-01)?	This can be considered later by QRPH. For now, BFDR will define a new message.

Item Count	Issue Description	Status
7	The use of Null flavors for unknown is under review by HL7. This is slated for discussion in May HL7. This also impacts the output mapping to CDA documents as we are 'silent' on how to handle the 'N' status of each observation.	This document includes a link to the HL7 DSTU which will include the HL7 resolution on this matter in the published version. No profiling will be done at this time pending the outcome of the HL7 decision.
8	Child breastfed at discharge: may want to align the LDS-VR approach to use the LOINC question/answer observation as done in the BFDR CDA. This is also under consideration for nutrition and healthy weight.	For now, it should be represented differently in secondary use than in the primary clinical setting.
9	Infant living at time of report: approach to use the LOINC question/answer observation as done in the BFDR CDA	Deceased Indicator extension may be populated in the header, or newborn information section to be reviewed with PCC. Not critical as we still need to go deeper into the body of the newborn section to find time of death.
10	Date of Last Other Pregnancy Outcome: Not aligned with LDS-VR model which uses 68500-8 Date last other pregnancy outcome, but this modelling contains two concepts 1) number of other pregnancy outcomes that did not result in a live birth (uses the same code); 2)date that the last pregnancy that did not result in a live birth ended	
11	Date of First Prenatal Care visit: : Not aligned with LDS-VR model - code for whole act indicates '73776-7" No-prenatal care - seems it should be separate observation for first and last prenatal care visit	
12	PNC – needs to be added from Spec to data dictionary and mapping tables 73776-7 No-prenatal care	
13	73773-4 Number of infants in this delivery born alive is different from LDS-VR mapping and HBS; which uses Births.live consistent with BFDR and HBS	
14	Review of Birth vs FDeath Forms to assess any impact on logic in using numbers as a reference. Some information is needed in one form vs the other, and there may be differences in the information captured on the form for similar concepts.	There are differences in the form numbers between the 2 documents, so any reference to the form numbers needs to be handled separately between birth and fetal death.
15	Failed External cephalic Version – mapping to CDA output is listed as 'Pending' due to underlying HL7 Specification – missing. Profiling deferred pending HL7 resolution of the modelling.	
16	HL7 CDA document is missing specification of UCUM units for some metrics. No profiling added pending HL7 resolution of this issue.	
17	PPO: HL7 CDA using History of Pregnancy rather than bfdr '169584000 Antenatal care: poor obstetric history (situation)'	
18	International considerations for form options currently identified as US Form Option on form manager	

Item Count	Issue Description	Status
19	Apgar5 and Apgar10 need to be updated to reflect new PCC modeling for Apgar once PCC work is completed	
20	Handling of these 'Pending' flag indicators from the Edit Specifications needs to be reviewed in the context of the workflow. This status flags may not be pertinent in the proposed profile use cases.	
21	model update under consideration for Autopsy and Hysterectomy/Hysterotomy in answer modelling: use current value set that indicates planned and unplanned or use Boolean with a second question to add a planned indicator which needs a new loinc code	
22	Vocabulary – Unplanned Operation seems there should be a better code than selected '177217006' Immediate repair of obstetric laceration (procedure)	
23	Need to post sample CDA documents for BFDR-Birth and BFDR-FD	
24	A01, A03 – appear to be missing - not in HL7	Review with HL7 to potentially add these
25	Header value sets: SHALL – may be better in the national extension – Structure and value set conformance discussion needed for international considerations in the longer term	
26	Fertility Enhancing Drugs Medications (NCHS) expected to be on the medications list– this is not the best place to document this as the drug would have been discontinued long before the delivery and may not be in the record.	Further discussion needed with clinical, vocabulary, EMR, and profiling stakeholders to review modeling and approach to capturing this more accurately in the EMR for use in LDS. Perhaps a new event code (e.g., LOINC code – where would this be found or SNOMED for problem finding)
27	Fever Greater Than 100.4 (NCHS) value set - This is not likely to be present on a problem list and instead will be represented in discrete data if the temperature was taken	Verify with DVS and clinical team that this is clinically equivalent to the Chorioamnionitis so that they can use instead
28	Unplanned Operation – There are several references in the documentation to Unplanned Operation, Unplanned Hysterectomy and Scheduled C Section. These time-related measurements need to be precise or we will not be able to send them. How do we determine that the operation is unplanned	Further discussion needed with clinical, vocabulary, EMR, and profiling stakeholders to review modeling and approach to capturing this more accurately in the EMR for use in LDS.
29	Schedule-CSection: More common measurements today would involve a Cesarean or an Emergent Cesarean instead of a Scheduled Cesarean. Clinician review needed for use of 'Elective' Cesarean codes in the value sets.	Further discussion needed with clinical, vocabulary, EMR, and profiling stakeholders to review modeling and approach to capturing this more accurately in the EMR for use in LDS. Consider renaming to Elective CSection to avoid confusion.

Item Count	Issue Description	Status
30	Timing and capture of chromosomal/congenital conditions is not necessarily conducive to clinical workflow (e.g., suspected is not usually documented in the record). Review of systems is probably correct, but missing symptoms or other observations that would specifically put this into a status of 'suspected'	Further discussion needed with clinical, vocabulary, EMR, and profiling stakeholders to review modeling and approach to capturing this more accurately in the EMR for use in LDS.
31	Direct submission from EMR considerations: Some jurisdictions may require human sign-off before submitting a message	
32	The finalized and published HL7 CDA DSTU documents are expected to be available to HL7 members early June 2014, and to non-members by early September 2014.	
33	The number of fetal deaths in the delivery (FDTH) is not currently mapped to the HL7 CDA Fetal Death Document. There is currently no attribute in the CDA given that there is no request for this information on the forms used as a basis for this work.	Further review is under way with NCHS and HL7. Until this is completed, the mapping will remain listed as PENDING.
34	Admission Source – need to consider use of the Transfer entry rather than the header information where it is now mapped. Consideration for the appropriate section to use to hold this entry is needed.	

Closed Issues

Closed Issue List:

Item	Issue Description	Status
1	Name of value sets implying domain 'BFDR' will be updated to generic naming. These references will be updated once the renaming is completed and published in PHIN-VADS.	Closed
2	PCC CP to LDS - Coded Vital Signs section needs to be pulled out to a separate section for Mother and Newborn	Closed
3	Do we continue to offer grouping guidance?	No required grouping

Item	Issue Description	Status
4	If MU requires Race/Ethnicity then we may require this. Resolved: The CMS Meaningful Use Objectives support recording race and ethnicity information in the EHR as stated in: §170.304 (c) Record demographics updated 8/13/2010 http://healthcare.nist.gov/docs/170.304. c_RecordDemographicsAmb_v1.0.pdf Also Requires use of OMB Race & Ethnicity Codes available at: http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr.	We will modify the description to indicate that race and ethnicity information will be reported by the funeral director or next of kin as the primary source of information. However, the EHR may also serve as a resource for documenting race and ethnicity information. - modifying from pre-populated to direct data entry. Added note: Pre-populateData Entry Required. Included NOTE: data elements would be reported by the funeral director or next of kin, and the EHR would not be the primary source. However, the EHR may also serve as a resource for documenting race and ethnicity information to inform the content of this attribute.
5	We will need to review whether both XPHR and MS are both appropriate for this profile or whether we need to limit to MS to capture the required attributes for the U.S. death certificate. Also the HL7 Continuity of Care Document (CCD).	Considerations deferred. Continue with LDS. Pre-population using currently CCDA will remain out of scope pending IHE harmonization efforts. CCDA Refactoring impact on XPHR, MS, CCD references.
6	We will need to review whether both XPHR and MS are both appropriate for this profile or whether we need to limit to MS to capture the required attributes for the U.S. death certificate. Also the HL7 Continuity of Care Document (CCD).	Considerations deferred. Continue with LDS. Pre-population using currently CCDA will remain out of scope pending IHE harmonization efforts. CCDA Refactoring impact on XPHR, MS, CCD references.
7	The 'Save Form For Continued Editing' Option on the Form Manager has no specific strategies identified.	George Cole confirmed this is intended and supported functionality for RFD.
8	Review representation of RFD pre-pop options with 2 CDA pre-pop documents (LDS and LDHP) and content constrained by this profile	Can be done, but committee selected to update LDS-VR rather than use 2 pre-pop documents basted on implementer feedback

General Introduction

Update the following Appendices to the General Introduction as indicated below. Note that these are not appendices to Volume 1.

Appendix A - Actor Summary Definitions

Add the following actors to the IHE Technical Frameworks General Introduction list of actors:

Actor	Definition
Information Source	The Information Source Actor is responsible for creating and transmitting an HL7 V2.5.1 message to an Information Recipient. This actor was initially defined in the QRPH VRDR Technical Supplement.
Information Recipient	The Information Recipient Actor is responsible for receiving the HL7 V2.5.1 message from an Information Source or from a Form Receiver Message Exporter. This actor was initially defined in the QRPH VRDR Technical Supplement.
Form Receiver CDA Exporter	This Form Receiver CDA Exporter receives data submitted through the Submit Form Transaction (ITI-35), transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer. This actor was initially defined in the QRPH VRDR Technical Supplement.
Form Receiver Message Exporter	This Form Receiver Message Exporter receives data submitted through the Submit Form Transaction (ITI-35), transforms that data to an HL7 message and sends that message to an Information Recipient. This actor was initially defined in the QRPH VRDR Technical Supplement.

Appendix B - Transaction Summary Definitions

Add the following transactions to the IHE Technical Frameworks General Introduction list of Transactions:

Transaction	Definition
BFDRFeed [QRPH-37]	This transaction transmits the HL7 V2.5.1 formatted message containing the Birth and Fetal Death Reporting information

Glossary

Add the following glossary terms to the IHE Technical Frameworks General Introduction Glossary:

Glossary Term	Definition
Apgar score	Apgar score is a systematic measure for evaluating the physical condition of the infant at specific intervals following birth. It is a score that assesses the general physical condition of a newborn or infant by assigning a value of 0, 1, or 2 to each of five criteria: heart rate, respiratory effort, muscle tone, skin color, and response to stimuli. The five scores are added together, with a perfect score being 10. Apgar scores are usually evaluated at one minute and five minutes after birth. If the 5 minute Apgar score is < 6 then additional Apgar scores at 10 minutes are required.
Antibiotic	Antibiotic is a chemotherapeutic agent that inhibits or abolishes the growth of micro-organisms, such as bacteria, fungi, or protozoans.
Anorexia	Anorexia nervosa is a psychiatric illness that describes an eating disorder characterized by extremely low body weight and body image distortion with an obsessive fear of gaining weight.
Asthma	Asthma is a chronic (long-lasting) inflammatory disease of the airways. In those susceptible to asthma, this inflammation causes the airways to narrow periodically; this, in turn, produces wheezing and breathlessness, sometimes to the point where the patient gasps for air.
Breech presentation	Breech presentation is a presentation of the fetal buttocks or feet in labor; the feet may be alongside the buttocks (complete breech presentation); the legs may be extended against the trunk and the feet lying against the face (frank breech presentation); or one or both feet or knees may be prolapsed into the maternal vagina (incomplete breech presentation).
Cesarean section	Cesarean section, or C-section, is an extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.
Cephalic presentation	Cephalic presentation is the presentation of part of the fetus, listed as vertex, occiput anterior (OA), occiput posterior (OP).
Cerebral palsy	Cerebral palsy describes a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to nonprogressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, perception, cognition, communication, and behavior, by epilepsy, and by secondary musculoskeletal problems.
Chromosome abnormalities	Chromosome abnormalities consist of any change occurring in the structure or number of any of the chromosomes of a given species. In humans, a number of physical disabilities and disorders are directly associated with aberrations of both the autosomes and the sex chromosomes, including Down, Turner's, and Kleinfelter's syndromes.
Cleft lip	Cleft lip with or without cleft palate is the incomplete closure of the lip. It may be unilateral, bilateral, or median.
Cleft palate	Cleft palate is an incomplete fusion of the palatal shelves. It may be limited to the soft palate, or may extend into the hard palate.
Congenital heart defect	Congenital heart defect (CHD) is a defect in the structure of the heart and great vessels of a newborn. Obstruction defects. CHD can be classified as: Obstruction defects occur when heart valves, arteries, or veins are abnormally narrow or blocked. Septal defects, for defects concerning the separation between left heart and right heart Cyanotic defects, including persistent truncus arteriosus, total anomalous pulmonary venous connection, tetralogy of Fallot, transposition of the great vessels, and tricuspid atresia.

Glossary Term	Definition
Congenital hip dysplasia	Congenital hip dysplasia is a hip joint malformation present at birth, thought to have a genetic component Clinical Hip dislocation, asymmetry of legs and fat folds; congenital hip dislocation may be asymptomatic and must be diagnosed by physical examination.
Cystic fibrosis	Cystic fibrosis (CF) is an inherited disease that affects the lungs, digestive system, sweat glands, and male fertility. Its name derives from the fibrous scar tissue that develops in the pancreas, one of the principal organs affected by the disease.
Down syndrome	Down syndrome or trisomy 21 is a genetic disorder caused by the presence of all or part of an extra 21st chromosome.
Eczema	Eczema is an acute or chronic noncontagious inflammation of the skin, characterized chiefly by redness, itching, and the outbreak of lesions that may discharge serous matter and become encrusted and scaly.
Endocrine disorder	Endocrine system is an integrated system of small organs which involve the release of extracellular signaling molecules known as hormones. Hypofunction of endocrine glands can occur as result of loss of reserve, hyposecretion, agenesis, atrophy or active destruction. Hyperfunction can occur as result of hypersecretion, loss of suppression, hyperplastic or neoplastic change, or hyperstimulation.
Epidural anesthesia	Epidural anesthesia is a regional anesthetic that is administered to the mother to control the pain of labor. It includes delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.
Esophageal atresia	Congenital esophageal atresia (EA) represents a failure of the esophagus to develop as a continuous passage. Instead, it ends as a blind pouch.
Food allergies	Food allergies are the body's abnormal responses to harmless foods; the reactions are caused by the immune system's reaction to some food proteins.
Gastroesophageal reflux	Gastroesophageal reflux is the reflux of the stomach and duodenal contents into the esophagus.
Gastroschisis	Gastroschisis is an abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. It is differentiated from omphalocele by the location of the defect and the absence of a protective membrane.
General anesthesia	General anesthesia is the induction of a state of unconsciousness with the absence of pain sensation over the entire body, through the administration of anesthetic drugs. It is used during certain medical and surgical procedures.
Genitourinary tract	Genitourinary tract is the organ system of all the reproductive organs and the urinary system. These are often considered together due to their common embryological origin.
Gestational age (weeks of amenorrhea)	One measure of gestational age is the number of completed weeks elapsed between the first day of the last normal menstrual period and the date of delivery. Gestational age can also be measured based on ultrasound early in pregnancy.
Gestational diabetes	Gestational diabetes – glucose intolerance requiring treatment - is a condition that occurs during pregnancy. Like other forms of diabetes, gestational diabetes involves a defect in the way the body processes and uses sugars (glucose) in the diet.
Heart malformation	Heart malformation or congenital heart defect (CHD) is a defect in the structure of the heart and great vessels of a newborn. Most heart defects either obstruct blood flow in the heart or vessels near it or cause blood to flow through the heart in an abnormal pattern, although other defects affecting heart rhythm can also occur.

Glossary Term	Definition
Hemoglobin disease	Hemoglobin is produced by genes that control the expression of the hemoglobin protein. Defects in these genes can produce abnormal hemoglobins and anemia, which are conditions termed "hemoglobinopathies". Abnormal hemoglobins appear in one of three basic circumstances: Structural defects in the hemoglobin molecule. Diminished production of one of the two subunits of the hemoglobin molecule. Abnormal associations of otherwise normal subunits.
Hydrocephalus	Hydrocephalus is the abnormal accumulation of cerebrospinal fluid (CSF) in the ventricles, or cavities, of the brain. This may cause increased intracranial pressure inside the skull and progressive enlargement of the head, convulsion, and mental disability.
Immunoglobulin	Immunoglobulin is a concentrated preparation of gamma globulins, predominantly IgG, from a large pool of human donors; used for passive immunization against measles, hepatitis A, and varicella and for replacement therapy in patients with immunoglobulin deficiencies.
Induction of labor	Induction of labor is the initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun).
In-utero transfer	An in-utero transfer consists in transferring, while the fetus is still in-utero, of the high-risks pregnant mother to another specialized birthing facility. Conversely, post-natal transfers are transfers that occur after the delivery.
Intra-uterine growth retardation (IUGR)	Intrauterine growth retardation (IUGR) occurs when the unborn baby is at or below the 10th weight percentile for his or her age (in weeks).
Intubation	Tracheal intubation is the placement of a flexible plastic tube into the trachea to protect the patient's airway and provide a means of mechanical ventilation.
Meningomyelocele	Meningomyelocele is a herniation of the meninges and spinal cord tissue.
Neural tube defects	Neural tube defect will occur in human embryos if there is an interference with the closure of the neural tube.
Nonvertex Presentation	Nonvertex presentation is the presentation of other than the upper and back part of the infant’s head.
Nuchal translucency scan	Nuchal translucency scan is an ultrasonographic prenatal screening scan to help identify higher risks of Down syndrome in a fetus. The scan is carried out at 11-13 weeks pregnancy and assesses the amount of fluid behind the neck of the fetus. Fetuses at risk of Down tend to have a higher amount of fluid around the neck.
Omphalocele	Omphalocele is a defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk
Pre-eclampsia	Pre-eclampsia is a disorder occurring during late pregnancy or immediately following parturition, characterized by hypertension, edema, and proteinuria. Also called toxemia of pregnancy.
Preterm birth	Preterm birth is a live birth of less than 37 completed weeks of gestation.
Premature labor	Premature labor describes the contractions of the uterus less than 37 weeks in a pregnancy.
Presentation	Presentation is the part of the fetus lying over the pelvic inlet; the presenting body part of the fetus.

Glossary Term	Definition
Polymalformative syndrome	Polymalformative syndrome is set of non-random birth defects deriving from the same cause. It involves multiple systems of the organism (eyes, ears, central nervous system, heart, musculoskeletal...). Its screening, mostly by clinical examination means, is systematically made at birth.
Spina bifida	Spina bifida is a herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure.
Spinal anesthesia	Spinal anesthesia or sub-arachnoidal block is a form of regional anesthesia involving the injection of local anesthetic into the cerebrospinal fluid.
Fetal death	Fetal death is a death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus 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 the voluntary muscles. Heartbeats are to be distinguished from fleeting respiratory efforts or gasps.
Metabolism disorder	Metabolism disorders are disorders that affect chemical processes that take place in living organisms, resulting in growth, generation of energy, elimination of wastes, and other body functions as they relate to the distribution of nutrients in the blood after digestion.
Ultrasound	Ultrasound study is a radiologic study using sound waves used in the assessment of gestational age, size, growth, anatomy, and blood flow of a fetus or in the assessment of maternal anatomy and blood flow.
Vaginal birth/spontaneous	Vaginal birth/spontaneous birth is the delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.
Vaginal birth with forceps	Vaginal birth with forceps is the delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head.
Vaginal birth with vacuum	Vaginal birth with vacuum is the delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head.
Vertex Presentation	Vertex presentation is the presentation of the upper or back part of the infant’s head

Volume 1 – Profiles

Copyright Licenses

Not applicable

Domain-specific additions

Not applicable

Add Section X

X Birth and Fetal Death Reporting-Enhanced (BFDR-E) Profile

The Birth and Fetal Death Reporting-Enhanced (BFDR-E) Profile provides a means to capture and communicate information needed to report births and fetal deaths for vital registration purposes. BFDR-E builds upon the earlier Birth and Fetal Death Reporting (BFDR) Profile that utilizes actors and transactions defined in the ITI Retrieve Form for Data Capture (RFD) Profile to capture structured data using digital forms.

BFDR-E defines a specialized Labor and Delivery Summary (LDS-VR) CDA document. The LDS-VR document is used to prepopulate an electronic form (worksheet) that collects the information needed for submission to vital records. BFDR-E supports pre-population of the worksheet form using either the specialized LDS-VR document or a more general Labor and Delivery Summary (LDS) document that does not conform to all the further constraints of an LDS-VR document. Use of the LDS-VR pre-population option optimizes the initial Birth and Fetal Death Report form data population.

BFDR-E further defines a mechanism to transform form submission data and record it in a CDA document designed to exchange the information in a standard format. BFDR-E defines a Form Receiver CDA Exporter Actor to perform the transform on the form submission data and share that document with a Content Consumer. BFDR-E defines the IHE BFDR Document Template which adapts the HL7 BFDR CDA document template to support standard interchange of the information gathered from the form.

BFDR-E also defines a mechanism to transform form submission data and transmit it as a standard HL7 v2 message. The IHE BFDR Message adapts the HL7 V2.5.1 BFDR Message for this purpose. BFDR-E defines the BFDRfeed transaction to transmit this message. The BFDRfeed transaction is just like the VRDRfeed [QRPH-38] transaction defined in the QRPH Vital Records Profile, but is carries a different message payload.

X.1 Actors, Transactions, and Content Modules

This section defines the actors, transactions, and/or content modules in this profile. General definitions of actors are given in the Technical Frameworks General Introduction Appendix A at http://www.ihe.net/Technical_Frameworks.

The BFDR-E Profile defines three ways to exchange data required for birth and fetal death reporting in an electronic form. First, creation of a BFDR Birth CDA Document Content and a BFDR Fetal Death CDA Document is supported. Second, communication of the BFDR content in an HL7 message is supported. Third, a form-based data collection method is supported using RFD transactions and pre-population mechanisms to supplement human data entry. A specialized LDS-VR document is specified to maximize the number of data elements that can be

prepopulated in the form so as to minimize the amount of human data entry required. The form data may be used directly by a birth reporting system, or there may be further processing of the form data to produce standard birth and fetal death content in the BFDR Birth CDA Document, the BFDR Fetal Death CDA Document, or the BFDR message format.

Figure X.1-1 shows the actors directly involved in the BFDR-E Profile and the relevant transactions between them.

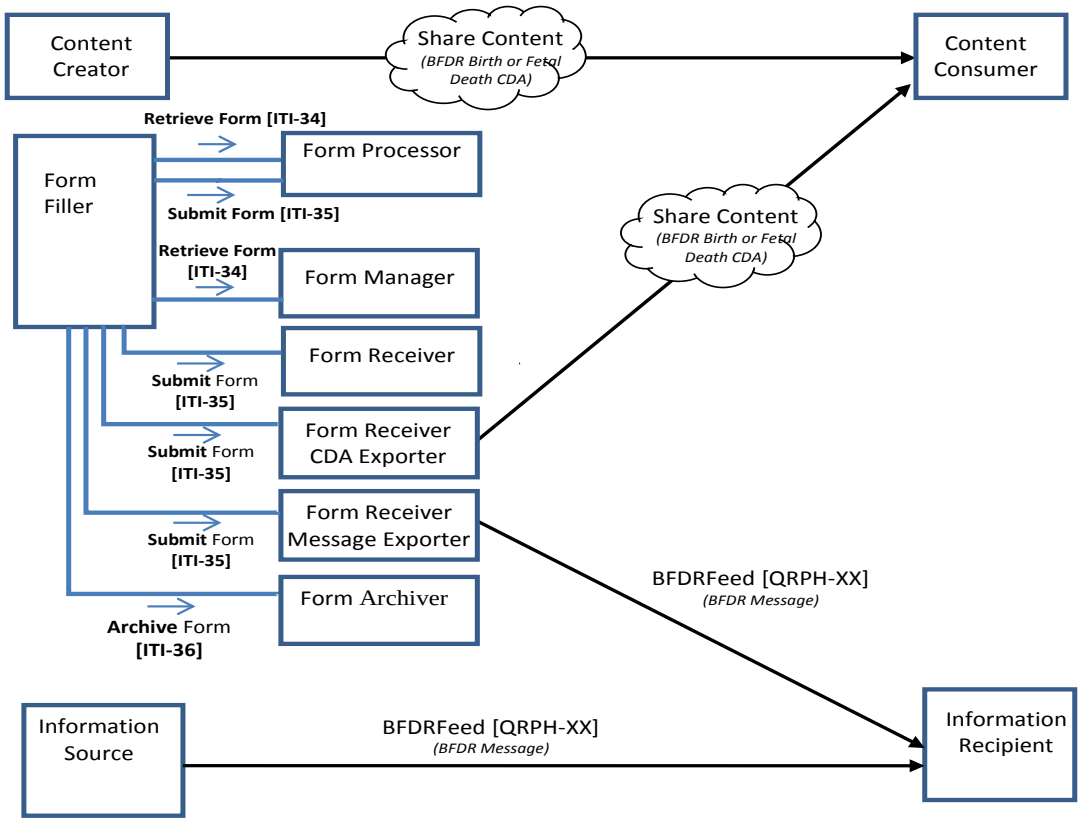

Figure X.1-1: BFDR-E Actor Diagram

Table X.1-1: BFDR Profile - Actors and Transactions

Actors (see Note 1 and Note 2)	Transactions	Optionality	Section in Vol. 2
Form Filler	Retrieve Form [ITI-34]	R	ITI TF-2b: 3.34
	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
	Archive Form [ITI-36]	O	ITI TF-2b: 3.36

Actors (see Note 1 and Note 2)	Transactions	Optionality	Section in Vol. 2
Form Manager	Retrieve Form [ITI-34]	R	ITI TF-2b: 3.34
Form Processor	Retrieve Form [ITI-34]	R	ITI TF-2b: 3.34
	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Receiver	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Receiver CDA Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Receiver Message Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
	BFDR Feed [QRPH-37]	R	QRPH TF 2: 3.xx
Form Archiver	Archive Form [ITI-36]	R	ITI TF-2b: 3.36
Information Source	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.xx
Information Recipient	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.xx
Content Creator	NA	O	NA
Content Consumer	NA	O	NA

Note 1: Systems initiating communications of Birth and Fetal Death Reporting information SHALL implement either Content Creator (QRPH BFDR Document) or Information Source (QRPH BFDR Message), or Form Filler (with LDS or LDS-VR Option)

Note 2: Systems receiving/consuming communications of Birth and Fetal Death Reporting information SHALL implement either Content Consumer (QRPH BFDR Document), Information Recipient (QRPH BFDR Message), or one of the four Form Receiver Actors (Form Receiver, Form Receiver CDA Exporter, Form Receiver Message Exporter, or Form Processor).

X.1.1 Actor Descriptions and Actor Profile Requirements

X.1.1.1 Content Creator

The Content Creator SHALL be able to create both a valid CDA document which conforms to the IHE BFDR Birth Document template and a valid CDA document which conforms to the IHE BFDR Fetal Death Document template. These BFDR documents are defined in section QRPH 3:6.3.1.D1.5 (IHE BFDR Birth Document) for live births and in section QRPH 3:6.3.1.D2.5 (IHE BFDR Fetal Death Document) for fetal deaths.

The Content Creator SHALL conform to all requirements specified for the Content Creator Actor in the QRPH IHE Birth and Fetal Death Reporting (IHE BFDR) Integration Profile.

X.1.1.2 Content Consumer

The Content Consumer SHALL consume both a valid CDA document which conforms to the IHE BFDR Birth Document template and a valid CDA document which conforms to the IHE BFDR Fetal Death Document template.

The Content Consumer SHALL implement the Discrete Data Import Option when consuming a QRPH IHE BFDR Birth Document or IHE BFDR Fetal Death Document.

X.1.1.3 Form Filler

The Form Filler Actor SHALL support requirements defined for the Form Filler in the ITI RFD Profile with the following qualifications:

The Form Filler SHALL support XHTML and SHALL NOT support the XFORMS Option of the Retrieve Form [ITI-34] transaction.

The Form Filler SHALL include functionality to initiate a Retrieve Form (ITI-34) transaction when a certifier is ready to enter birth or fetal death information for the purpose of completing the vital records information.

The Form Filler SHALL support one of two possible pre-population options: The LDS Pre-pop Option or the LDS-VR Pre-pop Option.

- A Form Filler implementing the Pre-Pop Option SHALL supply a valid LDS Documents (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2) as the pre-prop document for the Retrieve Form (ITI-34) transaction.
- A Form Filler implementing the LDS-VR Pre-pop Option SHALL supply a valid LDS-VR Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1) as the pre-prop document for the Retrieve Form (ITI-34) transaction.

The Form Filler SHALL encode the prepopData parameter of the Retrieve Form [ITI-34] transaction using the XML content of the pre-pop document.

The Form Filler MAY support the Archive Form Option to support recording of the form submission data at an alternate actor identified by the Form Filler.

In order to support the need to save a form for editing at a later time, the Form Filler SHALL be able to request a form for the same patient multiple times. (Further guidance on the workflow requirements to support this capability is outside the scope of this profile.)

X.1.1.4 Form Manager

The Form Manager SHALL support all the requirements defined for the Form Manager in the ITI RFD Profile with the following qualifications:

The Form Manger SHALL support XHTML and SHALL NOT support XFORMS of the Retrieve Form [ITI-34] transaction.

The system fulfilling the Form Manager Actor in the BFDR-E Profile SHALL accept pre-pop data in the form of content defined by the IHE PCC LDS document template (Template id 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2) or the IHE QRPH LDS-VR document template (Template id 1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1), and return a form that has been appropriately pre-populated based on the pre-population rules specified in 6.3.1.D3.4 Data Element Requirement Mappings for Form Pre-Population.

If a form is requested for the same patient then the form manager shall supply the previously populated and saved form.

X.1.1.5 Form Receiver

The Form Receiver is defined in the ITI RFD Profile.

The Form Receiver SHALL receive the populated form from the Form Filler when the form is submitted. No further requirements are placed on the Form Receiver within the scope of this profile.

X.1.1.6 Form Processor

The Form Processor is defined in the ITI RFD Profile.

The Form Processor SHALL support XHTML and SHALL NOT support XFORMS of the Retrieve Form transaction.

The system fulfilling this role in the BFDR Profile SHALL accept pre-pop data in the form of content defined by the IHE PCC LDS Profile (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2 or the IHE QRPH (LDS-VR) (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1) and return a form that has been appropriately pre-populated based on the mapping rules specified in 6.3.1.D2.4 Data Element Requirement Mappings for Form Pre-Population.

If the same request is submitted for the same patient then the form shall supply the partially filled and saved form.

The Form Processor SHALL receive the populated form from the Form Filler when the form is submitted. No further requirements are placed on the Form Processor within the scope of this profile.

X.1.1.7 Form Receiver CDA Exporter

The Form Receiver CDA Exporter receives data submitted through the Submit Form Transaction (ITI-35), transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer. For BFDR, this transforms that data to create the BFDR Birth CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.2) defined in QRPH 3:6.3.1.D1 or the BFDR Fetal Death CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.3) defined in QRPH 3:6.3.1.D2, and shares that newly created BFDR content document with a Content Consumer. Detailed rules for the BFDR Birth CDA Document Content are fully defined in QRPH 3:6.3.1.D1. Detailed rules for the BFDR Fetal Death CDA Document Content are fully

defined in QRPH 3:6.3.1.D2. Specification of the transformation rules from the US BFDR Form to the CDA content is defined in the BFDR-E Profile, volume 4 US Realm, Section 4.I.2.1.2 Form Data Element Mappings to Output Content Document.

X.1.1.8 Form Receiver Message Exporter

The Form Receiver Message Exporter receives data submitted through the Submit Form Transaction (ITI-35), transforms that data to an HL7 message and sends that message to an Information Recipient. For BFDR, this transforms that data to be in compliance with the requirements of the HL7 V.2.5.1 BFDRFeed transaction (QRPH-37) and sends that data to an Information Recipient using QRPH-37. Detailed rules for the BFDRFeed transaction are fully defined in QRPH 2:3.XX.4.1 BFDRFeed [QRPH-37]. Transformation rules from the form to the message content arefully specified in BFDR-E Profile Volume 4 US Realm, Section 4.I.2.1.3 Form Data Element Mappings to Output HL7 Message .

X.1.1.9 Form Archiver

The actions of the Form Archiver are defined in the ITI RFD Profile.

The Form Archiver MAY be leveraged to support traceability of the form data used to create submitted documents. No further refinements of that document are stated by this profile.

X.1.1.10 Information Source

The Information Source Actor is responsible for the creation of a BFDRFeed Message (QRPH-37) containing the Birth and Fetal Death Reporting attributes and transmitting this message to an Information Recipient. The Information Source SHALL transmit content as specified by in QRPH BFDR-E Volume 2.

X.1.1.11 Information Recipient

The Information Recipient Actor is responsible for receiving the BFDRFeed Message (QRPH-37) containing the Birth and Fetal Death Reporting attributes from the Information Source.

X.2 Actor Options

Table X.2-1: BFDR-E - Actors and Options

Actor	Option Name	Reference
Content Creator	None	--
Content Consumer	View	PCC TF V1:3.4.1.1
	Document Import	PCC TF V1:3.4.1.2
	Discrete Data Import	PCC TF V1:3.4.1.4

Actor	Option Name	Reference
Form Filler	Pre-Pop	QRPH: X.2.1.1
	VR Pre-Pop	QRPH: X.2.1.2
	Archive Form	QRPH: X.2.1.3
Form Manager	US BFDR Form Option	QRPH TF-1: X.2.2.1
Form Receiver	None	--
Form Receiver CDA Exporter	None	--
Form Receiver Message Exporter	None	--
Form Archiver	None	--
Information Source	None	--
Information Recipient	None	--

X.2.1 Form Filler: Pre-Pop Option

This option defines the document submission requirements placed on Form Fillers for providing pre-pop data to the Form Manager. The Form Filler's support for the Pre-Pop Option determines how pre-population data is handled when the Form Filler retrieves the form using ITI-34:

- If the Form Filler supports the Pre-Pop Option, the value of the pre-pop Data parameter in the Retrieve Form Request (see RFD Profile, ITI TF 2b:3.34.4.1.2) shall be a well-formed xml document as defined in the PCC Labor and Delivery Summary (LDS) Content Profile (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2, see Labor and Delivery Profiles Trial Implementation Supplement, section Y.7). See QRPH 1: Appendix X for the specification of the desired pre-pop data.

X.2.2 Form Filler: VR Pre-Pop Option

This option defines the document submission requirements placed on Form Fillers for providing pre-pop data to the Form Manager, describing specific content and vocabulary constraints to the PCC LDS that will optimize the ability to process the clinical content to fill in the BFDR Form. The Form Filler's support for the VR Pre-Pop Option determines how pre-population data is handled when the Form Filler retrieves the form using ITI-34.

If the Form Filler supports the VR Pre-Pop Option, the value of the pre-pop Data parameter in the Retrieve Form Request (see RFD Profile, ITI TF 2b:3.34.4.1.2) shall be a well-formed xml document as defined in the PCC Labor and Delivery Summary (LDS) Content Profile (see Labor and Delivery Profiles Trial Implementation Supplement, section Y.7) as constrained by QRPH 3: 6.3.1.A for the specification of the LDS content required as and LDS-VR Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1).

X.2.3 Form Filler: Archive Form Option

If the Form Filler supports the Archive Form Option, it shall implement the Archive Form transaction ITI-36.

X.2.4 Form Manager: US BFDR Form Option

This option defines the pre-population rules and requirements placed on Form Managers for parsing and assigning pre-pop data attributes for the pre-populated form returned to the Form Filler in the ITI-34. Detailed prepopulation rules for the US BFDR attributes are fully defined in 4.I.2.1 BFDR US Form Option.

X.3 BFDR-E Required Actor Groupings

This profile does not include any required groupings.

X.4 BFDR-E Overview

The National Vital Statistics System has a long and enduring history that serves to provide essential data on births and deaths within the United States and is the oldest and most successful example of inter-governmental data sharing in Public Health. Currently, these data typically are gathered by hospital personnel from the hospital's medical records using paper worksheets. The process of capturing Vital Records information manually is duplicative, labor-intensive, costly and can be error prone. As a result, the timeliness and quality of these data are adversely affected.

X.4.1 Concepts

Sets of detailed specifications have been developed for collecting and reporting the items on the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death. It is critical that all U.S. vital registration areas follow these standards to promote uniformity in data collection across registration areas. The best sources for specific data items are identified in the Birth and Fetal Death Edit Specifications for the 2003 Revisions of the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death.

Additionally, standard worksheets are used to enhance the collection of quality, reliable data. A common, standard form, entitled "Mother's Worksheet for Child's Birth Certificate", has been established to identify information to be collected directly from the mother. The "Facility Worksheet for the Live Birth Certificate" was developed to identify information for which the best sources are the mother's and infant's medical records. The use of separate worksheets promotes a standardized collection across states. The "Patient's Worksheet for the Report of Fetal Death" and the "Facility Worksheet for the Report of Fetal Death" have also been established for the purpose of reporting fetal death information.

The hospital is responsible for completing the Record of Live Birth in the jurisdiction's Electronic Birth Registration System (EBRS). Information collected from the mother on the

Mother's Worksheet must be data entered into the EBRS. Facility Worksheet data transmitted electronically into the EBRS from the EHR must be reviewed for completeness and accuracy. The birth records specialist plays an essential role in gathering the information and ensuring that all information is complete before transmission to the vital registration system at the states/jurisdictional vital record offices. Select birth data may be transmitted later to public health authorities as allowed by individual state statute and other vital records stakeholders.

Example Forms:

- Facility Worksheet (http://www.cdc.gov/nchs/data/dvs/facwksBF04.pdf)
- U.S. Standard Certificate of Live Birth (http://www.cdc.gov/nchs/data/dvs/birth11-03final-ACC.pdf)

Note: The Mother's Worksheet includes legal and other attributes that are required to be obtained through direct data entry and are not specified by this profile

In the following use cases, the birth information specialist (BIS) will review and complete the Facilities Worksheet using information that has already been prepopulated by the EHR system. The BIS verifies the accuracy of the information and submits the form. This may be constrained in the US Extension to support only the forms for data submission for specific jurisdictional implementations. The form is received by a system that is configured to transform the facilities worksheet information into a standard CDA document or HL7 message, depending upon the input format preferred by the vital registration system of the jurisdiction. The information is communicated to the vital registration system where further vital registration functions are addressed to formalize the birth certificate or fetal death report. The use case will also support the option for the CDA document or HL7 message to be generated directly by a system, without using form-based collection.

X.4.2 Use Cases

X.4.2.1 Use Case #1: Forms Data Capture with Messaging

The Forms Data Capture with Messaging use case uses Retrieve Form for Data Capture (RFD) to present Facilities Worksheet for pre-population, and the Form Receiver system transforms the information into a BFDRFeed (QRPH-37) message to transmit the information to Public Health.

X.4.2.1.1 Use Case Description

When the delivery has been documented in the system, a Labor and Delivery Summary document (LDS, LDS-VR) is created with Vital Record Birth and Fetal Death Reporting Content requirements. This summary document is provided as pre-population data to a public health IHE ITI Retrieve Form for Data Capture (RFD) Forms Manager. The RFD Form Receiver provides the content to the EBRS by way of a transform to the corresponding BFDRFeed (QRPH-37) message.

X.4.2.1.2 Processing Steps

X.4.2.1.2.1 Pre-conditions

A delivery has been documented in the EHR system.

X.4.2.1.2.2 Main Flow

This flow captures the EBRS information using forms provided by public health and transmits the data that is captured to public health using HL7 Messaging (BFDRFeed).

X.4.2.1.2.3 Post-conditions

The EBRS has received the data.

X.4.2.1.3 Process Flow

The process flow of this profile is defined by the ITI RFD Profile. Please refer to ITI TF-1:17 for a description of the process flow for RFD. The Form Filler may be implemented by the birthing facility or by the child's clinician in instances of home birth etc. The process flow for the BFDR-E is described below.

The provider EHR presents the Facilities Worksheet providing a LDS or LDS-VR document for Pre-population by the Form Manager. The birth information specialist completes the form, verifies the accuracy of all information, and submits the form. The Form Receiver transforms the information from the form into a HL7 BFDR message and transmits that message to the EBRS system using the Send BFDR Message (QRPH-37).

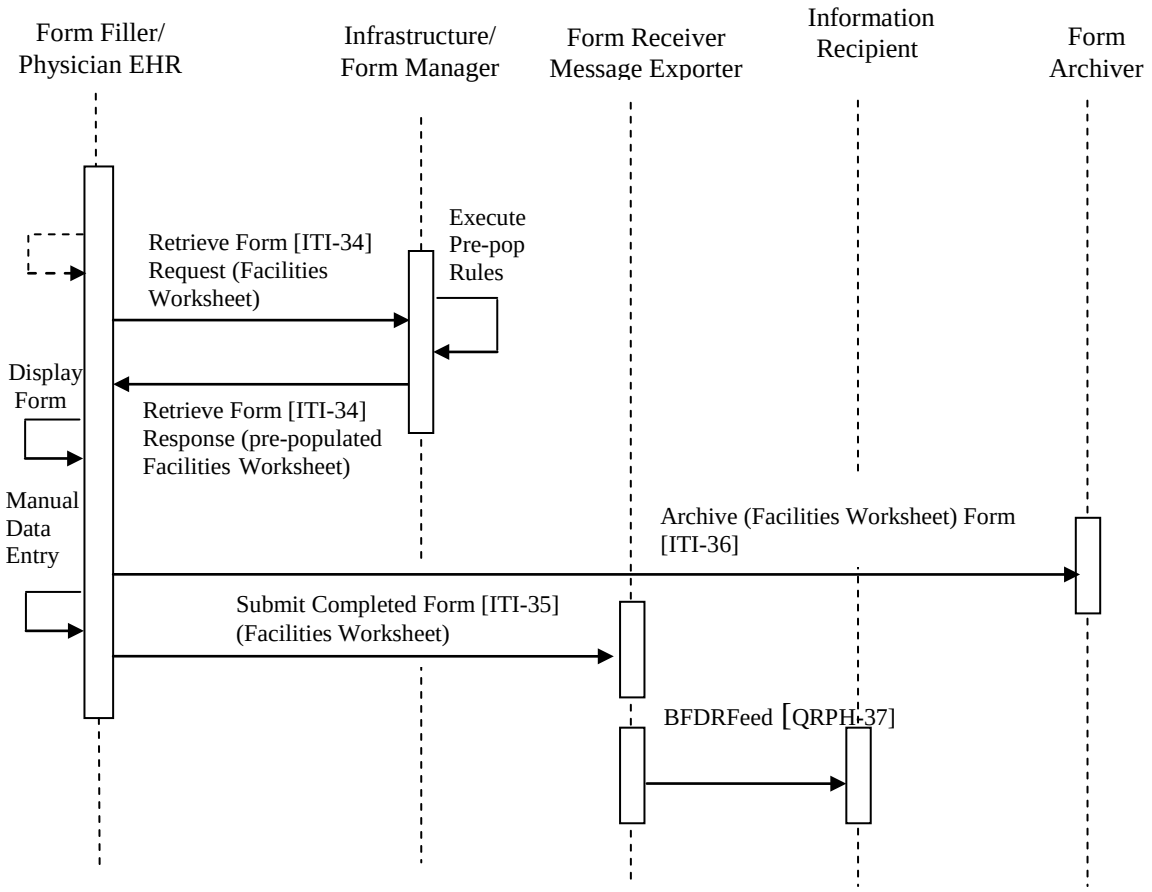

Figure X.4.2.1.3-1: Use Case 1 - Forms Data Capture with Messaging

X.4.2.2 Use Case #2: Forms Data Capture with Document Submission

The Forms Data Capture with Document Submission use case uses Retrieve Form for Data Capture (RFD) to present the Facilities Worksheet for pre-population, and the Form Receiver system transforms the information into a BFDR Birth CDA Document or a BFDR Fetal Death CDA Document to transmit the information to Public Health.

X.4.2.2.1 Use Case Description

When the delivery has been documented in the system, a Labor and Delivery Summary document (LDS, LDS-VR) is created with Vital Record Birth and Fetal Death Reporting Content requirements. This summary document is provided as pre-population data to a public health IHE ITI Retrieve Form for Data Capture (RFD) Forms Manager. The RFD Form Receiver provides the content to the EBRS by way of a transform to the corresponding BFDR Birth CDA Document or the BFDR Fetal Death CDA Document.

X.4.2.2.2 Processing Steps

X.4.2.2.2.1 Pre-conditions

A delivery has been documented in the EHR system.

X.4.2.2.2.2 Main Flow

This flow captures the EBRS information using forms provided by public health and transmits the data that is captured to public health using the BFDR Birth CDA Document or the BFDR Fetal Death CDA Document.

X.4.2.2.2.3 Post-conditions

The EBRS has received the data.

X.4.2.2.3 Process Flow

The process flow of this profile is defined by the ITI RFD Profile. Please refer to ITI TF-1:17for a description of the process flow for RFD. The Form Filler may be implemented by the birthing facility or by the child's clinician in instances of home birth etc. The process flow for the BFDR-E is described below.

The provider EHR presents the Facilities Worksheet providing a LDS or LDS-VR document for Pre-population by the Form Manager. The birth information specialist completes the form, verifies the accuracy of all information, and submits the form. The RFD Form Receiver provides the content to the EBRS by way of a transform to the corresponding BFDR Birth CDA Document or the BFDR Fetal Death CDA Document.

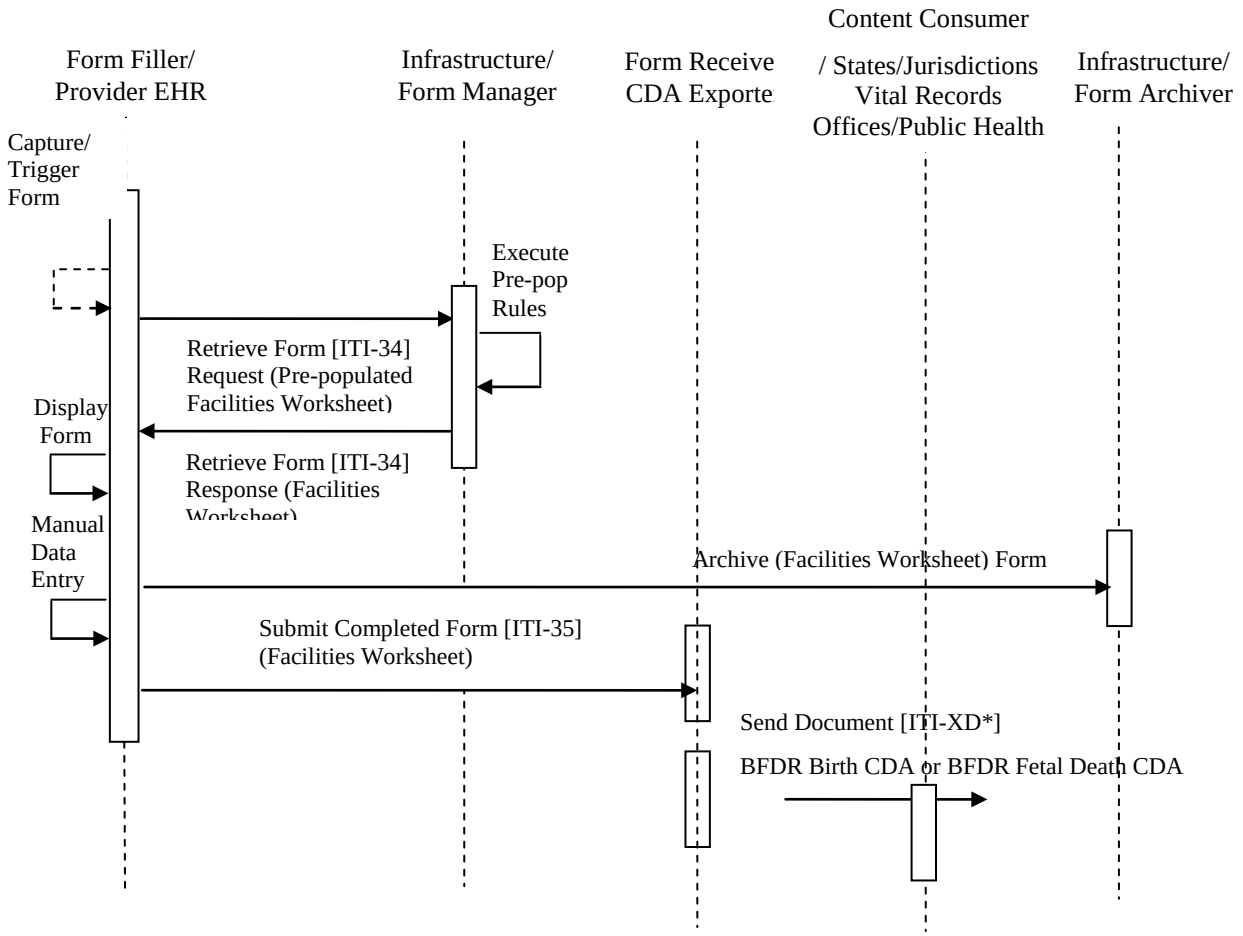

Figure X.4.2.2.3-1: Use Case 2- Forms Data Capture with Document Submission

X.4.2.3 Use Case #3: Native Forms Data Capture

The birth information specialist logs into the EHR and accesses the record of a newborn patient to begin the process of completing information required for birth and fetal death reporting. The EHR presents a form to the BIS that contains some data that has been pre-populated. She reviews the form, completes the remaining items, and verifies that the record is complete and accurate before submitting to transmit the data electronically into the EBRS. The EBRS record is saved and filed electronically with the state vital statistics office.

X.4.2.3.1 Use Case Description

When the delivery has been documented in the system, a Labor and Delivery Summary document (LDS, LDS-VR) is created with Vital Record Birth and Fetal Death Reporting Content requirements. This document is provided as pre-population data to a public health IHE ITI Retrieve Form for Data Capture Forms Manager. The RFD Form Receiver information is consumed directly by the EBRS.

X.4.2.3.2 Processing Steps

X.4.2.3.2.1 Pre-conditions

A delivery has been documented in the EHR system.

X.4.2.3.2.2 Main Flow

This flow captures the EBRS information using forms provided by public health and incorporates the data that is captured using product defined methods.

X.4.2.3.2.3 Post-conditions

The EBRS has received the data.

X.4.2.3.3 Process Flow

The provider EHR presents the Facilities Worksheet providing a LDS or LDS-VR document for Pre-population by the Form Manager. The birth information specialist completes the form, verifies the accuracy of all information, and submits the form. The RFD Form Receiver information is consumed directly by the EBRS.

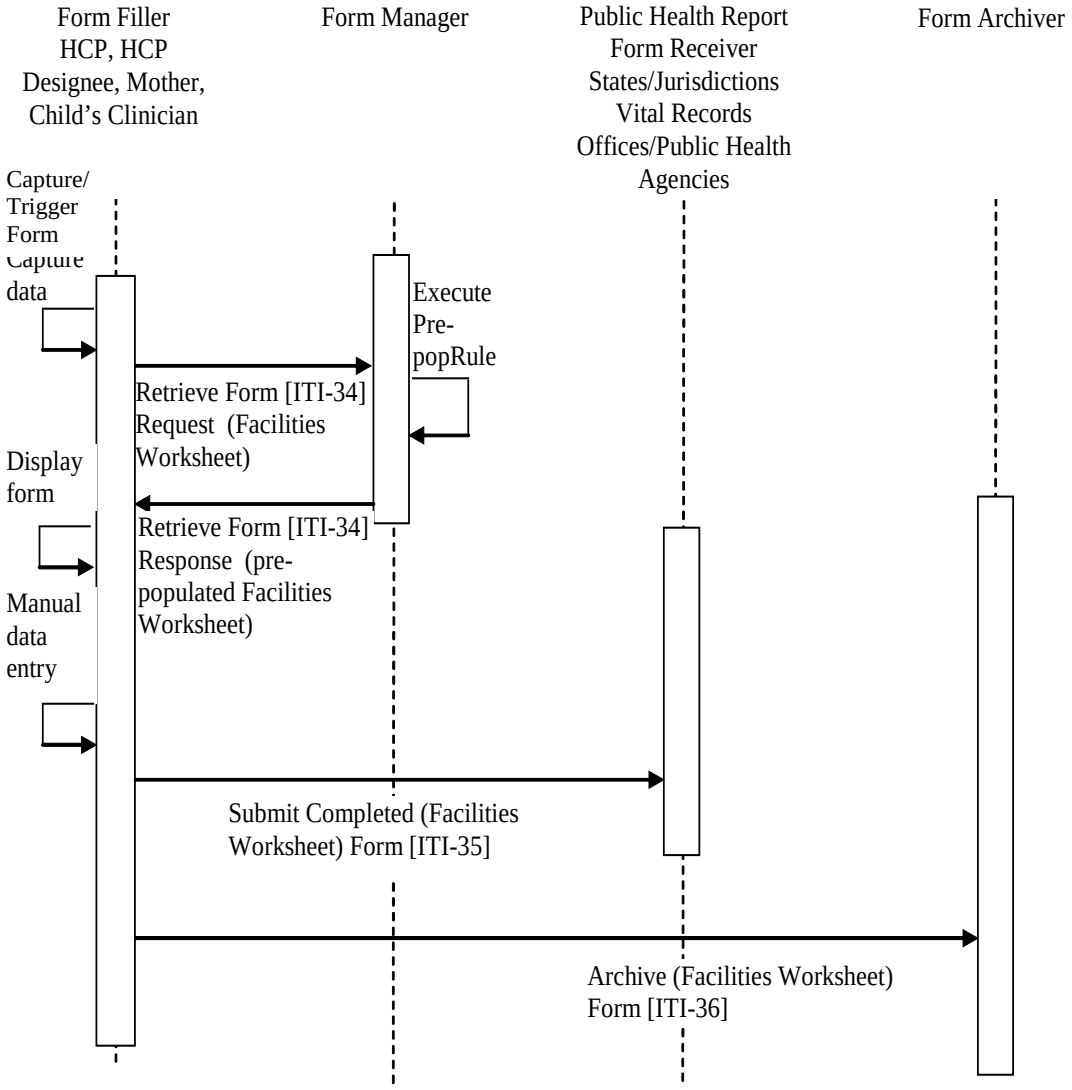

Figure X.4.2.3.3-1: Use Case 3 - Native Forms Data Capture

X.4.2.4 Use Case #4: EHR BFDR Messaging

The EHR BFDR Messaging use case creates the HL7 BFDR message directly and transmits the information to the EBRS.

X.4.2.4.1 Use Case Description

When the delivery has been documented in the system, the EHR system creates an HL7 BFDR message and sends the message to the EBRS directly.

X.4.2.4.2 Processing Steps

X.4.2.4.2.1 Pre-conditions

A delivery has been documented in the EHR system.

X.4.2.4.2.2 Main Flow

This flow sends the birth registration information to the EBRS using the BFDRFeed [QRPH-37].

X.4.2.4.2.3 Post-conditions

The EBRS has received the data.

X.4.2.4.3 Process Flow

The provider EHR sends the HL7 BFDR message to the EBRS.

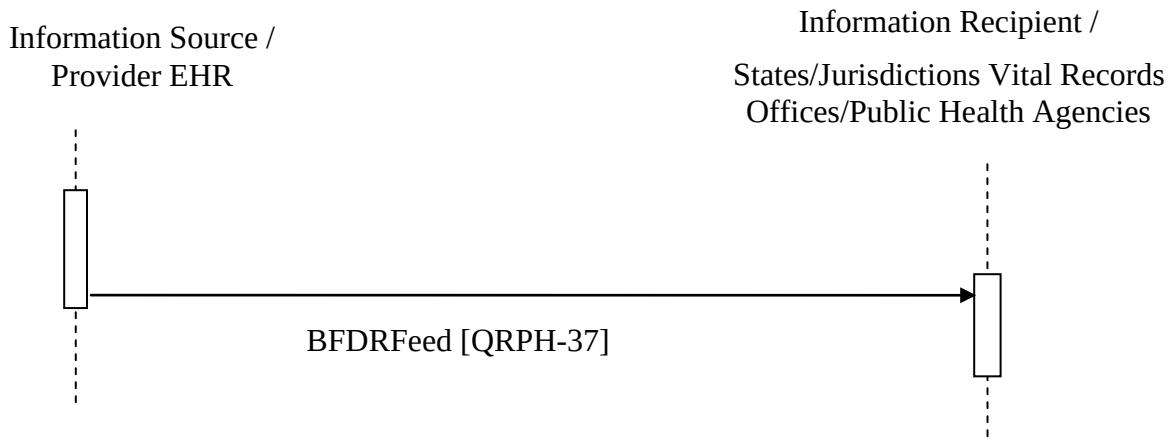

Figure X.4.2.4.3-1: Use Case 4-EHR BFDR Messaging

X.4.2.5 Use Case #5: EHR BFDR Document Submission

The EHR BFDR Messaging use case creates the HL7 BFDR message directly and transmits the information to the EBRS.

X.4.2.5.1 Use Case Description

When the delivery has been documented in the system,, the EHR system creates an HL7 BFDR message and sends the message to the EBRS directly.

X.4.2.5.2 Processing Steps

X.4.2.5.2.1 Pre-conditions

A delivery has been documented in the EHR system.

X.4.2.5.2.2 Main Flow

This flow sends the birth registration information to the EBRS using the BFDR Document (CDA).

X.4.2.5.2.3 Post-conditions

The EBRS has received the data.

X.4.2.5.3 Process Flow

The provider EHR sends the HL7 BFDR message to the EBRS.

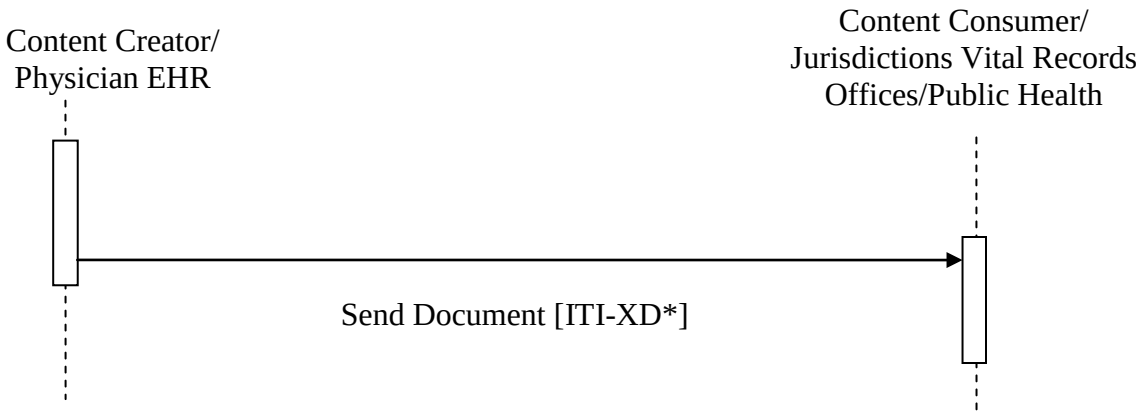

Figure X.4.2.5.3-1: Use Case 5- EHR BFDR Document Submission

X.5 Security Considerations

BFDR includes clinical content related to the information subject. As such, it is anticipated that the transfers of Personal Health Information (PHI) will be protected. The IHE ITI ATNA Integration Profile SHOULD be implemented by all of the actors involved in the IHE transactions specified in this profile to protect node-to-node communication and to produce an audit trail of the PHI related actions when they exchange messages, though other private security mechanisms MAY be used to secure content within enterprise managed systems. Details regarding ATNA logging will be further described in Volume 2.

The content of the form also results in a legal document, and the Form Manager MAY include a digital signature using ITI DSG to assure that the form content submitted cannot be changed.

For security purposes, when sending information specifically to vital records Electronic Registration Systems, systems will also need to know the identity of the user and the location to identify the data source. In this case, XUA MAY be utilized to support this implementation.

X.6 Cross Profile Considerations

The following informative narrative is offered as implementation guidance.

X.6.1 XDS.b, XDM, or XDR XDS.b, XDM, or XDR – Cross Enterprise Document Sharing.b, Cross Enterprise Document Media Interchange, or Cross Enterprise Document Reliable Interchange

The use of the IHE XD* family of transactions is encouraged to support standards-based interoperability between systems acting as Content Creator and Content Consumer. The grouping of Content Creator and Content Consumer Actors with ITI XD* Actors is defined in the PCC Technical Framework (PCC TF 1:3.7.1). Below is a summary of recommended IHE transport transactions that MAY be utilized by systems playing the roles of Content Creator or Content Consumer to support the use cases defined in this profile:

- A Document Source in XDS.b, a Portable Media Creator in XDM, or a Document Source in XDR might be grouped with the BFDR Content Creator. A Document Consumer in XDS.b, a Portable Media Importer in XDM, or a Document Recipient in XDR might be grouped with the BFDR Content Consumer, A registry/repository-based infrastructure is defined by the IHE Cross Enterprise Document Sharing (XDS.b) that includes profile support that can be leveraged to facilitate retrieval of public health related information from a document sharing infrastructure: Multi-Patient Query (MPQ), Document Metadata Subscription (DSUB) and notification of availability of documents (NAV),
- A media-based infrastructure is defined by the IHE Cross Enterprise Document Media Interchange (XDM) Profile. A Portable Media Creator in XDM might be grouped with the BFDR Content Creator. A Portable Media Importer in XDM might be grouped with the BFDR Content Consumer,

- A reliable messaging-based infrastructure is defined by the IHE Cross Enterprise Document Reliable Interchange (XDR) Profile. A Document Source in XDR might be grouped with the BFDR Content Creator. A Document Recipient in XDR might be grouped with the BFDR Content Consumer,
- All of these infrastructures support Security and privacy through the use of the Consistent Time (CT) and Audit Trail and Node Authentication (ATNA) Profiles. A Time Client in CT might be grouped with the BFDR Content Creator and the BFDR Content Consumer. A Secure Node and/or a Secure Application in ATNA might be grouped with the BFDR Content Creator and the BFDR Content Consumer.

Detailed description of these transactions can be found in the IHE IT Infrastructure Technical Framework.

X.6.2 Sharing Value Set (SVS)

Actors in the BFDR Profile may support the Sharing Value Set (SVS) Integration Profile in order to use a common uniform managed vocabulary for dynamic management of form mapping rules.

X.7 BFDR Data Elements

This profile defines specific data element content. These data elements are used to create of the BFDR Birth CDA Document or the BFDR Fetal Death CDA Document, generate the HL7 BFDR Message, or populate a form defined to gather the required structured data, such as the US BFDR Form. That set of data elements in the form are identified and defined in Appendix D.

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Appendix A – Sample US Facilities Worksheet

The sample Birth and Fetal Death Reporting Facilities Worksheet form included in this content profile reflects the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death reporting requirements from the birthing facility. However, the BFDR Content Profile may be modified to include and accommodate international birth and fetal death reporting requirements.

Mother's medical record # _____
Mother's name _____

FINAL (2/5/04)

FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE

For pregnancies resulting in the births of two or more live-born infants, this worksheet should be completed for the 1st live born infant in the delivery. For each subsequent live-born infant, complete the "Attachment for Multiple Births." For any fetal loss in the pregnancy reportable under State reporting requirements, complete the "Facility Worksheet for the Fetal Death Report."
For detailed definitions, instructions, information on sources, and common key words and abbreviations please see "The Guide to Completing Facility Worksheets for the Certificate of Live Birth."

1. Facility name:* _____
(If not institution, give street and number)

2. Facility I.D. (National Provider Identifier): _____

3. City, Town or Location of birth: _____

4. County of birth: _____

5. Place of birth:

- ❑ Hospital□
- ❑ Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with □ an operative delivery center.) □
- ❑ Home birth□
  Planned to deliver at home ❑ Yes ❑ No□
- ❑ Clinic/Doctor's Office □
- ❑ Other (specify, e.g., taxi cab, train, plane, etc.)_____□

*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for births which occur at their institutions.

Prenatal

Sources: Prenatal care records, mother's medical records, labor and delivery records

Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart, as well as the infant's medical record. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

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6(a). Date of first prenatal care visit (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

M M D D Y Y Y Y

❑ **No prenatal care** (The mother did not receive prenatal care at any time during the pregnancy. If this box is checked skip 6(b)

6(b). Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records):

M M D D Y Y Y Y

7. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record. If none enter "0"): _____

8. Date last normal menses began: M M D D Y Y Y Y

9. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):□

____ Number • •None □

10. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):□

____ Number • •None □

11. Date of last live birth: M M Y Y Y Y

12. Total number of other pregnancy outcomes (Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy):

____ Number □ None

13. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):

M M Y Y Y Y

14. Risk factors in this pregnancy (Check all that apply):

Diabetes - (Glucose intolerance requiring treatment)□

❑ Prepregnancy - (Diagnosis prior to this pregnancy)□

❑ Gestational - (Diagnosis in this pregnancy)□

Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)

❑ Prepregnancy - (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy)

❑ Gestational - (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).)

❑ Eclampsia - (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.)

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- ❑ Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)
- ❑ Other previous poor pregnancy outcome - (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) - (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)
- ❑ Pregnancy resulted from infertility treatment - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).
  If Yes, check all that apply:
  - ❑ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
  - ❑ Assisted reproductive technology - Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.
- ❑ Mother had a previous cesarean delivery - (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)
  If Yes, how many____
- ❑ None of the above

15. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):

- ❑ Gonorrhea - (a diagnosis of or positive test for Neisseria gonorrhoeae)
- ❑ Syphilis - (also called lues - a diagnosis of or positive test for Treponema pallidum)
- ❑ Chlamydia - (a diagnosis of or positive test for Chlamydia trachomatis)
- ❑ Hepatitis B - (HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus)
- ❑ Hepatitis C - (non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus)□
- ❑ None of the above□

16. Obstetric procedures - (Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically□ in the treatment of the pregnancy, management of labor and/or delivery.) (Check all that apply): □

- ❑ Cervical cerclage - (Circumferential banding or suture of the cervix to prevent or treat passive dilatation. Includes MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy.)
- ❑ Tocolysis - (Administration of any agent with the intent to inhibit preterm uterine contractions to extend length of the pregnancy.)
- ❑ External cephalic version - (Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.)
  - ❑ Successful ❑ Failed
- ❑ None of the above

Labor and Delivery

Sources: Labor and delivery records, mother's medical records

17. Onset of Labor (Check all that apply):

- ❑ Premature Rupture of the Membranes (prolonged >=12 hours) (Spontaneous tearing of the amniotic sac, (natural breaking of the bag of waters), 12 hours or more before labor begins.) □
- ❑ Precipitous labor (<3 hours) (Labor that progresses rapidly and lasts for less than 3 hours.)□
- ❑ Prolonged labor (>=20 hours) (Labor that progresses slowly and lasts for 20 hours or more.) □
- ❑ None of the above □

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18. Date of birth: M M D D Y Y Y Y

19. Time of birth: _____ 24 hour clock

20. Certifier's name and title: _____
(The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth.)

- ❑ M.D.
- ❑ D.O.
- ❑ Hospital administrator or designee
- ❑ CNM/CM (Certified Nurse Midwife / Certified Midwife)
- ❑ Other Midwife (Midwife other than CNM/CM)
- ❑ Other (Specify)_____

21. Date certified: M M D D Y Y Y Y

22. Principal source of payment for this delivery (At time of delivery):

- ❑ Private Insurance
- ❑ Medicaid (Comparable State program)
- ❑ Self-pay (No third party identified)
- ❑ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local))

_____

23. Infant's medical record number: _____

24. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?
(Transfers include hospital to hospital, birth facility to hospital, etc.)

❑ Yes ❑ No

If Yes, enter the name of the facility mother transferred from:

_____

25. Attendant's name, title, and N.P.I. (National Provider Indentifier) (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

_____ _____
Attendant's name N.P.I.

Attendant's title:

- ❑ M.D.
- ❑ D.O.
- ❑ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
- ❑ Other Midwife - (Midwife other than CNM/CM)
- ❑ Other specify):_____

26. Mother's weight at delivery (pounds):_____

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27. Characteristics of labor and delivery (Check all that apply):

- ❑ Induction of labor - (Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.)
- ❑ Augmentation of labor - (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.)
- ❑ Non-vertex presentation - (Includes any non-vertex fetal presentation, e.g., breech, shoulder, brow, face presentations, and transverse lie in the active phase of labor or at delivery other than vertex.)
- ❑ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery - (Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment.)
- ❑ Antibiotics received by the mother during labor - (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.)
- ❑ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F) - (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38°C (100.4°F).
- ❑ Moderate/heavy meconium staining of the amniotic fluid - (Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery which is more than enough to cause a greenish color change of an otherwise clear fluid.)
- ❑ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery - (*In Utero Resuscitative measures* such as any of the following - maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following - scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery* – operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.)
- ❑ Epidural or spinal anesthesia during labor - (Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.)
- ❑ None of the above

28. Method of delivery (The physical process by which the complete delivery of the infant was effected) (Complete A, B, C, and D):

A. Was delivery with forceps attempted but unsuccessful? - (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

❑ Yes ❑ No

B. Was delivery with vacuum extraction attempted but unsuccessful? - (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

❑ Yes ❑ No

C. Fetal presentation at birth (Check one):

- ❑ Cephalic - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP))
- ❑ Breech - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
- ❑ Other - (Any other presentation not listed above)

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D. Final route and method of delivery (Check one):

- ❑ Vaginal/Spontaneous - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- ❑ Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- ❑ Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- ❑ Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)
❑ Yes ❑ No

29. Maternal morbidity (Serious complications experienced by the mother associated with labor and delivery)
(Check all that apply):

- ❑ Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- ❑ Third or fourth degree perineal laceration - (3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission of the mother to a facility/unit designated as providing intensive care.)
- ❑ Unplanned operating room procedure following delivery - (Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)
- ❑ None of the above

Newborn

Sources: Labor and delivery records, Newborn's medical records, mother's medical records

30. Birthweight: _____(grams) (Do not convert lb/oz to grams)
If weight in grams is not available, birthweight: _____(lb/oz)

31. Obstetric estimate of gestation at delivery (completed weeks):_____
(The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of birth.)

32. Sex (Male, Female, or Not yet determined): _____

33. Apgar score (A systematic measure for evaluating the physical condition of the infant at specific intervals at birth):
Score at **5** minutes _____
If 5 minute score **is less than 6:**
Score at **10** minutes _____

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34. Plurality (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.) □
(Include all live births and fetal losses resulting from this pregnancy.):_____ □

35. If not single birth (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): _____

36. If not single birth, specify number of infants in this delivery born alive:_____

37. Abnormal conditions of the newborn □(Disorders or significant morbidity experienced by the newborn)
(Check all that apply):

- ❑ Assisted ventilation required immediately following delivery - (Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.)
- ❑ Assisted ventilation required for more than six hours - (Infant given mechanical ventilation (breathing assistance) by□ any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).) □
- ❑ NICU admission - (Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.)
- ❑ Newborn given surfactant replacement therapy - (Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.)
- ❑ Antibiotics received by the newborn for suspected neonatal sepsis - (Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine etc.) given systemically (intravenous or intramuscular).)
- ❑ Seizure or serious neurologic dysfunction - (Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.)
- ❑ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) - (Defined as present immediately following delivery or manifesting soon after delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and/or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma.)
- ❑ None of the above

38. Congenital anomalies of the newborn (Malformations of the newborn diagnosed prenatally or after delivery.)
(Check all that apply):

- ❑ Anencephaly - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)
- ❑ Meningomyelocele/Spina bifida - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- ❑ Cyanotic congenital heart disease - (Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)

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- ❑ Congenital diaphragmatic hernia - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)
- ❑ Omphalocele - (A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)
- ❑ Gastroschisis - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)
- ❑ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)
- ❑ Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- ❑ Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- ❑ Down Syndrome - (Trisomy 21) □
  - ❑ Karyotype confirmed □
  - ❑ Karyotype pending □
- ❑ Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
  - ❑ Karyotype confirmed
  - ❑ Karyotype pending
- ❑ Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)
- ❑ None of the anomalies listed above

39. Was infant transferred within 24 hours of delivery ? (Check "yes" if the infant was transferred from this facility to another within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.)

❑ Yes ❑ No

If yes, name of facility infant transferred to:_____

40. Is infant living at time of report? (Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.) □

❑ Yes ❑ No ❑ Infant transferred, status unknown□

41. Is infant being breastfed at discharge?

❑ Yes ❑ No

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A. 1 Form Data Element Key

The following table reflects the mapping between the form elements in the sample Birth and Fetal Death Reporting Facilities Worksheet form above and the data elements described in Appendix B.

Data Element #	BFDR Data Element Code	Data Element Name
1	FNAME	<!-- 1. Facility name: Include the name of Facility where birth occurred-->
2	FNPI	<!-- 2. Facility I.D. (National Provider Identifier)-->
3	ADDRESS_D	<!-- 3. Facility: City, Town or Location of birth-->
4	CNAME	<!-- 4. Facility: County of birth -->
5	BPLACE	<!-- 5. Type of Place of birth
6	DOFP_YR, DOFP_MO, DOFP_DY	<!-- #6.(a) Date of first prenatal care visit -->
6	DOLP_YR, DOLP_MO, DOLP_DY	<!-- #6.(b) Date of last prenatal care visit -->
7	NPREV	<!-- #7. Total number of prenatal care visits for this pregnancy -->
8	DLMP_YR, DLMP_MO, DLMP_DY	<!-- #8. Date last normal menses began -->
9	PLBL	<!-- #9. Number of previous live births now living -->
10	PLBD	<!-- #10. Number of previous live births now dead -->
11	YLLB, MLLB	<!-- #11. Date of last live birth -->
12	POPO	<!-- #12. Total number of other pregnancy outcomes -->
13	YOPO, MOPO	<!-- #13. Date of last other pregnancy outcome-->
14		<!-- #14. Risk factors in this pregnancy -->
15		<!-- 15 Infections present and/or treated during this pregnancy.
16		<!-- 16. Obstetric procedures-->
17		<!-- 17. Onset of Labor -->
18	IDOB_YR, IDOB_MO, IDOB_DY	<!-- 18. Date of birth: -->
19	TB	<!-- 19. Time of birth -->
20		<!-- 20. Certifier's name and title: OMIT-->
21		<!-- 21. Date certified: OMIT-->
22	PAY	<!-- 22. Principal source of payment for this delivery-->
23	IRECNUM	<!-- 23. Infant’s medical record number-->

Data Element #	BFDR Data Element Code	Data Element Name
24		<!-- 24. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?-->
25A	ATTENDN	<!-- 25. Attendant's name -->
25B	ATTEND	<!-- Attendants title -->
25C	NPI	<!-- Attendant's N.P.I. -->
26	DWGT	<!-- 26. Mother's weight at delivery-->
27		<!-- 27. Characteristics of labor and delivery-->
28		<!-- 28. Method of Delivery: -->
29	UHYS	<!-- 29. Maternal morbidity: -->
30	BWG	<!-- 30. Birthweight: -->
31	OWGEST	#31. Obstetric estimate of gestation at delivery-->
32	ISEX	<!-- 32. Sex (Male, Female, or Not yet determined): -->
33A	APGAR5	<!-- APGAR Score at 5 minutes: 5-->
33B	APGAR10	<!-- APGAR Score at 10 minutes: 8-->
34	SORD	<!--Birth Order -->
34	PLUR	<!-- #34. Plurality)-->
35		<!-- 35. If not single birth(Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): Not Applicable-->
36	LIVEB	<!-- 36. If not single birth, specify number of infants in this delivery born alive-->
37A		<!-- 37. Abnormal conditions of the newborn -->
37B		<!-- 37. Abnormal conditions of the newborn -->
38		<!-- 38. Congenital anomalies of the newborn -->
39	ITRAN	<!-- 39. Was infant transferred within 24 hours of delivery-->
40	ILIV	<!-- 40. Is infant living at time of report -->
41	BFED	<!-- 41. Is infant being breastfed at discharge-->
42	HFT, HIN	<!-- 42. Maternal height -->
43	PWGT	<!-- 43. Maternal weight immediately before this pregnancy -->

Appendix B – Data Element Definitions

The following data elements are used in Vital Records Birth and Fetal Death Reporting:

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Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ANTI	Y	N	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Any antibacterial drug given systemically (intravenous or intramuscular.) For example, penicillin, ampicillin, gentamicin, cefotoxine, etc.)
AVEN1	Y	N	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Infant given manual breaths with bag and mask or bag and endotracheal tube within the first several minutes from birth for any duration. Excludes oxygen only and laryngoscopy for aspiration of meconium.
AVEN6	Y	N	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).
BINJ	Y	N	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	Significant birth injury: (skeletal fracture(s), peripheral nerve injury and/or soft tissue/solid organ hemorrhage which requires intervention). Defined as present immediately following delivery or manifesting following delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and /or extremity ecchymossi accompanied by evidence of anemia and/or hypovolemia and or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma. All require confirmation by diagnostic imaging or exploratory laparotomy.
NICU	Y	N	Abnormal conditions of the newborn: Admission to NICU	Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
SEIZ	Y	N	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	Seizure defined as any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction defined as severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxicischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.
SURF	Y	N	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	Newborn given surfactant replacement therapy: Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency either due to preterm birth or pulmonary injury resulting in decreased lung compliance (respiratory distress). Includes both artificial and extracted natural surfactant.
NOA54	Y	N	Abnormal conditions of the newborn: None of the above	None of the listed abnormal conditions of the newborn.
DNA54	Y	N	Abnormal conditions of the newborn: Pending	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.
APGAR5	Y	N	Apgar Score: 5 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. Enter the infant's Apgar score at 5 minutes.
APGAR10	Y	N	Apgar Score: 10 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes.
ATTENDN	Y	Y	Attendant's name	The name of the attendant (the person responsible for delivering the child), their title, and their National Provider Identification (NPI) Number.
ATTEND	Y	Y	Attendant's title:	The title of the person (attendant) responsible for delivering the child. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery. Titles include: M.D. (doctor of medicine); D.O. (doctor of osteopathy); CNM/CM (certified nurse midwife/certified midwife); Other midwife (midwife other than a CNM/CM); and Other (specify)

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ATTENDS	Y	Y	Attendant: Other specified	The specific title of the person (attendant) responsible for delivering the child if not included in the list of provided titles. Examples include nurse, father, police officer, and EMS technician. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.
NPI	Y	Y	Attendant's NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.
BWG	Y	N	Birth weight (Infant's)	Infant's birthweight in grams.
BWO	Y	N	Birth weight (Infant's)	Infant's birthweight in ounces.
BWP	Y	N	Birth weight (Infant's)	Infant's birthweight in pounds.
ANTB	Y	N	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	Antibiotics received by the mother during labor. Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxine, and Ceftriaxone. Information about the course of labor and delivery.
AUGL	Y	N	Characteristics of labor and delivery: Augmentation of labor	Augmentation of labor: Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun). Information about the course of labor and delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CHOR	Y	N	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Any recorded maternal temperature at or above 38oC (100.4oF) or clinical diagnosis of chorioamnionitis during labor made by the delivery attendant (usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, or fetal tachycardia). Information about the course of labor and delivery.
ESAN	Y	N	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body. Information about the course of labor and delivery.
FINT	Y	N	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	Fetal intolerance of labor was such that one or more of the following actions was taken: In utero resuscitative measures, further fetal assessment, or operative delivery. Includes any of the following: Maternal position change; Oxygen Administration to the mother; Intravenous fluids administered to the mother; Amnioinfusion; Support of maternal blood pressure; Administration of uterine relaxing agents. Further fetal assessment including any of the following: scalp pH, scalp stimulation, acoustic stimulation. Operative delivery to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.
INDL	Y	N	Characteristics of labor and delivery: Induction of labor	Induction of labor: Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun). Information about the course of labor and delivery.
MECS	Y	N	Characteristics of labor and delivery: Meconium staining	Moderate or heavy meconium staining of the amniotic fluid Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery that is more than enough to cause a greenish color change of an otherwise clear fluid. Information about the course of labor and delivery.
STER	Y	N	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Steroids (glucocorticoids): For fetal lung maturation received by the mother before delivery. Includes: Betamethasone dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Does not include: Steroid medication given to the mother as an anti- inflammatory treatment before or after delivery. Information about the course of labor and delivery.
NOA04	Y	N	Characteristics of labor and delivery: None of the above	None of the listed characteristics of labor and delivery that provide information about the course of labor and delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
DNA04	Y	N	Characteristics of labor and delivery: Pending	If the data are not available when the characteristics of labor and delivery are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.
IDOB_YR	Y	N	Child: Date of Birth: Year	The infant's date (year) of birth.
IDOB_MO	Y	N	Child: Date of Birth: Month	The infant's date (month) of birth.
IDOB_DY	Y	N	Child: Date of Birth: Day	The infant's date (day) of birth.
KIDFNAME	Y	Y	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	The legal name (first) of the child as provided by the parents.
KIDMNAME	Y	Y	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	The legal name (middle) of the child as provided by the parents.
KIDLNAME	Y	Y	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	The legal name (last) of the child as provided by the parents.
KIDSUFFX	Y	Y	Child's Last Name Suffix:	The legal name (suffix) of the child as provided by the parents.
BFED	Y	N	Child: Infant being breastfed?	Information on whether the infant was being breast-fed during the period between birth and discharge from the hospital.
ILIV	Y	N	Child: Infant living at time of report?	Information on the infant's survival. Check "Yes" if the infant is living. Check "Yes" if the infant has already been discharged to home care. Check "No" if it is known that the infant has died. If the infant was transferred but the status is known, indicate the known status.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
IRECNUM	Y	N	Child: Newborn Medical Record Number	The medical record number assigned to the newborn.
ISEX	Y	N	Child: (infant) Sex -	The sex of the infant.
ITRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	Transfer status of the infant within 24 hours after delivery.
FTRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility	
TB	Y	N	Child: Time of Birth	The infant's time of birth.
ANEN	Y	Y	Congenital anomalies of the Newborn: Anencephaly	Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain .Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).
CCHD	Y	Y	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Congenital heart defects that cause cyanosis.
CDH	Y	Y	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.
CDIC	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Suspected chromosomal disorder karyotype confirmed

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CDIS	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.
'CDIP	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Suspected chromosomal disorder karyotype pending.
CL	Y	Y	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.
CP	Y	Y	Congenital anomalies of the Newborn: Cleft Palate alone	Cleft palate refers to incomplete fusion of the palatal shelves. This may be limited to the soft palate or may also extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without cleft Palate" category, rather than here.
DOWC	Y	Y	Congenital anomalies of the Newborn: Down Karyotype Confirmed	Down Karyotype confirmed
DOWN	Y	Y	Congenital anomalies of the Newborn: Down Syndrome	Down Syndrome: Trisomy 21
DOWP	Y	Y	Congenital anomalies of the Newborn: Down Karyotype Pending	Down Karyotype pending
GAST	Y	Y	Congenital anomalies of the Newborn: Gastroschisis	An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.
HYPO	Y	Y	Congenital anomalies of the Newborn: Hypospadias	Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree – on the glans ventral to the tip, second degree – in the coronal sulcus, and third degree – on the penile shaft.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
LIMB	Y	Y	Congenital anomalies of the Newborn: Limb reduction defect	Limb reduction defect: (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.
MNSB	Y	Y	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).
OMPH	Y	Y	Congenital anomalies of the Newborn: Omphalocele	A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.
NOA55	Y	Y	Congenital anomalies of the Newborn: None of the anomalies listed above	None of the listed congenital anomalies of the newborn or fetus.
DNA55	Y	Y	Congenital anomalies of the Newborn: Pending	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.
YLLB	Y	Y	Date of last live birth:	The year of birth of the last live-born infant.
MLLB	Y	Y	Date of last live birth:	The month of birth of the last live-born infant.
DLMP_DY	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
DLMP_MO	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.
DLMP_YR	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.
YOPO	Y	Y	Date of Last Other Pregnancy Outcome: Year	The date (year) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.
MOPO	Y	Y	Date of Last Other Pregnancy Outcome: Month	The date (month) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.
ADDRESS_D	Y	Y	Facility Address	
FNAME	Y	Y	Facility Name (if Not institution, give street and number)	The name of the facility where the delivery took place.
FNPI	Y	Y	Facility National Provider Identifier	National Provider Identifier.
CHAM	Y	Y	Infections present and treated during this pregnancy: Chlamydia	Chlamydia: A positive test for Chlamydia trachomatis. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
GON	Y	Y	Infections present and treated during this pregnancy: Gonorrhea	Gonorrhea: A positive test/culture for Neisseria gonorrhea. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
HEPB	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis B	Hepatitis B (HBV, serum hepatitis): A positive test for the hepatitis B virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
HEPC	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis C	Hepatitis C (non-A, non-B hepatitis (HCV)): A positive test for the hepatitis C virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
SYPH	Y	Y	Infections present and treated during this pregnancy: Syphilis	Syphilis (also called lues) A positive test for Treponema pallidum. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
NOA02	Y	Y	Infections present and treated during this pregnancy: None of the above	None of the listed infections were present and treated during this pregnancy.
AINT	Y	Y	Maternal Morbidity: - Admission to Intensive care [unit]	Admission to intensive care unit: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care. Serious complications experienced by the mother associated with labor and delivery.
MTR	Y	Y	Maternal Morbidity: Maternal Transfusion	Maternal transfusion: Includes infusion of whole blood or packed red blood cells within the period specified. Serious complications experienced by the mother associated with labor and delivery.
PLAC	Y	Y	Maternal Morbidity: [Third or fourth degree] perineal laceration	Third or fourth degree perineal laceration: 3rd degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4th degree laceration is all of the above with extension through the rectal mucosa. Serious complications experienced by the mother associated with labor and delivery.
RUT	Y	Y	Maternal Morbidity: Ruptured Uterus	Ruptured Uterus: Tearing of the uterine wall. Serious complications experienced by the mother associated with labor and delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
UHYS	Y	Y	Maternal Morbidity: Unplanned hysterectomy	Unplanned hysterectomy: Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure. Serious complications experienced by the mother associated with labor and delivery.
UOPR	Y	Y	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Unplanned operating room procedure following delivery: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations. Serious complications experienced by the mother associated with labor and delivery.
NOA05	Y	Y	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	None of the listed serious complications experienced by the mother associated with labor and delivery.
PRES	Y	Y	Method of Delivery: Fetal presentation [at birth]: Cephalic	The physical process by which the complete delivery of the fetus was affected. Fetal presentation at birth - Cephalic: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP); Breech: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech; Other: Any other presentation not listed above.
ROUT	Y	Y	Method of Delivery: [Final]Route and method of delivery	The physical process by which the complete delivery of the fetus was affected. Includes: Vaginal/spontaneous: delivery of the entire fetus through the vagina by the nature force of labor with or without manual assistance from the delivery attendant; Vaginal/forceps Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head; Vaginal/vacuum Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head; or Cesarean: Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
TLAB	Y	Y	Method of Delivery: Trial of labor attempted	If cesarean, indicate if a trial of labor was attempted (labor was allowed, augmented, or induced with plans for a vaginal delivery).
MFNAME	Y	Y	Mother's Current Legal Name: First Name	The current legal first name of the mother.
MMNAME	Y	Y	Mother's Current Legal Name: Middle Name	The current legal middle name of the mother.
MLNAME	Y	Y	Mother's Current Legal Name: Last Name	The current legal last name of the mother.
MSUFF	Y	Y	Mother's Current Legal Name: suffix	The current legal name suffix of the mother.
HFT	Y	Y	Mother's Height: Feet	Mother’s height feet
HIN	Y	Y	Mother's Height: Inches	Mother’s height inches
MRECNUM	Y	Y	Mother's medical record number	The mother’s medical record number for this facility admission
PWGT	Y	Y	Mother's pre-pregnancy weight	The mother’s prepregnancy weight
NFACL	Y	Y	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Indicates the name of the facility the mother was transferred from if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
TRAN	Y	Y	Mother transferred for maternal medical or fetal indications for delivery?	Indicates if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.
DWGT	Y	Y	Mother's weight at delivery	The mother's weight at the time of delivery.
POPO	Y	Y	Number of other pregnancy outcomes	Total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.
PLBD	Y	Y	Number of previous live births now dead (do not include this child)	The total number of previous live-born infants now dead.
PLBL	Y	Y	Number of previous live births now living (do not include this child)	The total number of previous live-born infants now living.
OWGEST	Y	Y	Obstetric Estimate of Gestation	The best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of g**estation** This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred.
CERV	Y	N	Obstetric procedures: Cervical cerclage	Cervical cerclage: Circumferential banding or suture of the cervix to prevent or treat dilation. Includes: MacDonald's suture; Shirodkar procedure; and Abdominal cerclage via laparotomy. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ECVF	Y	N	Obstetric procedures: Failed External cephalic Version	Failed External cephalic version: Failed attempt to convert a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.
ECVS	Y	N	Obstetric procedures: Successful External cephalic version	Successful External cephalic version: Successful conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.
TOC	Y	N	Obstetric procedures: Tocolysis	Tocolysis: Administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Medications: Magnesium sulfate (for preterm labor); Terbutaline; Indocin (for preterm labor). Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.
NOA03	Y	N	Obstetric procedures: None of the above	None of the listed obstetric procedures were performed for medical treatment or invasive/manipulative procedures during this pregnancy to treat the pregnancy or to manage labor and/or delivery.
PROM	Y	N	Onset of labor: Premature Rupture	Premature Rupture of the Membranes (prolonged≥12 hours): Spontaneous tearing of the amniotic sac, (natural breaking of the "bag of waters"), 12 hours or more before labor begins. Serious complications experienced by the mother associated with labor and delivery.
PRIC	Y	N	Onset of labor: Precipitous Labor	Precipitous labor (<3hours): Labor that progresses rapidly and lasts for less than 3 hours. Serious complications experienced by the mother associated with labor and delivery.
PROL	Y	N	Onset of labor: Prolonged Labor	Prolonged labor (≥ 20 hours): Labor that progresses slowly and lasts for 20 hours or more. Serious complications experienced by the mother associated with labor and delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
NOA05	Y	N	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	None of the listed serious complications experienced by the mother associated with labor and delivery.
SFN	Y	Y	Place where birth occurred: State Facility Number	
FLOC	Y	Y	Place where birth occurred: Facility City/Town	
CNAME	Y	Y	Place where birth occurred: County Name	
CNTYO	Y	Y	Place where birth occurred: County Code	
BPLACE	Y	N	Place where birth occurred: Birth Place	
PLUR	Y	Y	Plurality	The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy. ("Reabsorbed" fetuses, those which are not "delivered" (expulsed or extracted from the mother) should not be counted.)
DOFP_MO	Y	Y	Prenatal care visits: Date of first prenatal care visit: Month	The month a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.
DOFP_DY	Y	Y	Date of first prenatal care visit: Day	The day a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.
DOFP_YR	Y	Y	Date of first prenatal care visit: Year	The year a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
DOLP_MO	Y	Y	Prenatal care visits: Date of last prenatal care visit: Month	The month of the last prenatal care visit recorded in the records.
DOLP_DY	Y	Y	Prenatal care visits: Date of last prenatal care visit: Day	The day of the last prenatal care visit recorded in the records.
DOLP_YR	Y	Y	Prenatal care visits: Date of last prenatal care visit: Year	The year of the last prenatal care visit recorded in the records.
NPREV	Y	Y	Prenatal care visits: Total number of prenatal visits for this pregnancy	The total number of visits recorded in the record.
PAY	Y	N	Principal source of payment for this delivery	The principal source of payment at the time of delivery: Includes: Private insurance (Blue Cross/Blue Shield, Aetna, etc.); Medicaid (or a comparable State program); Self-pay (no third party identified); Other (Indian Health Service, CHAMPUS/ TRICARE, other government [Federal, State, local]); Unknown
PDIAB	Y	Y	Risk factors in this pregnancy: Prepregnancy Diabetes	Prepregnancy Diabetes (diagnosis of glucose intolerance requiring treatment before this pregnancy).
GDIAB	Y	Y	Risk factors in this pregnancy: Gestational Diabetes	Gestational Diabetes (diagnosis of glucose intolerance requiring treatment during this pregnancy).
PHYPE	Y	Y	Risk factors in this pregnancy: Prepregnancy Hypertension	Prepregnancy (Chronic) Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis prior to the onset of this pregnancy. Does not include gestational (pregnancy induced) hypertension (PIH).)
GHYPE	Y	Y	Risk factors in this pregnancy: Gestational Hypertension	Gestational Hypertension (Elevation of blood pressure above normal for age, gender, and.physiological condition with diagnosis in this pregnancy (pregnancy-induced hypertension or preeclampsia).

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
EHYPE	Y	Y	Risk factors in this pregnancy: Eclampsia	Eclampsia Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with proteinuria with generalized seizures or coma. May include pathologic edema.
PPB	Y	Y	Risk factors in this pregnancy: Previous preterm births	History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.
PPO	Y	Y	Risk factors in this pregnancy: Poor pregnancy outcomes	History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: Perinatal death (including fetal and neonatal deaths); Small for gestational age; Intrauterine-growth-restricted birth.
INFT	Y	Y	Risk factors in this pregnancy: Infertility treatment	Any assisted reproductive treatment used to initiate the pregnancy. Includes: Drugs (such as Clomid, Pergonal); Artificial insemination; Technical procedures (such as in-vitro fertilization).
INFT_DRG	Y	Y	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Fertility-enhancing drugs, artificial insemination or intrauterine insemination Any fertility enhancing drugs (e.g., Clomid, Pergonal), artificial insemination or intrauterine insemination used to initiate the pregnancy.
INFT_ART	Y	Y	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer GIFT)) Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy.
PCES	Y	Y	Risk factors in this pregnancy: Previous cesarean	Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.
NPCES	Y	Y	Risk factors in this pregnancy: Number of previous cesareans	Number of previous deliveries extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.
NOA01	Y	Y	Risk factors in this pregnancy: None of the above	The patient had none of the listed risk factors in this pregnancy.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
SORD	Y	Y	Set Order	Order this infant was delivered in the set.
FSEX	Y	N	Child: (infant) Sex -	The sex of the infant.
FDOD_YR	N	Y		Date of Delivery (Fetus) Year
FDOD_MO	N	Y		Date of Delivery (Fetus) Month
FDOD_DY	N	Y		Date of Delivery (Fetus) Day
ETIME	N	Y	Estimated Time of Fetal Death	Item to indicate when the fetus died with respect to labor and assessment.
LIVEB	Y	N	Not single birth - specify number of infants in this delivery born alive.	Specify the number of infants in this delivery born alive
FDTH	N	Y	Number of fetal deaths	Specify the number of fetal deaths in this delivery
HYST	N	Y	Method of Delivery: Hysterotomy/Hysterectomy?	Hysterotomy/Hysterectomy was the physical process by which the complete delivery of the fetus was affected. Hysterotomy: Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy: Surgical removal of the uterus. May be performed abdominally or vaginally.
TD	N	Y	Time of delivery	Hour and minute fetus was delivered.
AUTOP	N	Y	Was an autopsy performed?	Information on whether or not an autopsy was performed
FWO	N	Y	Weight of Fetus (in ounces)	Fetus' weight in ounces.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
FWG	N	Y	Weight of Fetus (grams preferred, specify unit)	Fetus' weight in grams.
FWP	N	Y	Weight of Fetus (in pounds)	Fetus' weight in pounds.
LM	N	Y	Infections present and treated during this pregnancy: Listeria	Listeria: A diagnosis of or positive test for Listeria monocytogenes. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
GBS	N	Y	Infections present and treated during this pregnancy: Group B Streptococcus	Group B Streptococcus: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
CMV	N	Y	Infections present and treated during this pregnancy: Cytomeglovirus	Cytomegalovirus (CMV): A diagnosis of or positive test for Cytomegalovirus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
B19	N	Y	Infections present and treated during this pregnancy: Parvovirus	Parvovirus: A diagnosis of or positive test for Parvovirus B19. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record
HISTOP	N	Y	Was a Histological Placental Examination performed?	Information on whether or not a histological placental examination was performed
TOXO	N	Y	Infections present and treated during this pregnancy: Toxoplasmosis	Toxoplasmosis: A diagnosis of or positive test for Toxoplasma gondii.

Volume 2 – Transactions

Add section 3.37

3.37 BFDRFeed [QRPH-37]

3.37.1 Scope

This transaction is used to communicate clinician-sourced birth and fetal death information from the Information Source to the Information Recipient. This transaction may alternatively be initiated by a Form Receiver Message Exporter and communicated to the Information Recipient. This transaction uses the Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU).

3.37.2 Actor Roles

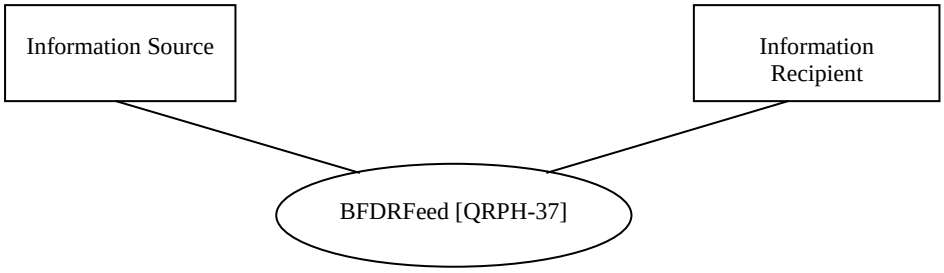

Figure 3.37.2-1: Use Case Diagram between Information Source and Information Recipient

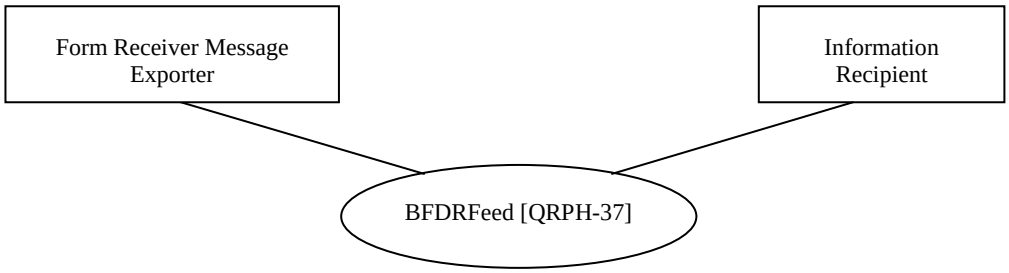

Figure 3.37.2-2: Use Case Diagram between Form Receiver Message Exporter and Information Recipient

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The Roles in this transaction are defined in the following table and may be played by the actors shown here:

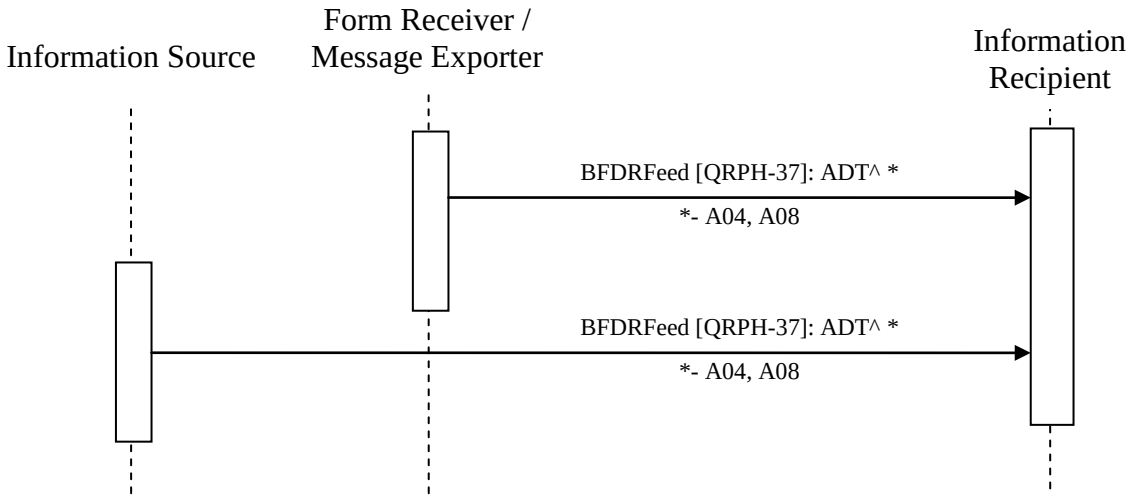
Table 3.37.2-1: Actor Roles

Actor:	Information Source
Role:	The Information Source Actor is responsible for creating and transmitting an HL7 V2.5.1 message to an Information Recipient.
Actor:	Information Recipient
Role:	The Information Recipient Actor is responsible for receiving the HL7 V2.5.1 message from an Information Source or from a Form Receiver Message Exporter.
Actor:	Form Receiver Message Exporter
Role:	The Form Receiver Message Exporter receives data submitted through the Submit Form Transaction (ITI-35), transforms that data to be in compliance with the requirements of the HL7 V.2.5.1 BFDR transaction (QRPH-37) and sends that data to an Information Recipient using QRPH-37.

3.37.3 Referenced Standards

1. Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)
2. Birth Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Live Birth
3. Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Report of Fetal Death

3.37.4 Interaction Diagram



3.37.4.1 BFDRFeed [QRPH-37]

This transaction transmits the HL7 V2.5.1 formatted message containing the clinician-sourced birth and fetal death information from Information Source or the Form Receiver / Message Exporter to the Information Recipient. A given Information Recipient implemented at a public health jurisdiction may receive this transaction from multiple sources.

3.37.4.1.1 Trigger Events

When a delivery has been documented in the system, an Information Source Actor will trigger one of the Admit/Register or Update messages:

- A04 – Report Birth Information Record
- A04 - Report Fetal Death Information Record (NOTE: there may not be a patient chart for a fetal death, but this is not an issue for surfacing the form)

Changes to patient demographics (e.g., change in patient name, patient address, etc.) or updating previously transmitted information about a live birth or fetal death to Vital Records shall trigger the following Admit/Register or Update message:

- A08 – Revise Birth Information Record
- A08 - Revise Fetal Death Information Record

3.37.4.1.2 Message Semantics

The segments of the message listed below are required, and their detailed descriptions are provided in the following subsections.

Required segments for the BFDRFeed [QRPH-37] are defined below. Other segments are optional. This transaction requires Information Source Actors to include some attributes not already required by the corresponding HL7 message. This transaction does not require Information Recipient Actors to attributes beyond what is required by the corresponding HL7 message.

Table 3.37.4.1.2-1: BFDRFeed [QRPH-37]

ADT	Patient Administration Message	Optionality	Chapter in HL7 BFDR V2.5.1 IG
MSH	Message Header	R	5.1
SFT	Software Segment	R	5.2
EVN	Event Type	R	5.5
PID	Patient Identification	R	5.6
NK1	Next of Kin/Associated Parties	R	5.7
PV1	Patient Visit Information	R	5.8
ROL	Role	R	5.9
OBX	Observation/Result	R	5.10
MSA	Acknowledgement	R	5.3
ERR	Error	R	5.4

3.37.4.1.2.1 MSH Segment

The Information Source SHALL populate MSH segment. The Information Recipient SHALL have the ability to accept and process this segment.

MSH segment shall be constructed as defined in ITI TF-2x: C.2.2 “Message Control”.

3.37.4.1.2.2 SFT Segment

The Information Source SHALL populate SFT segment. The Information Recipient SHALL have the ability to accept and process this segment.

No further constraints are required of the SFT segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

3.37.4.1.2.3 EVN Segment

The Information Source SHALL populate EVN segment. The Information Recipient SHALL have the ability to accept and process this segment.

See ITI TF-2x: C.2.4 for the list of all required and optional fields within the optional EVN segment.

3.37.4.1.2.4 PID Segment

The Information Source SHALL populate the PID segment. The Information Recipient SHALL have the ability to accept and process this segment.

In order to allow for consistency with environments that support IHE ITI PIX or IHE ITI PDQ, the PID segment shall be constructed to be consistent with ITI TF-2a: 3.8.4.1.2.3 as described below.

Bolded text in the table below highlights areas in this profile that are different from the underlying HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

Table 3.37.4.1.2.4-1: IHE Profile - PID segment

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
1	4	SI	R		00104	Set ID - Patient ID	Literal Value: ‘1’.
2	20	CX	X		00105	Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
3	250	CX	R		00106	Patient Identifier List	Field used to convey all types of patient/person identifiers. Use of the Medical Record Number is expected if the birth or fetal death takes place in a hospital, or the baby is admitted to one.
4	20	CX	X		00107	Alternate Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3.
5	250	XPN	R		00108	Patient Name	New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.
6	**250**	**XPN**	**R2**		**00109**	**Mother's Maiden Name**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
7	26	TS	R2		00110	Date/Time of Birth	Newborn's date and time of birth, or (for fetal death reporting) the delivery date and time of delivery of the fetus. Format: YYYY[MM[DD[HH[MM[SS[.S[S[S[S]]]]]]]][+/-ZZZZ]
8	1	IS	R2	0001	00111	Administrative Sex	Sex of the newborn or of the fetus.
9	250	XPN	X		00112	Patient Alias	Deprecated as of HL7 Version 2.4. See PID-5 Patient Name.
10	**250**	**CE**	**O**	**0005**	**00113**	**Race**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
11	250	XAD	R2		00114	Patient Address	Address type code = Birth Address. Only use the field, if the birth or fetal delivery does not take place in a healthcare facility. When used, the field captures the place of birth, or the place of fetal delivery. Street address, city, state and zip code are expected. If descriptive information is provided instead of an address, the Other Geographic Designation component of the XAD data type is used. Note, either PID.11 or ROL.11 may be used to record the place of birth or delivery depending on circumstances.

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
12	4	IS	X	0289	00115	County Code	Deprecated as of HL7 Version 2.3. See PID-11 - Patient Address, component 9 County/Parish Code.
13	**250**	**XTN**	**O**		**00116**	**Phone Number – Home**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
14	**250**	**XTN**	**O**		**00117**	**Phone Number - Business**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
15	**250**	**CE**	**O**	**0296**	**00118**	**Primary Language**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
16	**250**	**CE**	**O**	**0002**	**00119**	**Marital Status**	**Not supported in IG, but Optional in PIX** **Not expected for newborns, but if the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
17	**250**	**CE**	**O**	**0006**	**00120**	**Religion**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
18	**250**	**CX**	**O**		**00121**	**Patient Account Number**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
19	16	ST	X		00122	SSN Number – Patient	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.
20	25	DLN	X		00123	Driver's License Number - Patient	Deprecated as of HL7 Version 2.5. See PID-3 Patient Identifier List.
21	**250**	**CX**	**O**		**00124**	**Mother's Identifier**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
22	**250**	**CE**	**O**	**0189**	**00125**	**Ethnic Group**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
23	**250**	**ST**	**O**		**00126**	**Birth Place**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
24	1	ID	O	0136	00127	Multiple Birth Indicator	Indicates whether the baby or fetus was part of a multiple birth.
25	2	NM	O		00128	Birth Order	Indicate the order delivered in the pregnancy of the baby or fetus, aka "Set Number". Leave the field empty for singleton births or deliveries.
26	**250**	**CE**	**O**	**0171**	**00129**	**Citizenship**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
27	**250**	**CE**	**O**	**0172**	**00130**	**Veterans Military Status**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
28	250	CE	X	0212	00739	Nationality	Deprecated as of HL7 Version 2.4. See PID-10 Race, PID-22 Ethnic Group, and PID-26 Citizenship.

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
29	**26**	**TS**	**R2**		**00740**	**Patient Death Date and Time**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
30	**1**	**ID**	**O**	**0136**	**00741**	**Patient Death Indicator**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
31			**O**			**Identity Unknown Indicator**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
32			**O**			**Identity Reliability Code**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the BFDR Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
33			**O**			**Last Update Date/Time**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
34			**O**			**Last Update Facility**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
35			**O**			**Species Code**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
36			**O**			**Breed Code**	**Not supported in IG, but Conditional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
37			**O**			**Strain**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**
38			**O**			**Production Class Code**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

SEQ	LEN	DT	OPT	TBL#	ITEM #	ELEMENT NAME	Description/ Comments
39			**O**			**Tribal Citizenship**	**Not supported in IG, but Optional in PIX** **When the attribute is populated, the Information receiver shall either accept this information or ignore the attribute, but SHALL NOT raise an application error**

Adapted from the HL7 standard, Version 2.5.1

This message shall use the field PID-3 Patient Identifier List to convey the Patient ID uniquely identifying the patient within a given Patient Identification Domain.

The Information Source Actor shall provide the patient identifier in the ID component (first component) of the PID-3 field (PID-3.1). The Information Source Actor shall use component PID-3.4 to convey the assigning authority (Patient Identification Domain) of the patient identifier. Either the first subcomponent (namespace ID) or the second and third subcomponents (universal ID and universal ID type) shall be populated. If all three subcomponents are populated, the first subcomponent shall reference the same entity as is referenced by the second and third components.

3.37.4.1.2.5 NK1 Segment

The Information Source SHALL populate NK1 segment. The Information Recipient SHALL have the ability to accept and process this segment.

No further constraints are required of the NK1 segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

3.37.4.1.2.6 PV1 Segment

The Information Source SHALL populate PV1 segment. The Information Recipient SHALL have the ability to accept and process this segment.

No further constraints are required of the PV1 segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

3.37.4.1.2.7 ROL Segment

The Information Source SHALL populate ROL segment. The Information Recipient SHALL have the ability to accept and process this segment.

No further constraints are required of the ROL segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

3.37.4.1.2.8 OBX Segment

The Information Source SHALL populate OBX segment. All OBX observations SHALL be included. If there are no observations available (e.g., injury information, cause of death), then the appropriate flavor of NULL SHALL be communicated. The Information Recipient SHALL have the ability to accept and process this segment.

No further constraints are required of the OBX segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.5.1 Implementation Guide (IG): Reporting Birth and Fetal Death information From the EHR to Vital Records Draft Standard for Trial Use (DSTU)).

3.37.4.1.3 Expected Actions

3.37.4.1.3.1 ACK

Having received the ADT message from the Information Source, the Information Recipient SHALL parse this message and integrate its content, and then an applicative acknowledgement message is sent back to the Information Source. This General Acknowledgement Message ACK SHALL be built according to the HL7 V2.5.1 standard, following the acknowledgement rules described in IHE ITI TF-2:C.2.3 (IHE IT I TF-2: Appendix C.2.3).

3.37.5 Security Considerations

3.37.5.1 Security Audit Considerations BFDRFeed [QRPH-37] (ADT)

The QRPH-37 (ADT) transactions are to be audited as “PHI Export” events, as defined in ITI TF-2a: Table 3.20.6-1. The actors involved in the transaction shall create audit data in conformance with DICOM (Supp 95) “Export”. The following tables show items that are required to be part of the audit record for these specific BFDRFeed transactions.

3.37.5.1.1 Information Source Actor audit message

	Field Name	Opt	Value Constraints
Event **AuditMessage/ EventIdentification**	EventID	M	EV(110106, DCM, “Export”)
	EventActionCode	M	“C” (create)
	EventDateTime	*M*	*not specialized*
	EventOutcomeIndicator	*M*	*not specialized*
	EventTypeCode	M	EV(“QRPH-37”, “IHE Transactions”, “BFDRFeed”)
Source (Information Source Actor) (1)			
Human Requestor (0..n)			
Destination (Information Recipient Actor) (1)			
Audit Source (Information Source Actor) (1)			
Patient (1)			

Where:

Source **AuditMessage/ ActiveParticipant**	UserID	M	The identity of the Information Source Actor facility and sending application from the HL7 message; concatenated together, separated by the | character.
	AlternativeUserID	M	The process ID as used within the local operating system in the local system logs.
	UserName	*U*	*not specialized*
	UserIsRequestor	M	*not specialized*
	RoleIDCode	M	EV(110153, DCM, “Source”)
	NetworkAccessPointTypeCode	M	“1” for machine (DNS) name, “2” for IP address
	NetworkAccessPointID	M	The machine name or IP address, as specified in RFC 3881.

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Human Requestor (if known) **AuditMessage/ ActiveParticipant**	UserID	M	Identity of the human that initiated the transaction.
	AlternativeUserID	*U*	*not specialized*
	UserName	*U*	*not specialized*
	UserIsRequestor	M	*not specialized*
	RoleIDCode	U	Access Control role(s) the user holds that allows this transaction.
	NetworkAccessPointTypeCode	*NA*	
	NetworkAccessPointID	*NA*	

Destination **AuditMessage/ ActiveParticipant**	UserID	M	The identity of the Information Recipient Public Health Organization and receiving application from the HL7 message; concatenated together, separated by the | character.
	AlternativeUserID	*M*	*not specialized*
	UserName	*U*	*not specialized*
	UserIsRequestor	*M*	*not specialized*
	RoleIDCode	M	EV(110152, DCM, "Destination")
	NetworkAccessPointTypeCode	M	"1" for machine (DNS) name, "2" for IP address
	NetworkAccessPointID	M	The machine name or IP address, as specified in RFC 3881.

Audit Source **AuditMessage/ AuditSourceIdentification**	*AuditSourceID*	*U*	*not specialized*
	AuditEnterpriseSiteID	*U*	*not specialized*
	AuditSourceTypeCode	*U*	*not specialized*

Patient **(AuditMessage/ ParticipantObjectIdentification)**	ParticipantObjectTypeCode	M	"1" (person)
	ParticipantObjectTypeCodeRole	M	"1" (patient)
	ParticipantObjectDataLifeCycle	*U*	*not specialized*
	ParticipantObjectIDTypeCode	M	EV(2, RFC-3881, "Patient Number")
	ParticipantObjectSensitivity	*U*	*not specialized*
	ParticipantObjectID	M	The patient ID in HL7 CX format.
	ParticipantObjectName	*U*	*not specialized*
	ParticipantObjectQuery	*U*	*not specialized*
	ParticipantObjectDetail	M	Type=MSH-10 (the literal string), Value=the value of MSH-10 (from the message content, base64 encoded)

3.37.5.1.2 Information Recipient Actor audit message

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	Field Name	Opt	Value Constraints
Event **AuditMessage/ EventIdentification**	EventID	M	EV(110107, DCM, "Import")
	EventActionCode	M	"C" (create)
	EventDateTime	M	not specialized
	EventOutcomeIndicator	M	not specialized
	EventTypeCode	M	EV("QRPH-37", "IHE Transactions", "BFDRFeed")
Source (Information Source Actor) (1)			
Destination (Information Recipient Actor) (1)			
Audit Source (Information Recipient Actor) (1)			

Patient(1)

Where:

Source **AuditMessage/ ActiveParticipant**	UserID	M	The identity of the Information Source Actor facility and sending application from the HL7 message; concatenated together, separated by the | character.
	AlternativeUserID	*U*	*not specialized*
	UserName	*U*	*not specialized*
	UserIsRequestor	M	*not specialized*
	RoleIDCode	M	EV(110153, DCM, "Source")
	NetworkAccessPointTypeCode	M	"1" for machine (DNS) name, "2" for IP address
	NetworkAccessPointID	M	The machine name or IP address, as specified in RFC 3881.

Destination **AuditMessage/ ActiveParticipant**	UserID	M	The identity of the Information Recipient Public Health Organization and receiving application from the HL7 message; concatenated together, separated by the | character.
	AlternativeUserID	M	The process ID as used within the local operating system in the local system logs.
	UserName	*U*	*not specialized*
	UserIsRequestor	M	*not specialized*
	RoleIDCode	M	EV(110152, DCM, "Destination")
	NetworkAccessPointTypeCode	M	"1" for machine (DNS) name, "2" for IP address
	NetworkAccessPointID	M	The machine name or IP address, as specified in RFC 3881.

Audit Source **AuditMessage/ AuditSourceIdentification**	*AuditSourceID*	*U*	*Not specialized.*
	AuditEnterpriseSiteID	*U*	*not specialized*
	AuditSourceTypeCode	*U*	*not specialized*

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Patient	ParticipantObjectTypeCode	M	"1" (person)

	ParticipantObjectTypeCodeRole	M	"1" (patient)
	ParticipantObjectDataLifeCycle	*U*	*not specialized*
	ParticipantObjectIDTypeCode	M	EV(2, RFC-3881, "Patient Number")
	ParticipantObjectSensitivity	*U*	*not specialized*
	ParticipantObjectID	M	The patient ID in HL7 CX format.
	ParticipantObjectName	*U*	*not specialized*
	ParticipantObjectQuery	*U*	*not specialized*
	ParticipantObjectDetail	M	Type=MSH-10 (the literal string), Value=the value of MSH-10 (from the message content, base64 encoded)

3.Y.5.2 Security Audit Considerations – Retrieve Form [ITI-34] audit message

When the Retrieve Form Transaction in the Birth and Fetal Death Reporting Profile is supporting a PHI-Export event, as defined in ITI TF-2a: Table 3.20.6-1, the actors involved in the transaction SHALL create audit log data in conformance with Retrieve Form ([ITI-34]) audit messages as defined in QRPH 5.Z.3.1 Retrieve Form ([ITI-34]) audit messages where such PHI Audit required by Jurisdictional Law.

3.Y.5.3 Security Audit Considerations – Submit Form ([ITI-35]) audit messages

The Submit Form Transaction MAY be a PHI-Export event, as defined in ITI TF-2a: Table 3.20.6-1. The actors involved in the transaction SHALL create audit data in conformance with Retrieve Form ([ITI-34]) audit messages as defined in QRPH 5.Z.3.2 Submit Form ([ITI-35]) audit messages where such PHI Audit is required by Jurisdictional Law.

3.Y.5.4 Security Audit Considerations –Archive Form ([ITI-36]) audit messages audit messages

The Archive Form Transaction MAY be a PHI-Export event, as defined in ITI TF-2a: Table 3.20.6-1. The actors involved in the transaction SHALL create audit data in conformance with Retrieve Form ([ITI-34]) audit messages as defined in QRPH 5.Z.3.3 Archive Form ([ITI-35]) audit messages where such PHI Audit is required by Jurisdictional Law.

Volume 2 Namespace Additions

Add the following terms to the IHE General Introduction Appendix G:

None

Volume 3 – Content Modules

5. Namespaces and Vocabularies

Add to section 5 Namespaces and Vocabularies

codeSystem	codeSystemName	Description
2.16.840.1.113883.6.1	LOINC	Logical Observation Identifier Names and Codes
2.16.840.1.113883.6.96	SNOMED-CT	Systematized Nomenclature Of Medicine Clinical Terms
2.16.840.1.113883.6.88	RxNorm	RxNorm
2.16.840.1.113883.12.1	AdministrativeGender	See the HL7 AdministrativeGender Vocabulary
2.16.840.1.113883	ServiceDeliveryLocation	See the HL7 ServiceDeliveryLocation Vocabulary

Add to section 5.1.1 IHE Format Codes

Profile	Format Code	Media Type	Template ID
Birth and Fetal Death Reporting – LDS-VR	urn:ihe:qrph:LDS-VR:2013	Text/xml	1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1
BFDR Birth CDA document	urn:ihe:qrph:BFDR-Birth:2014	Text/xml	1.3.6.1.4.1.19376.1.7.3.1.1.19.2
BFDR Fetal Death CDA document	urn:ihe:qrph:BFDR-FDeath:2014	Text/xml	1.3.6.1.4.1.19376.1.7.3.1.1.19.3

Add to section 5.1.2 IHE ActCode Vocabulary

No new ActCode vocabulary

Add to section 5.1.3 IHE RoleCode Vocabulary

No new RoleCode vocabulary

6. CDA Content Modules

6.3.1 CDA Document Templates

Add to section 6.3.1.D Document Content Modules

6.3.1.D1 Birth Reporting (BFDR-Birth) Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.2)

6.3.1.D1.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:qrph:BFDR-Birth:2014**

6.3.1.D1.2 Parent Template(s)

This document is a specialization of the HL7 Birth and Fetal Death Reporting Document: Reporting Birth Information from a clinical setting to vital records (ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1).

This document is a specialization of the IHE PCC Medical Document template (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1)

Note: The Medical Document includes requirements for various header elements; name, addr and telecom elements for identified persons and organizations; and basic participations record target, author, and legal authenticator.

6.3.1.D1.3 Referenced Standards

All standards which are reference in this document are listed below with their common abbreviation, full title, and link to the standard.

Table 6.3.1.D1.3-1: Birth Reporting (BFDR-Birth) - Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/Library/General/HL7_CDA_R2_final.zip
HL7 BFDR CDA: Reporting Birth Information from a clinical setting to vital records	HL7 IG for Clinical Document Architecture (CDA) Release 2: Reporting Birth and Fetal Death information to Vital Records, Release 1 (DSTU) US Realm	http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=102.
LOINC	Logical Observation Identifiers, Names and Codes	http://loinc.org
SNOMED	Systemized Nomenclature for Medicine	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html

6.3.1.D1.4 Data Element Mapping to CDA

Refer to Volume 4, 4.I.2.1.2 for mapping from BFDR Form data elements to the output the BFDR Birth CDA Document or the BFDR Fetal Death CDA Document.

6.3.1.D1.5 Content Module Specifications

This section specifies the header and body content modules which comprise the document-level Content Module. Templates constraining the information are listed by id.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified. Header constraints to the parent HL7 CDA document for Reporting Birth Information from a Clinical Setting to Vital Records are identified. Only the constrained sections and clinical statements are listed here, but there are additional requirements in the HL7 CDA Implementation Guide.

6.3.1.D1.5.1 Document Constraints

Template Name	BFDR Birth CDA document
Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.19.2
Parent Template	Reporting Birth Information from a clinical setting to vital records 2.16.840.1.113883.10.20.26.1 (HL7) NOTE: Constraints to the Header Section Apply
General Description	Document specification covers the provision of Birth reporting data to the applicable jurisdictional vital reporting agencies
Document Code	SHALL be 68998-4 (CodeSystem: 2.16.840.1.113883.6.1 LOINC), "U.S. standard certificate of live birth - 2003 revision "

Opt and Card	**Condition**	**Header Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Demographic Header Elements					
R[1..1]		Personal Information: name		HL7 Birth Reporting to VR CDA	
R2[0..1]	**QRPH 3: 6.3.1.D1.5.2.1**	**Mother's Information: birthtime**		**QRPH 3: 6.3.1.D1.5.2.1**	
R2[0..1]		Mother's Information: addr		HL7 Birth Reporting to VR CDA	
O[0..1]	**QRPH 6.3.1.D1.5.2.2**	**Mother's Information: ethnicity**		**QRPH 6.3.1.D1.5.2.2**	**HL7 0189**

O[0..*]	**QRPH 6.3.1.D1.5.2.3**	**Mother's Information: race**		**QRPH 6.3.1.D1.5.2.3**	**HL7 0005**
O[0..1]	**QRPH 6.3.1.D1.5.2.4**	**Mother's Information: gender**		**QRPH 6.3.1.D1.5.2.4**	**HL7 0001**
R[1..1]		Mother's Information: id		HL7 Birth Reporting to VR CDA	
R[1..1]	**QRPH 6.3.1.D1.5.2.5**	**realmCode**		**QRPH 6.3.1.D1.5.2.5**	
Sections					
No Section Constraints apply					

6.3.1.D1.5.2 Header Constraints - Further Vocabulary or Conditional Constraints

6.3.1.D1.5.2.1 Mother's Information: birthtime

The Mother's birthtime SHOULD be included in the document header if known.

6.3.1.D1.5.2.2 Mother's Information: ethnicity

The Mother's ethnicity MAY be included in the document header if known. The value for ethnicity/ code SHALL be drawn from value set 2.16.840.1.114222.4.11.6066 PHVS_EthnicGroup_HL7_2x.

6.3.1.D1.5.2.3 Mother's Information: race

The Mother's race MAY be included in the document header if known. The value for race/ code SHALL be drawn from value set PHINVADS link for HL7 V3 Race

2.16.840.1.113883.1.11.14914 unless further extended by national extension.

6.3.1.D1.5.2.4 Mother's Information: gender

The Mother's gender MAY be included in the document header if known. The value for gender/ code SHALL be drawn from value set 2.16.840.1.113883.1.11.1 HVS_AdministrativeGender_HL7_V3.

6.3.1.D1.5.2.4 realmCode

The realmCode SHALL be included and SHALL indicate the country for the jurisdiction of the implementation. The value for realmCode SHALL be drawn from CodeSystem: 1.0.3166.1

Country (ISO 3166-1). NOTE: this is an extension of the underlying HL7 Implementation Guide for CDA Release 2: Birth and Fetal Death Report, Release 1.

6.3.1.D1.5.3 Body Constraints – Further Vocabulary or Conditional Constraints

There are no body constraints to the underlying HL7 Reporting Birth Information from a Clinical Setting to Vital Records.

6.3.1.D1.6 Document Example

A complete example of the Birth Reporting CDA document (BFDR-Birth) Document Content Module is available on the IHE ftp server at: ftp://ftp.ihe.net/TF_Implementation_Material/QRPH/packages/.Note that this is an example and is meant to be informative and not normative. This example shows the1.3.6.1.4.1.19376.1.7.3.1.1.19.2 elements for all of the specified templates.

6.3.1.D2 Fetal Death Reporting (BFDR-FDeath) Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.3)

6.3.1.D2.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:qrph:BFDR-FDeath:2014**

6.3.1.D2.2 Parent Template(s)

This document is a specialization of the HL7 Birth and Fetal Death Reporting Document: Reporting Fetal Death Information from a clinical setting to vital records (ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2).

This document is a specialization of the IHE PCC Medical Document template (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1)

Note: The Medical Document includes requirements for various header elements; name, addr and telecom elements for identified persons and organizations; and basic participations record target, author, and legal authenticator.

6.3.1.D2.3 Referenced Standards

All standards which are reference in this document are listed below with their common abbreviation, full title, and link to the standard.

Table 6.3.1.D2.3-1: Fetal Death Reporting (BFDR-FDeath) - Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/Library/General/HL7_CDA_R2_final.zip

Abbreviation	Title	URL
HL7 BFDR CDA: Reporting Fetal Death Information from a clinical setting to vital records	HL7 IG for Clinical Document Architecture (CDA) Release 2: Reporting Birth and Fetal Death information to Vital Records, Release 1 (DSTU) US Realm	http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=102.
LOINC	Logical Observation Identifiers, Names and Codes	http://loinc.org
SNOMED	Systemized Nomenclature for Medicine	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html

6.3.1.D2.4 Data Element Mapping to CDA

Refer to Volume 4, 4.I.2.2.1 for mapping from BFDR Form data elements to the output the BFDR Birth CDA Document or the BFDR Fetal Death CDA Document. Table 4.I.2.1.2-1 defines the form data element mapping to the output content document modules for Birth. Table 4.I.2.1.2-2 defines the form data element mapping to the output content document modules for Fetal Death.

6.3.1.D2.5 Content Module Specifications

This section specifies the header and body content modules which comprise the document-level Content Module. Templates constraining the information are listed by id.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified. Header constraints are inherited through the Medical Documents Specification parent template (1.3.6.1.4.1.19376.1.5.3.1.1.1). Only the constrained sections and clinical statements are listed here, but there are additional requirements in the HL7 CDA Implementation Guide.

6.3.1.D2.5.1 Document Constraints

Template Name	BFDR Fetal Death CDA document
Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.19.3
Parent Template	Reporting Fetal Death Information from a clinical setting to vital records 2.16.840.1.113883.10.20.26.2 (HL7) NOTE: Constraints to the Header Section Appl
General Description	Document specification covers the provision of Birth and Fetal Death reporting data to the applicable jurisdictional vital reporting agencies
Document Code	SHALL be 69045-3 (CodeSystem: 2.16.840.1.113883.6.1 LOINC), “U.S. standard report of fetal death - 2003 revision “

Opt and Card	Condition	Header Element or Section Name	Template ID	Specification Document	Vocabulary Constraint
Header Elements					
R[1..1]		Personal Information: name		HL7 Birth Reporting to VR CDA	
R2[0..1]	QRPH 3: 6.3.1.D2.5.2.1	Mother's Information: birthtime		QRPH 3: 6.3.1.D2.5.2.1	
R2[0..1]		Mother's Information: addr		HL7 Birth Reporting to VR CDA	
O[0..1]	QRPH 6.3.1.D2.5.2.2	Mother's Information: ethnicity		QRPH 6.3.1.D2.5.2.2	HL7 0189
O[0..*]	QRPH 6.3.1.D2.5.2.3	Mother's Information: race		QRPH 6.3.1.D2.5.2.3	HL7 0005
O[0..1]	QRPH 6.3.1.D2.5.2.4	Mother's Information: gender		QRPH 6.3.1.D2.5.2.4	HL7 0001
R[1..1]		Mother's Information: id		HL7 Birth Reporting to VR CDA	
R[1..1]	QRPH 6.3.1.D2.5.2.5	realmCode		QRPH 6.3.1.D2.5.2.5	
Sections					
No section constraints					

6.3.1.D2.5.2 Header Constraints - Further Vocabulary or Conditional Constraints

6.3.1.D2.5.2.1 Mother's Information: birthtime

The Mother's birthtime SHOULD be included in the document header if known.

6.3.1.D2.5.2.2 Mother's Information: ethnicity

The Mother's ethnicity MAY be included in the document header if known. The value for ethnicity/ code SHALL be drawn from value set 2.16.840.1.114222.4.11.6066 PHVS_EthnicGroup_HL7_2x.

6.3.1.D2.5.2.3 Mother's Information: race

The Mother's race MAY be included in the document header if known. The value for race/ code SHALL be drawn from value set 2.16.840.1.114222.4.11.6066 PHVS_Race_HL7_2x.

6.3.1.D2.5.2.4 Mother's Information: gender

The Mother's gender MAY be included in the document header if known. The value for gender/ code SHALL be drawn from value set 2.16.840.1.113883.1.11.1
HVS_AdministrativeGender_HL7_V3.

6.3.1.D2.5.2.5 realmCode

The realmCode SHALL be included and SHALL indicate the country for the jurisdiction of the implementation. The value for realmCode SHALL be drawn from CodeSystem: 1.0.3166.1

Country (ISO 3166-1).

6.3.1.D2.5.3 Body Constraints – Further Vocabulary or Conditional Constraints

There are no body constraints to the underlying HL7 Reporting Fetal Death Information from a Clinical Setting to Vital Records.

6.3.1.D2.6 Document Example

A complete example of the Fetal Death Reporting CDA document (BFDR-FDeath) Document Content Module is available on the IHE ftp server at: ftp://ftp.ihe.net/TF_Implementation_Material/QRPH/packages/.Note that this is an example and is meant to be informative and not normative. This example shows the 1.3.6.1.4.1.19376.1.7.3.1.1.19.3 elements for all of the specified templates.

6.3.1.D3 Labor and Delivery Summary for Vital Records (LDS-VR) Document

6.3.1.D3.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:qrph:ldsvr:2014**

6.3.1.D3.2 Parent Template(s)

This document is an adaptation of the IHE PCC Medical Document template (templateID 1.3.6.1.4.1.19376.1.5.3.1.1.1). The Medical Document template includes requirements for various header elements; name, addr and telecom elements for identified persons and organizations; and basic participations record target, author, and legal authenticator.

This document template is also an adaptation of the IHE PCC Labor and Delivery Summary Document (templateId 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2).

6.3.1.D3.3 Referenced Standards

All standards which are reference in this document are listed below with their common abbreviation, full title, and link to the standard.

Table 6.3.1.D3.3-1: Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/Library/General/HL7_CDA_R2_final.zip
XDS-MS	IHE PCC Medical Summary	
LDS	IHE Labor and Delivery Profile	
LOINC	Logical Observation Identifiers, Names and Codes	
SNOMED	Systemized Nomenclature for Medicine	
RxNorm	RxNorm	http://www.nlm.nih.gov/research/umls/rxnorm/
FIPS 5-2	Codes for the Identification of the States, the District of Columbia, and the Outlying Areas	http://www.itl.nist.gov/fipspubs/fip5-2.htm
NUBC	National Uniform Billing Committee	http://www.nubc.org/
HL7	Health Level Seven	http://www.hl7.org

6.3.1.D3.4 Data Element Mapping to CDA

Refer to Volume 4, 4.I.2.1.1 for mapping from BFDR Form data elements to the pre-pop LDS-VR CDA Document

6.3.1.D3.5 Content Module Specifications

This section specifies the header, section, and entry content modules which comprise the LDS-VR Document Content Module, using the Template ID as the key identifier.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified.

6.3.1.D3.5.1 Document Constraints

Table 6.3.1.D3.5.1-1: LDS-VR Document Template

Template Name	Labor and Delivery Summary – Vital Records
Template ID	1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1
Parent Template	Specialization of 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2 Labor and Delivery Summary Document Template, IHE PCC Specialization of 1.3.6.1.4.1.19376.1.5.3.1.1.1 Medical Document Template, IHE PCC
General Description	The Labor and Delivery Summary (LDS-VR) CDA document template specifies a specialized version of the Labor and Delivery Summary Document. It is used to prepopulate an electronic form (worksheet) that collects the information needed for submission to vital records. Use of the LDS-VR pre-population Option optimizes the initial Birth and Fetal Death Report form data population.
Document Code	SHALL be 57057-2 codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"

Opt and Card	Condition	Header Element or Section Name	Template ID	Specification Document	Vocabulary Constraint
Header Elements					
R[1..1]		documentationOf/EncompassingEncounter	2.16.840.1.113883.10.20.1.21	PCC TF vol 2 6.3.1.1.3	6.3.1.D3.5.2.1
Sections					
R[1..1]		Hospital Admission Diagnosis	1.3.6.1.4.1.19376.1.5.3.1.3.3	PCC TF vol 2 6.3.3.1.4	None
R[1..1]		Admission Medication History	1.3.6.1.4.1.19376.1.5.3.1.3.20	PCC TF vol 2 6.3.3.3.2	6.3.1.D3.5.3.1
R[1..1]		Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	PCC TF vol 2 6.3.3.1.3	None
R[1..1]		Transport Mode	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	PCC TF vol 2 6.3.3.6.7	None
R2[0..1]		Assessment and Plan	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	PCC TF vol 2 6.3.3.6.2	None
R[1..1]		Pain Assessment Panel	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	PCC TF vol 2 6.3.3.2.23	None
R[1..1]		Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	PCC TF vol 2 6.3.3.5.2	None
R2[0..1]		Coded Antenatal Testing and Surveillance	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	PCC TF vol 2 6.3.3.5.7	None
R[1..1]		Coded History of Infection	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	PCC TF vol 2 6.3.3.2.37	6.3.1.D3.5.3.2
R[1..1]		Pregnancy History	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	PCC TF vol 2 6.3.3.2.18	6.3.1.D3.5.3.3
R[1..1]		History of Present Illness	1.3.6.1.4.1.19376.1.5.3.1.3.4	PCC TF vol 2 6.3.3.2.1	None
R[1..1]		History of Past Illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	PCC TF vol 2 6.3.3.2.5	None
R[1..1]		Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	PCC TF vol 2 6.3.3.2.3	6.3.1.D3.5.3.4
R2[0..1]		Coded Advance Directives	1.3.6.1.4.1.19376.1.5.3.1.3.35	PCC TF vol 2 6.3.3.6.5	None
R2[0..1]		Birth Plan	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	PCC TF vol 2 6.3.3.6.12	None

R[1..1]		Allergies and Other Adverse Reactions	1.3.6.1.4.1.19376.1.5.3.1.3.13	PCC TF vol 2 6.3.3.4.15	None
R[1..1]		Coded Detailed Physical Examination □	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	PCC TF vol 2 6.3.3.4.2	6.3.1.D3.5.3.5
R[1..1]		Estimated Delivery Dates	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	PCC TF vol 2 6.3.3.2.28	None
R[1..1]		Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	PCC TF vol 2 6.3.3.3.3	6.3.1.D2.5.3.7
R2[0..1]		Intravenous Fluids Administered	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	PCC TF vol 2 6.3.3.8.4	None
R2[0..1]		Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	PCC TF vol 2 6.3.3.6.17	None
R2[0..1]		EBS Estimated Blood Loss	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	PCC TF vol 2 6.3.3.1.6	None
R[1..1]		History of Blood Transfusions	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	PCC TF vol 2 6.3.3.2.31	None
R2[0..1]		History of Surgical Procedures	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	PCC TF vol 2 6.3.3.2.44	None
R[1..1]		Labor and Delivery Events	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	PCC TF vol 2 6.3.3.2.39	6.3.1.D3.5.3.8
R[1..1]		Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	PCC TF vol 2 6.3.3.8.3	6.3.1.D3.5.3.9
R[1..1]		Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	PCC TF vol 2 6.3.3.2.49	6.3.1.D3.5.3.10
R[1..1]		Newborn Delivery Information	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	PCC TF vol 2 6.3.3.2.40	6.3.1.D3.5.3.11
R[1..1]		Coded Detailed Physical Examination Section	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	PCC TF vol 2 6.3.3.4.2	6.3.1.D3.5.3.12
R[1..1]		Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	PCC TF vol 2 6.3.3.4.5	6.3.1.D3.5.3.13
R[1..1]		General Appearance	1.3.6.1.4.1.19376.1.5.3.1.1.9.16	PCC TF vol 2 6.3.3.4.6	6.3.1.D3.5.3.14
R[1..1]		Neurologic System	1.3.6.1.4.1.19376.1.5.3.1.1.9.35	PCC TF vol 2 6.3.3.4.26	6.3.1.D3.5.3.12
R[1..1]		Heart	1.3.6.1.4.1.19376.1.5.3.1.1.9.29	PCC TF vol 2 6.3.3.4.20	6.3.1.D3.5.3.12

R[1..1]		Musculoskeletal System	1.3.6.1.4.1.19376.1.5.3.1.1.9.34	PCC TF vol 2 6.3.3.4.25	6.3.1.D3.5.3.12
R[1..1]		Abdomen	1.3.6.1.4.1.19376.1.5.3.1.1.9.31	PCC TF vol 2 6.3.3.4.22	6.3.1.D3.5.3.12
R[1..1]		Genitalia	1.3.6.1.4.1.19376.1.5.3.1.1.9.36	PCC TF vol 2 6.3.3.4.27	6.3.1.D3.5.3.12
R[1..1]		Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	PCC TF vol 2 6.3.3.2.3	6.3.1.D3.5.3.15
R[1..1]		Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	PCC TF vol 2 6.3.3.8.3	6.3.1.D3.5.3.16
R[1..1]		Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	PCC TF vol 2 6.3.3.3.3	6.3.1.D3.5.3.17
[0..1]		Event Outcomes	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	PCC TF vol 2 6.3.3.2.42	None
R[1..1]		Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	PCC TF vol 2 6.3.3.2.49	6.3.1.D3.5.3.18
R[1..1]		Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	PCC TF vol 2 6.3.3.5.2	6.3.1.D3.5.3.19
C[0..1]		Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	PCC TF vol 2 6.3.3.6.17	None
R[1..1]		Payers	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	PCC TF vol 2 6.3.3.7.1	6.3.1.D3.5.3.20

6.3.1.D3.5.2 Header – Further Vocabulary or Conditional Constraints

6.3.1.D3.5.2.1 documentationOf/encompassingEncounter

Admission Source

encompassingEncounter/participant[@typeCode='ORG']/code

/

Transfer In (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

6.3.1.D3.5.3 Body - Further Vocabulary or Conditional Constraints

6.3.1.D3.5.3.1 Admission Medication History

Medication Coded Product

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.20]]/**entry**/substanceAdministration/code

SHALL include the following substance administration history if known and associated administration dates/times:

Fertility Enhancing Drugs Medications (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144

6.3.1.D3.5.3.2 Coded History of Infection

The concept domain bound to the ProblemObservation/value/@code where the status is active within the Problem Concern Entry required by this section, SHALL be bound to the value set defined to combine the following value sets.

Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071

Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98

Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

6.3.1.D3.5.3.3 Pregnancy History

The concept domain bound to the PregnancyObservation/code/@code SHALL be bound to the value set defined to combine the following value sets.

SHALL include the following observations if known:

Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70 (e.g., spontaneous or induced losses or ectopic pregnancy)

Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122

Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123

Number of Preterm Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187

Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124

Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148

Last Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134

Number Prenatal Care Visits (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135

Previous Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

Prepregnancy Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136

Gestational Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137

Prepregnancy Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138

Gestational Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139

Eclampsia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140

Preterm Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141

Poor Pregnancy Outcome History (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142

Infertility Treatment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143

Artificial or Intrauterine Insemination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145

Assistive Reproductive Technology (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146

First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133

6.3.1.D3.5.3.4 Active Problems

Problem code, ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code

SHALL include the following problems if known:

Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176 Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071

Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98

Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

Chorioamnionitis During Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24

Fever Greater Than 100.4 (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25

6.3.1.D3.5.3.5 Coded Detailed Physical Examination

No further constraints.

6.3.1.D3.5.3.6 Coded Detailed Physical Examination.Coded Vital Signs

Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Result type code,

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Height (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

3141-9 Body Weight with methodCode detailing:

Mothers Delivery Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120

Pre-Pregnancy Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118

6.3.1.D3.5.3.7 Medications Administered

Medication Coded Product,

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code

SHALL include the following substance administrations if known and associated route and administration dates/times:

Antibiotics (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3

Augmentation of Labor - Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23

Epidural Anesthesia - Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26

Spinal Anesthesia – Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28

Glucocortico Steroids (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38

Route SHALL be coded using HL7 Route of Administration (2.16.840.1.113883.12.162), specifically indicating the route where IV or IM administration route is used:

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode

IV Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4

IM Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5

6.3.1.D3.5.3.8 Labor and Delivery Events

No further constraints.

6.3.1.D3.5.3.9 Labor and Delivery Events.Procedures and Interventions

Procedure, Procedure Date and Time

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime

SHALL include for the following procedure codes and associated date/timestamps if known:

Augmentation of Labor - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22

Epidural Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27

Spinal Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29

In-utero Resuscitation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31

Operative Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33

Further Fetal Assessment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32

Induction of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

Unplanned Operation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105

Cervical Cerclage (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125

External Cephalic Version (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

Tocolysis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128

Hysterotomy Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150

Transfusion Whole Blood or Packed Red Bld (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99

Unplanned Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103

Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138

For the delivery event identified by the following procedure value set:

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

the Procedures an Interventions SHALL also indicate the NPI, Provider Type, and the Provider Name:

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/id

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/code

Physician (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15

Doctor of Osteopathic Medicine (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16

Certified Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17

Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/assignedPerson/name

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/act/entryRelationship/observation/methodCode

Route and Method of Delivery - Spontaneous (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111

Route and Method of Delivery - Forceps (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112

Route and Method of Delivery - Vacuum (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113

Route Method of Delivery - Trial of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115

Route and Method of Delivery - Scheduled C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116

Route and Method of Delivery - Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114

6.3.1.D3.5.3.10 Labor and Delivery Events.Coded Event Outcomes

Coded Event Outcome

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code

Birth Plurality of Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132

Number of Live Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68

Number of Fetal Deaths This Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164

ICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188

Fetal Intolerance of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30

Meconium Staining (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36

Third Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100

Fourth Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101

Ruptured Uterus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102

Fetal Presentation at Birth- Breech (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108

Fetal Presentation at Birth- Cephalic (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109

Fetal Presentation at Birth- Other (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110

Precipitous Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130

Prolonged Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131

Premature Rupture (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129

Patient Transfer Entry

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/code

Transfer In (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/name

Institution Referred from (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.199

6.3.1.D3.5.3.11 Newborn Delivery Information

No further constraints.

6.3.1.D3.5.3.12 Newborn Delivery Information.Coded Physical Detailed Examination

Neurologic Systems: 1.3.6.1.4.1.19376.1.5.3.1.1.9.35

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.35]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Meningomyelocele/Spina Bifida - Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65

Anencephaly of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53

Cleft Lip with or without Cleft Palate (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58

Cleft Palate Alone (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189

Heart 1.3.6.1.4.1.19376.1.5.3.1.1.9.29

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.29]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Cyanotic Congenital Heart Disease (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54

Digestive System 1.3.6.1.4.1.19376.1.5.3.1.1.9.31

SHALL include the following observations, associated values, and units if known

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.31]]/entry/act/entryRelationship/observation/code

Gastroschisis of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62

Musculoskeletal System 1.3.6.1.4.1.19376.1.5.3.1.1.9.34

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.34]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Limb Reduction Defect (NCHS) 6.1.4.1.19376.1.7.3.1.1.13.8.64

Abdomen 1.3.6.1.4.1.19376.1.5.3.1.1.9.31

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.31]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Omphalocele of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66

Genitalia 1.3.6.1.4.1.19376.1.5.3.1.1.9.36

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/

component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.36]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Hypospadias (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63

6.3.1.D3.5.3.13 Newborn Delivery Information.Coded Physical Detailed Examination.Coded Vital Signs

Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Result type code,

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

3141-9 Body Weight

with methodCode detailing:

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode

Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

5 Min Apgar Score (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12

10 Min Apgar Score (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13

6.3.1.D3.5.3.14 Newborn Delivery Information.Coded Physical Detailed Examination.General Appearance

General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

Suspected Chromosomal Disorder (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

Downs Syndrome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

Congenital Diaphragmatic Hernia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55

Karyotype Confirmed (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56

6.3.1.D3.5.3.15 Newborn Delivery Information.Active Problems

Problem Code

ClinicalDocument/component/structuredBody/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code

SHALL be included for the following problem codes and associated date/timestamps if known:

Seizure or Serious Neurologic Dysfunction (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10

Breastfed Infant (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41

6.3.1.D3.5.3.16 Newborn Delivery Information.Procedures and Interventions

Procedure, Procedure Date and Time

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND

id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime

SHALL be included for the following procedure codes and associated date/timestamps if known:

Antibiotic Administration Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178

Assisted Ventilation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7

Further Fetal Assessment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32

Karyotype Determination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154

Fetal Autopsy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153

Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138

6.3.1.D3.5.3.17 Newborn Delivery Information.Medications Administered

Medication Coded Product

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/
component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code

SHALL include the following observations, associated values, and units if known

Newborn Receiving Surfactant Replacement Therapy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11

Antibiotics (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3

Route SHALL be coded using HL7 Route of Administration (2.16.840.1.113883.12.162), specifically indicating the route where IV or IM administration route is used where Antibiotics are administered for Neonatal Sepsis:

ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode

IM Medication Administration Route (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5
IV Medication Administration Route (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4

Medication indication SHALL be coded using SNOMED-CT where Antibiotics are administered for Neonatal Sepsis

ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/ entryRelationship[@typeCode='RSON']/observation[cda:templateId/@root='2.16.840.1.113883.10.20.1.28']

Neonatal Sepsis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6

6.3.1.D3.5.3.18 Newborn Delivery Information.Coded Event Outcomes

ClinicalDocument/component/structuredBody/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values, and units if known

NICU Care (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198
Time of Death (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.185

Significant Birth Injury (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9

Neonatal Death (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149

To represent the setting where the child was born, SHALL include

With observation value indicating the setting location:

Birthplace Setting (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/value

Birthplace Hospital (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192

Birth Place Home Intended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193

Birth Place Home Unintended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194

Birth Place Home Unknown Intention (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195

Birthplace Clinic Office (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197

Birth Place Freestanding Birthing Center (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196

Patient Transfer Entry

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/code

Transfer to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.

7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/name

Institution Referred to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.191

6.3.1.D3.5.3.19 Newborn Delivery Information.Coded Results

Coded results code,

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']] subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ /entry/act/entryRelationship/observation/code

SHALL include the following observations, associated values and units if known:

Karyotype Result (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59

6.3.1.D3.5.3.20 Payers

Payer (NOTE: payers is inherited from Medical Summary as an Optional Section)

SHOULD include payer information using:

ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7]]/code

6.3.1.D3.6 Document Example

CDA Release 2.0 documents that conform to the requirements of this document content module shall indicate their conformance by the inclusion of the 1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1 XML elements in the header of the document.

A CDA Document may conform to more than one template. This content module inherits from the PCC TF Medical Document, 1.3.6.1.4.1.19376.1.5.3.1.1.1, content module and the PCC TF Labor and Delivery Summary Document Template, 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2, and so must conform to the requirements of those templates as well this document specification, Labor and Delivery Summary – Vital Records 1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1

A complete example of the Labor and Delivery Summary – Vital Records (LDS-VR) Document Content Module is available on the IHE ftp server at: ftp://ftp.ihe.net/TF_Implementation_Material/QRPH/packages/.Note that this is an example and

is meant to be informative and not normative. This example shows the 1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1 elements for all of the specified templates.

6.3.2 CDA Header Templates

Add to section 6.3.2 Header Content Module Templates

None

6.3.3 CDA Section Templates

Add to section 6.3.3.10 Section Content Module Templates

None

6.3.4 CDA Entry Content Module Templates

Add to section 6.3.4.E Entry Content Modules

None

6.4 Section not applicable

This heading is not currently used in a CDA document.

6.5 Value Sets

The following table describes each of the value sets used to support the BFDR Profile. These are all published by and available from the PHIN Vocabulary Access and Distribution System (PHIN VADS). Each of the value sets below are established as extensional with the discrete values available at the PHIN-VADS URL provided. Version status may change from time-to-time as these value sets are maintained by NCHS, so version number should not be referenced when using these value sets in support of the BFDR Profile. Similarly, associated date related metadata attributes will changed as a result of value set maintenance activities, and can be obtained at the PHIN-VADS URL provided.

6.5.1 Value Sets used by this profile

Table 6.5.1-1: LDS-VR Document Template Specification

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
10 Min Apgar Score (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13	To reflect the 10 Min Apgar Score	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
5 Min Apgar Score (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12	To reflect the 5 Min Apgar Score	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12	IHE BFDR
Anencephaly of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53	To reflect Anencephaly of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53	IHE BFDR
Antibiotic Administration Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178	To reflect Antibiotic Administration Procedure during labor and delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178	IHE BFDR
Antibiotics (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3	To reflect that antibiotics were received by the mother during delivery and by the newborn for suspected neonatal sepsis	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3	IHE BFDR
Artificial or Intrauterine Insemination (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145	To reflect the Artificial or Intrauterine Insemination as a Risk Factor in Pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145	IHE BFDR
Assisted Ventilation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7	To reflect that the newborn was provided assisted ventilation reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7	IHE BFDR
Assistive Reproductive Technology (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146	To reflect the Assistive Reproductive Technology as a Risk Factor in Pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146	IHE BFDR
Augmentation of Labor - Medication (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23	To reflect a medication used for the of Augmentation of Labor	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23	IHE BFDR
Augmentation of Labor - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22	To reflect a procedure of Augmentation of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Birth Plurality of Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132	To reflect the Plurality, which is the number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy. ("Reabsorbed" fetuses, those which are not "delivered" (expulsed or extracted from the mother) should not be counted.)	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132	IHE BFDR
Birth Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20	To reflect the Birth Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20	IHE BFDR
Birthplace Clinic Office (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197	To reflect the birth occurred in the at clinic or office	SNOMED-CT		IHE BFDR
Birth Place Freestanding Birthing Center (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196	To reflect the birth occurred at a freestanding birthing enter	SNOMED-CT		IHE BFDR
Birth Place Home Intended (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193	To reflect the birth occurred in the at home as intended	SNOMED-CT		IHE BFDR
Birth Place Home Unintended (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194	To reflect the birth occurred in the at home as unintended	SNOMED-CT		IHE BFDR
Birth Place Home Unknown Intention (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195	To reflect the birth occurred in the at home with intention unknown	SNOMED-CT		IHE BFDR
Birthplace Hospital (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192	To reflect the birth occurred in the hospital	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192	IHE BFDR
Birthplace Setting (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184	To reflect the birthplace of the newborn (setting)	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Breastfed Infant (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41	To reflect Breastfed Infant at discharge	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41	IHE BFDR
Certified Midwife (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17	To reflect the Title of the Attendant responsible for the delivery Procedure as a Certified Midwife	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17	IHE BFDR
Cervical Cerclage (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125	To reflect Obstetric Procedures as Cervical Cerclage	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125	IHE BFDR
Chlamydia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93	To reflect Chlamydia as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93	IHE BFDR
Chorioamnionitis During Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24	To reflect a Chorioamnionitis During Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24	IHE BFDR
Cleft Lip with or without Cleft Palate (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58	To reflect Cleft Lip with/without Cleft Palate as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58	IHE BFDR
Cleft Lip without Cleft Palate (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60	To reflect Cleft Lip without Cleft Palate as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60	IHE BFDR
Cleft Palate Alone (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189	To reflect Cleft Palate alone as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189	IHE BFDR
Conception Date (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180	To reflect Conception Date	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180	IHE BFDR
Congenital Diaphragmatic Hernia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55	To reflect Congenital Diaphragmatic Hernia as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55	IHE BFDR
Cyanotic Congenital Heart Disease (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54	To reflect Cyanotic Congenital Heart Disease as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54	IHE BFDR
Cytomegalovirus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167	To reflect infection with Cytomegalovirus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Date of Last Live Birth (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67	To reflect the Date of Last Live Birth	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67	IHE BFDR
Date of Last Menses (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69	To reflect the Date of Last Menses	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69	IHE BFDR
Date of Last Other Pregnancy Outcome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70	To reflect the Date of Last Other Pregnancy Outcome such as spontaneous or induced losses or ectopic pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70	IHE BFDR
Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14	To reflect the Delivery Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14	IHE BFDR
Discharge Transfer Codes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44	To reflect Discharge of the newborn as Transfer	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44	IHE BFDR
Doctor of Osteopathic Medicine (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16	To reflect the Title of the Attendant responsible for the delivery Procedure as a Doctor of Osteopathic Medicine	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16	IHE BFDR
Downs Syndrome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61	To reflect Downs Syndrome as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61	IHE BFDR
Eclampsia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140	To reflect Risk Factors of Eclampsia	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140	IHE BFDR
Epidural Anesthesia - Medication (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26	To reflect an Epidural Anesthesia	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26	IHE BFDR
Epidural Anesthesia - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27	To reflect an Epidural Anesthesia Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27	IHE BFDR
External Cephalic Version (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127	To reflect Obstetric Procedures as External Cephalic Version	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Facility Location ICU (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2	To reflect that the patient (mother) was treated in the ICU for complications associated with labor and delivery reflecting a maternal morbidity.	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2	IHE BFDR
Facility Location NICU (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	To reflect that the newborn was admitted to the NICU reflecting an abnormal condition of the newborn	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	IHE BFDR
Facility Location OR (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104	To reflect that the patient (mother) was treated in the OR for an unplanned operation for complications associated with labor and delivery reflecting unplanned operation	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104	IHE BFDR
Female Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43	To reflect the Female Gender	HL7 Administrative Gender	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43	IHE BFDR
Fertility Enhancing Drugs Medications (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144	To reflect that Fertility Enhancing Drugs were administered as a risk factor for pregnancy	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145	IHE BFDR
Fetal Autopsy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153	To reflect Fetal Autopsy was performed	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153	IHE BFDR
Fetal Death Time Point (NCHS)	2.16.840.1.114222.4.11.7112	A list of time points during the delivery process at which the fetal death is thought to have occurred. Note, SNOMED is being used as the primary source for codes within the value set.	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7112	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Fetal Intolerance of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30	To reflect that there was a Fetal Intolerance of Labor requiring In-utero Resuscitation measures including maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30	IHE BFDR
Fetal Presentation at Birth-Breech (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108	To reflect the Fetal Presentation at Birth-Breech method of delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108	IHE BFDR
Fetal Presentation at Birth-Cephalic (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109	To reflect the Fetal Presentation at Birth-Cephalic method of delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109	IHE BFDR
Fetal Presentation at Birth-Other (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110	To reflect the Fetal Presentation at Birth-Other	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110	IHE BFDR
Fever Greater Than 100.4 (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25	To reflect a Fever Greater Than 100.4 During Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25	IHE BFDR
First Prenatal Care Visit (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133	To reflect the Date of the First Prenatal Care Visit	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133	IHE BFDR
Fourth Degree Perineal Laceration (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101	To reflect Fourth Degree Perineal Laceration as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Further Fetal Assessment (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32	To reflect that there was a Fetal Intolerance of Labor Further Fetal Assessment including scalp pH, scalp stimulation, acoustic stimulation	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32	IHE BFDR
Gastroschisis of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62	To reflect Gastroschisis of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62	IHE BFDR
Gestational Diabetes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137	To reflect Risk Factors of Gestational Diabetes	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137	IHE BFDR
Gestational Hypertension (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139	To reflect Risk Factors of Gestational Hypertension	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139	IHE BFDR
Glucocortico Steroids (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38	To reflect administration of Glucocortico Steroids	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38	IHE BFDR
Gonorrhea (NCHS)	2.16.840.1.114222.4.11.6071	To reflect Gonorrhea as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.6071	IHE BFDR
Group B Streptococcus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166	To reflect Infection with Group B Streptococcus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166	IHE BFDR
Height (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	To reflect the mother's height	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	IHE BFDR
Hepatitis B (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96	To reflect Hepatitis B as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96	IHE BFDR
Hepatitis C (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97	To reflect Hepatitis C as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97	IHE BFDR
Histological Placental Examination (NCHS)	2.16.840.1.114222.4.11.7138	To reflect the Histological Placental Examination for fetal death		https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7138	IHE BFDR
Hypospadias (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63	To reflect Hypospadias as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Hysterotomy Hysterectomy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150	To reflect hysterotomy/hysterectomy as the method of delivery in fetal death	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150	IHE BFDR
ICU Care (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188	To reflect that the mother was transferred to ICU following the birth	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188	IHE BFDR
IM Medication Administration Route (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5	To reflect that Intramuscular Medication Administration Route was used to administer a medication	HL7 Route of Administration	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5	IHE BFDR
Induction of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34	To reflect that there was an Induction of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34	IHE BFDR
Infertility Treatment (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143	To reflect Risk Factors of Pregnancy Infertility Treatment	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143	IHE BFDR
Institution Referred to (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.191	To reflect the institution to which the patient was referred	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.191	IHE BFDR
Institution Referred from (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.199	To reflect the institution from which the patient was referred	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.199	IHE BFDR
In-utero Resuscitation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31	To reflect that there was a Fetal Intolerance of Labor requiring In-utero Resuscitation measures including maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
IV Medication Administration Route (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4	To reflect that IV Medication Administration Route was used to administer a medication	HL7 Route of Administration	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4	IHE BFDR
Karyotype Confirmed (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56	To reflect Karyotype Confirmed as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56	IHE BFDR
Karyotype Determination (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154	To reflect Karyotype determination as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154	IHE BFDR
Karyotype Result (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59	To reflect Karyotyping to determine that the result is pending	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59	IHE BFDR
Last Prenatal Care Visit (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134	To reflect the Date of the Last Prenatal Care Visit	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134	IHE BFDR
Limb Reduction Defect (NCHS)	6.1.4.1.19376.1.7.3.1.1.13.8.64	To reflect Limb Reduction Defect as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=6.1.4.1.19376.1.7.3.1.1.13.8.64	IHE BFDR
Listeria (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	To reflect Listeria as Infections present and treated during this pregnancy		https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	IHE BFDR
Male Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42	To reflect the Male Gender	HL7 AdministrativeGender	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42	IHE BFDR
Meconium Staining (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36	To reflect that there was moderate or heavy Meconium staining	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36	IHE BFDR
Meningomyelocele/Spina Bifida - Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65	To reflect Meningomyelocele/Spina Bifida of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Midwife (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18	To reflect the Title of the Attendant responsible for the delivery Procedure as a Midwife excluding registered midwife which is reflected in the 'certified midwife' value set	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18	IHE BFDR
Mothers Delivery Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120	To reflect the Mother's Delivery Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120	IHE BFDR
Neonatal Death (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149	To reflect that the newborn died	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149	IHE BFDR
Neonatal Sepsis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6	To reflect that the newborn had suspected neonatal sepsis reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6	IHE BFDR
Newborn Receiving Surfactant Replacement Therapy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11	To reflect that the Newborn received Surfactant Replacement Therapy reflecting an abnormal condition of the newborn	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11	IHE BFDR
NICU Care (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198	To reflect the that the baby was transferred to NICU following the birth	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198	IHE BFDR
Number of Fetal Deaths This Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164	To reflect the Number of Fetal Deaths This Delivery	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164	IHE BFDR
Number of Live Births (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68	To reflect the Number of Live Births for the current pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68	IHE BFDR
Number of Preterm Births (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187	To reflect the number of preterm births in prior pregnancies	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187	IHE BFDR
Number of Previous Cesareans (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148	To reflect the Number of Previous Cesareans as a Risk Factor in Pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.48	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Number of Previous Live Births Now Dead (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122	To reflect the Previous Other Pregnancy Outcomes	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122	IHE BFDR
Number of Previous Live Births Now Living (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123	To reflect the Previous Other Pregnancy Outcomes	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123	IHE BFDR
Number of Prior Pregnancies (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71	To reflect the Number of Prior Pregnancies	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71	IHE BFDR
Number Prenatal Care Visits (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135	To reflect the Number Prenatal Care Visits	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135	IHE BFDR
Obstetric Estimate of Gestation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	To reflect the Obstetric Estimate of Gestation of the newborn	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	IHE BFDR
Omphalocele of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66	To reflect Omphalocele of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66	IHE BFDR
Operative Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33	To reflect that there was an Operative Delivery including operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33	IHE BFDR
Parvovirus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168	To reflect infection with Parvovirus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168	IHE BFDR
Physician (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15	To reflect the Title of the Attendant responsible for the delivery Procedure as a Physician	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15	IHE BFDR
Poor Pregnancy Outcome History (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142	To reflect the Previous Other Pregnancy Outcomes	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Precipitous Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130	To reflect Onset of labor with Precipitous Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130	IHE BFDR
Premature Rupture (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129	To reflect Onset of labor with Premature Rupture	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129	IHE BFDR
Prepregnancy Diabetes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136	To reflect Risk Factors of Prepregnancy Diabetes	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136	IHE BFDR
Prepregnancy Hypertension (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138	To reflect Risk Factors of Prepregnancy Hypertension	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138	IHE BFDR
Pre-Pregnancy Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118	To reflect the mother's Pre-Pregnancy Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118	IHE BFDR
Preterm Birth (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141	To reflect Risk Factors of Preterm Birth (history)	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141	IHE BFDR
Previous Cesarean (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	To reflect Risk Factors of Pregnancy Previous Cesarean	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	IHE BFDR
Previous Other Pregnancy Outcomes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121	To reflect the Previous Other Pregnancy Outcomes	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121	IHE BFDR
Problem Status Active (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119	To reflect the Problem Status Active	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119	IHE BFDR
Prolonged Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131	To reflect Onset of labor with Prolonged Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131	IHE BFDR
Route and Method of Delivery - Cesarean (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114	To reflect the Route and Method of Delivery as Cesarean Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114	IHE BFDR
Route and Method of Delivery - Forceps (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112	To reflect the Route and Method of Delivery as Forceps Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Route and Method of Delivery - Scheduled C (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116	To reflect the Route and Method of Delivery as Scheduled Cesarean	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116	IHE BFDR
Route and Method of Delivery - Spontaneous (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111	To reflect the Route and Method of Delivery as Spontaneous Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111	IHE BFDR
Route Method of Delivery - Trial of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115	To reflect the Route and Method of Delivery if Cesarean was as Trial of Labor Attempted	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115	IHE BFDR
Route and Method of Delivery - Vacuum (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113	To reflect the Route and Method of Delivery as Vacuum Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113	IHE BFDR
Ruptured Uterus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102	IHE BFDR
Seizure or Serious Neurologic Dysfunction (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10	To reflect that the newborn suffered a Seizure or Serious Neurologic Dysfunction reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10	IHE BFDR
Significant Birth Injury (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9	To reflect that the newborn suffered a Significant Birth Injury (skeletal fracture(s), peripheral nerve injury, and/ or soft tissue/solid organ hemorrhage which requires intervention) reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9	IHE BFDR
Spinal Anesthesia – Medication (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28	To reflect a Spinal Anesthesia	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Spinal Anesthesia - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29	To reflect an Spinal Anesthesia Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29	IHE BFDR
Spontaneous Onset of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35	To reflect that there was a Spontaneous Onset of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35	IHE BFDR
Suspected Chromosomal Disorder (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57	To reflect Suspected Chromosomal Disorder as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57	IHE BFDR
Syphilis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98	To reflect Syphilis as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98	IHE BFDR
Third Degree Perineal Laceration (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100	To reflect Third Degree Perineal Laceration as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100	IHE BFDR
Time of Death (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.185	To reflect the Time of the Fetal Death	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.185	IHE BFDR
Tocolysis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128	To reflect Obstetric Procedures as Tocolysis	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128	IHE BFDR
Toxoplasmosis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169	To reflect infection with Toxoplasmosis	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169	IHE BFDR
Transfer In (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177	To reflect if the mother was transferred to this facility for maternal medical or fetal indications for delivery	NUBC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177	IHE BFDR
Transfer to (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	To reflect if the infant was transferred within 24 hours of delivery to another facility	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176	To reflect Transferred for Maternal Medical or Fetal Indications for Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176	IHE BFDR
Transfusion Whole Blood or Packed Red Bld (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99	To reflect Transfusion Whole Blood or Packed Red Blood as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99	IHE BFDR
Unplanned Hysterectomy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103	IHE BFDR
Unplanned Operation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105	IHE BFDR
U.S. Territories (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19	To reflect the U.S. Territories	FIPS 5-2	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19	IHE BFDR

6.5.2 Value Sets Defined by this profile

None

Appendices

Appendix A – BFDR Birth CDA Document Quick Reference

This table provides a reference showing the section structure of the BFDR Birth CDA Document and the BFDR Fetal Death CDA Documents, the templateId's which each sections conforms to, and the LOINC code used to identify the data in that section. The reference also show the types of entry templates used to encode data found in each section.

A.1 BFDR Birth CDA Document and BFDR Fetal Death CDA Document Template and LOINC Code Quick Reference

Birth/ FD Use		BFDR	TemplateId	LOINC	Type
Birth		Document	2.16.840.1.113883.10.20.26.1	68998-4	
FD		Document	2.16.840.1.113883.10.20.26.1	68998-4	Document
			Note: this document does not use the General H		
		Header			
Both		recordTarget	2.16.840.1.113883.10.20.26.1	n/a	
Both		Author	2.16.840.1.113883.10.20.26.1	n/a	
Both		Custodian	2.16.840.1.113883.10.20.26.1	n/a	
		Section and sub-section Specification			
Both	1	Prenatal Testing and Surveillance Section	2.16.840.1.113883.10.20.26.3	57078-8	
Both		*Prenatal Care*	*2.16.840.1.113883.10.20.26.42*	73776-7	*Entry*
Both	2	Prior Pregnancy History Section	2.16.840.1.113883.10.20.26.12	57073-9	
Both		*Date of Last Live Birth*	*2.16.840.1.113883.10.20.26.20*	*68499-3*	*Entry*

Both		*Last Menstrual Period Date*	*2.16.840.1.113883.10.20.26.33*	*8665-2*	*Entry*
Both		*Number of Births Now Living*	*2.16.840.1.113883.10.20.26.36*	*11638-4*	*Entry*
Both		*Number of Live Births Now Dead*	*2.16.840.1.113883.10.20.26.38*	*68496-9*	*Entry*
Both		*Other Pregnancy Outcome*	*2.16.840.1.113883.10.20.26.40*	*69043-8*	*Entry*
Both		*Estimate of Gestation*	*2.16.840.1.113883.10.20.26.21*	*11884-4*	*Entry*
Birth	3	History of Infection - Live Birth Section	2.16.840.1.113883.10.20.26.5	71459-2	Section
Birth		*Infection Present: Live Birth*	*2.16.840.1.113883.10.20.26.30*	*72519-2*	*Entry*
FD	3	History of Infection: Fetal Death Section	2.16.840.1.113883.10.20.26.48	71459-2	Section
FD		*Infection Present: Fetal Death*	*2.16.840.1.113883.10.20.26.49*	*73769-2*	*Entry*
	4	Labor and Delivery Section	2.16.840.1.113883.10.20.26.8	34079-4	Section
Both		*Onset of Labor*	*2.16.840.1.113883.10.20.26.32*	*73774-2*	*Entry*
Both		*Labor and Delivery Process*	*2.16.840.1.113883.10.20.26.31*	*57074-7*	*Entry*
Both		*Planned Home Birth*	*2.16.840.1.113883.10.20.26.26*	*73765-0*	*Entry Relationship*
Both		*Maternal Transfer*	*2.16.840.1.113883.10.20.26.35*	*73763-5*	*Entry Relationship*
Both		*Characteristic of Labor and Delivery*	*2.16.840.1.113883.10.20.26.18*	*73813-8*	*Entry Relationship*
Both		*Maternal Morbidity*	*2.16.840.1.113883.10.20.26.34*	*73781-7*	*Entry Relationship*
Both		*Pregnancy Risk Factor*	*2.16.840.1.113883.10.20.26.44*	*73775-9*	*Entry Relationship*
Both	4.1	Labor and Delivery Procedure Section	2.16.840.1.113883.10.20.26.7	29300-1	Sub-Section
Both		*Obstetric Procedure*	*2.16.840.1.113883.10.20.26.39*		*Entry*
Both		*Method of Delivery*	*2.16.840.1.113883.10.20.26.45*		*Entry*
Both	4.1	Mothers Vital Signs Section	2.16.840.1.113883.10.20.26.9	8716-3	Sub-Section
Both		*Mothers Vital Signs Observation*	*2.16.840.1.113883.10.20.26.46*		*Entry*
Birth	5	Newborn Delivery Section	2.16.840.1.113883.10.20.26.10	57075-4	Section

Birth			Plurality	2.16.840.1.113883.10.20.26.41	57722-1	*Entry*
Birth			Birth Order	2.16.840.1.113883.10.20.26.16	73771-8	*Entry*
Birth			Number of Infants Born Alive	2.16.840.1.113883.10.20.26.37	73773-4	*Entry*
Birth			Abnormal Conditions of the Newborn	2.16.840.1.113883.10.20.26.13	73812-0	*Entry*
Birth			Congenital Anomaly	2.16.840.1.113883.10.20.26.19	73780-9	*Entry*
Birth			Infant Transfer	2.16.840.1.113883.10.20.26.29	73758-5	*Entry*
Birth			Infant Living	2.16.840.1.113883.10.20.26.28	73757-7	*Entry*
Birth			Infant Breastfed	2.16.840.1.113883.10.20.26.27	73756-9	*Entry*
Birth	5.1		Newborns Vital Signs Section	2.16.840.1.113883.10.20.26.11	8716-3	Sub-Section
Birth	5.2		Assessments Section	2.16.840.1.113883.10.20.26.9	51848-0	Sub-Section
FD	5	Fetal Delivery Section		2.16.840.1.113883.10.20.26.4	MISSING LOINC	Section
FD			*Plurality*	*2.16.840.1.113883.10.20.26.41*	*57722-1*	*Entry*
FD			*Birth Order*	*2.16.840.1.113883.10.20.26.16*	*73771-8*	*Entry*
FD			*Number of Infants Born Alive*	*2.16.840.1.113883.10.20.26.37*	*73773-4*	*Entry*
FD			*Autopsy Performance*	*2.16.840.1.113883.10.20.26.15*	*73768-4*	*Entry*
FD			*Fetal Death Occurrence*	*2.16.840.1.113883.10.20.26.22*	*73811-2*	*Entry*
FD			*Congenital Anomaly*	*2.16.840.1.113883.10.20.26.19*	*73780-9*	*Entry*
FD			*Fetal Delivery Time*	*2.16.840.1.113883.10.20.26.23*	*11778-8*	*Entry*

Appendix B – LDS-VR Document Quick Reference

B.1 LDS-VR Document Template and LOINC Code Quick Reference

1665 This table provides a reference showing the section structure of the LDS-VR document, the templateId's which each sections conforms to, and the LOINC code used to identify the data in that section. The reference also show the types of entry templates used to encode data found in each section.

	LDS-VR	TemplateId	LOINC	Type
	Document	1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1	57057-2	Document
	Header Specifications			
	documentationOf/EncompassingEncounter	2.16.840.1.113883.10.20.1.21	n/a	Header
	Section and sub-section Specifications			
1	Hospital Admission Diagnosis	1.3.6.1.4.1.19376.1.5.3.1.3.3	46241-6	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
2	Admission Medication History	1.3.6.1.4.1.19376.1.5.3.1.3.20	42346-7	Section
	Medications			Entry
3	Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	10154-3	Section
	No entries defined			*Entry*
4	Transport Mode	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	11459-5	Section
	Transport (act)	*1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1*		*Entry*
5	Assessment and Plan	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	51847-2	Section
	No Entries Defined			*Entry*
6	Pain Assessment Panel	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	38212-7	Section
	No entries defined			*Entry*
7	Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	30954-2	Section
	Procedure Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
	References Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.4*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
8	Coded Antenatal Testing and Surveillance	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	57078-8	Section
	Antenatal Testing and Surveillance Battery	*1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10*		*Entry*
9	Coded History of Infection	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	56838-6	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*

10	Pregnancy History	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	10162-6	Section
	Pregnancy History Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5.1*		*Entry*
	Pregnancy Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5*		*Entry*
11	History of Present Illness	1.3.6.1.4.1.19376.1.5.3.1.3.4	10164-2	Section
	No Entries Defined			*Entry*
12	History of Past Illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	11348-0	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5*		*Entry*
13	Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	11450-4	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
14	Advance Directives	1.3.6.1.4.1.19376.1.5.3.1.3.34	42348-3	Section
	No entries defined			*Entry*
15	Birth Plan	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	57079-6	Section
	No entries defined			*Entry*
16	Allergies and Other Adverse Reactions	1.3.6.1.4.1.19376.1.5.3.1.3.13	48765-2	Section
	Allergy Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.3*		*Entry*
	Allergy Intolerances Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.6*		*Entry*
17	Detailed Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	29545-1	Section
	No Entries Defined			*Entry*
17.1	Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	8716-3	Section
	Vital Signs Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.1*		*Entry*
	Vital Signs Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.2*		*Entry*
18	Estimated Delivery Dates	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	57060-6	Section
	Estimated Delivery Date Observation (a simple observation)	*1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1*		*Entry*
19	Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	18610-6	Section
	Medications	*1.3.6.1.4.1.19376.1.5.3.1.4.7*		*Entry*

20	Intravenous Fluids Administered	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	57072-1	Section
	Intravenous Fluids (substanceAdministration)	*1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2*		*Entry*
21	Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	XX-IntakeAndOutput	Section
	No entries defined			*Entry*
22	Estimated Blood Loss	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	8717-1	Section
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
23	History of Blood Transfusions	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	56836-0	Section
	No Entries Defined			*Entry*
24	History of Surgical Procedures	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	10167-5	Section
	No Entries Defined			*Entry*
25	Labor and Delivery Events	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	57074-7	Section
	No Entries Defined			*Entry*
25.1	Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	10167-5	Section
	Procedures	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
25.2	Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	42545-4	Section
	Patient Transfer (act)	*1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26	Newborn Delivery Information	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	57075-4	Section
	No Entries Defined			*Entry*
26.1	Detailed Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	29545-1	Section
	No Entries Defined			*Entry*
26.1.1	Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	8716-3	Section
	Vital Signs Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.1*		*Entry*
	Vital Signs Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.2*		*Entry*
26.1.2	General Appearance	1.3.6.1.4.1.19376.1.5.3.1.1.9.16	10210-3	Section
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
26.2	Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	11450-4	Section

	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
26.3	Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	10167-5	Section
	Procedure	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
26.4	Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	18610-6	Section
	Medications	*1.3.6.1.4.1.19376.1.5.3.1.4.7*		*Entry*
26.5	Event Outcomes	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	42545-4	Section
	No entries defined.			*Entry*
26.6	Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	42545-4	Section
	Patient Transfer	*1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26.7	Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	30954-2	Section
	Procedure Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
	References Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.4*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26.8	Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	XX-IntakeAndOutput	Section
	No entries defined			*Entry*
27	Payers	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	48768-6	Section
	Coverage Entity	*1.3.6.1.4.1.19376.1.5.3.1.4.17*		*Entry*

Volume 3 Namespace Additions

Add the following terms to the IHE Namespace:

Add to section 5 Namespaces and Vocabularies

codeSystem	codeSystemName	Description
1.3.6.1.4.1.19376.1.5.3.1	IHE PCC Template Identifiers	This is the root OID for all IHE PCC Templates. A list of PCC templates can be found below in CDA Release 2.0 Content Modules.
1.3.6.1.4.1.19376.1.7.3.1.1	IHE BFDR Template Identifiers	This is the root OID for all the IHE BFDR Templates.
1.3.6.1.4.1.19376.1.5.3.2	IHEActCode	See IHEActCode Vocabulary below
1.3.6.1.4.1.19376.1.5.3.3	IHE PCC RoleCode	See IHERoleCode Vocabulary below
1.3.6.1.4.1.19376.1.5.3.4		Namespace OID used for IHE Extensions to CDA Release 2.0
2.16.840.1.113883.10.20.1	CCD Root OID	Root OID used for by ASTM/HL7 Continuity of Care Document
2.16.840.1.113883.5.112	RouteOfAdministration	See the HL7 RouteOfAdministration Vocabulary
2.16.840.1.113883.5.1063	SeverityObservation	See the HL7 SeverityObservation Vocabulary
2.16.840.1.113883.1.11.12212	MaritalStatus	See the HL7 MaritalStatus Vocabulary
2.16.840.1.113883	ServiceDeliveryLocation	See the HL7 ServiceDeliveryLocation Vocabulary
2.16.840.1.113883.12.1	AdministrativeGender	See the HL7 AdministrativeGender Vocabulary
2.16.840.1.113883.5.111	Role	See the HL7 Role Vocabulary
2.16.840.1.113883.5.1077	EducationLevel	See the HL7 EducationLevel Vocabulary
2.16.840.1.113883.6.1	LOINC	Logical Observation Identifier Names and Codes
2.16.840.1.113883.6.96	SNOMED-CT	SNOMED Clinical Terms
2.16.840.1.113883.6.103	ICD-9CM (diagnosis codes)	International Classification of Diseases, Clinical Modifiers, Version 9
2.16.840.1.113883.6.104	ICD-9CM (procedure codes)	International Classification of Diseases, Clinical Modifiers, Version 9
2.16.840.1.113883.6.3	ICD10	International Classification of Diseases Revision 10 (ICD 10) Note this does NOT have the CM changes, and is specifically for international use.
2.16.840.1.113883.6.4	ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
2.16.840.1.113883.6.90	ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
2.16.840.1.113883.6.26	MEDCIN	A classification system from MEDICOMP Systems.
2.16.840.1.113883.6.88	RxNorm	RxNorm

codeSystem	codeSystemName	Description
2.16.840.1.113883.6.63	FDDC	First DataBank Drug Codes
2.16.840.1.113883.6.12	C4	Current Procedure Terminology 4 (CPT-4) codes.
2.16.840.1.113883.6.257	Minimum Data Set for Long Term Care	The root OID for Minimum Data Set Answer Lists
2.16.840.1.113883.2.8.1.1	CCAM	Classification Commune des Actes Medicaux
2.16.840.1.113883.6.21	NUBC	National Uniform Billing Codes (US)

Add to section 5.1.1 IHE Format Codes

Profile	Format Code	Media Type	Template ID
Labor and Delivery Summary for Vital Records (VR) for Birth and Fetal Death Reporting (BFDR)	urn:ihe:qrph:BFDR:2011	Text/XML	1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1
BFDR Birth CDA document	urn:ihe:qrph:BFDR-Birth:2014	Text/xml	1.3.6.1.4.1.19376.1.7.3.1.1.19.2
BFDR Fetal Death CDA document	urn:ihe:qrph:BFDR-FDeath:2014	Text/xml	1.3.6.1.4.1.19376.1.7.3.1.1.19.3

Add to section 5.1.2 IHE ActCode Vocabulary

No new ActCode Vocabulary

Add to section 5.1.3 IHE RoleCode Vocabulary

No new RoleCode Vocabulary

Volume 4 – National Extensions

Add appropriate Country section

4 National Extensions

4.I National Extensions for IHE USA

4.I.1 Comment Submission

This national extension document was authored under the sponsorship and supervision of IHE QRPH with collaboration from the CDC/National Center for Health Statistics, who welcome comments on this document and the IHE USA initiative. Comments should be directed to:

http://www.ihe.net/qrph/qrphcomments.cfm

4.I.2 Birth and Fetal Death Reporting – Extended (BFDR-E)

4.I.2.1 BFDR US Form Option

The U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death SHALL use derived elements to populate the processing variables as indicated in Table 5.X.2-1 and as specified in the Birth Edit Specifications and the Fetal Death Edit Specifications for the 2003 Revisions of the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death.

Standard worksheets are used in the U.S. to enhance the collection of quality, reliable data for birth and fetal death events. A common, standard form, entitled “Mother’s Worksheet for Child’s Birth Certificate”, has been established to identify information to be collected directly from the mother. The “Facility Worksheet for the Live Birth Certificate” was developed to identify information for which the best sources are the mother’s and infant’s medical records.

The U.S. currently limits the data that may be pre-populated from an EHR for birth and fetal death events to a subset of vital records’ medical/health data requirements, that is, primarily those items included in the U.S. Standard Facility Worksheet for the Live Birth Certificate and the U.S. Standard Facility Worksheet for the Report of Fetal Death. The initial goal will be to monitor and assess the quality of the data that will be exchanged between electronic health record and vital records systems and the quality of the process of information exchange. This profile will not describe the data items on the U.S. Standard Mothers Worksheet for the Child’s Birth Certificate (excepting the two items “Mother’s prepregnancy weight” and “Mother’s height”) or the Patient’s Worksheet for the Report of Fetal Death. Additionally, these items will not be included for pre-population since these data elements are not collected from an EHR for vital records.

4.I.2.1.1 Form Data Element Mappings to Input Content Document to the US Standards

Certificate of Live Birth and US Standard Report of Fetal Death. A relevant mapping for BFDR content reporting include those elements identified within the US efforts under the CDC/National

Center for Health Statistics (NCHS) that can be computed from data elements in the Labor and Delivery Summary (LDS) of the electronic health record. The LDS mapping rules described below overlays these data elements typically presented to the birth registrar in a form. This Derived Data Element Index is an attempt to describe which sections are intended to cover which domains, the value sets to be used to interpret the LDS content, and rules for examining LDS content to determine whether or not the data element is satisfied. These rules may specify examination of one or more LDS locations to make a determination of the data element result. The list includes derived data elements that compose knowledge concepts not currently represented in standards, most of which are optional. While any LDS document may be used to populate the form, the IHE PCC Labor and Delivery Summary Document as constrained by the LDS-VR will result in the maximum number of pre-populated data elements.

Table 4.I.2.1.1 -1 describes the pre-population rules to derive the data elements to populate the following forms for U.S. vital registration: Facility Worksheet for the Live Birth Certificate and the Facility Worksheet for the Report of Fetal Death. This profile will not specify the data collected from the Mother's Worksheet. Additionally, these items will not be included for pre-population.

The Derivation Rule references the value sets and BFDR Code locations described indicated in this table. The value sets reference the Value Subsets provided in the document appendix which may be made available through a Value Set Repository as described by the IHE ITI ESVS Profile. Further edit specifications are in the Birth Edit Specifications and the Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Birth and Report of Fetal Death (http://www.cdc.gov/nchs/vital_certs_rev.htm) which shall be required in addition to the mapping below.

Table 4.I.2.1.1-1: Form Element Mapping Specification

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ANTI	Y	N	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Any antibacterial drug given systemically (intravenous or intramuscular.) For example, penicillin, ampicillin, gentamicin, cefotoxine, etc.)	IF (Indication CONTAINS ValueSet (Neonatal Sepsis (NCHS)) AND (Coded Product Name CONTAINS ValueSet (Antibiotics (NCHS))) AND (Route CONTAINS ValueSet (IM Medication Administration Route (NCHS)) OR ValueSet (IV Medication Administration Route (NCHS))), OR IF Procedure ID CONTAINS ValueSet (Antibiotic Administration Procedure (NCHS)) THEN ANTI SHALL = “Y” ELSE “N”	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Antibiotics (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Route 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode	IM Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5 IV Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Indication 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/entryRelationship[@typeCode='RSON']/observation[cda:templateId/@root='2.16.840.1.113883.10.20.1.28']/code	Neonatal Sepsis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Antibiotic Administration Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AVEN1	Y	N	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Infant given manual breaths with bag and mask or bag and endotracheal tube within the first several minutes from birth for any duration. Excludes oxygen only and laryngoscopy for aspiration of meconium.	IF (Procedure ID CONTAINS ValueSet (Assisted Ventilation (NCHS)) AND (Procedure Start Time -Birth Time< 5 minutes) THEN AVEN1 SHALL = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Assisted Ventilation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure Start Time ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime (LOW)	
						Birth Time /ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/birthTime	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AVEN6	Y	N	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).	IF (Procedure ID CONTAINS ValueSet (Assisted Ventilation (NCHS)) AND (Procedure End Time –Procedure Start time >=6 hours) THEN AVEN6 SHALL = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Assisted Ventilation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure Start Time ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime (LOW)	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure End Time ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime (HIGH)	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BINJ	Y	N	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	Significant birth injury: (skeletal fracture(s), peripheral nerve injury and/or soft tissue/solid organ hemorrhage which requires intervention). Defined as present immediately following delivery or manifesting following delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and /or extremity ecchymossi accompanied by evidence of anemia and/or hypovolemia and or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma. All require confirmation by diagnostic imaging or exploratory laparotomy.	IF Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Observation Code CONTAINS ValueSet (Significant Birth Injury (NCHS)), THEN BINJ **SHALL** = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/	Significant Birth Injury (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NICU	Y	N	Abnormal conditions of the newborn: Admission to NICU	Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn.	IF (Labor and Delivery Summary Newborn Delivery Information Coded Event Outcome Observation Code CONTAINS (NICU Care (NCHS))), THEN "NICU" SHALL = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	NICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
SEIZ	Y	N	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	Seizure defined as any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction defined as severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxicischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.	If (Labor and Delivery Summary Newborn Delivery Information Active Problems Problem Code CONTAINS ValueSet (Seizure or Serious Neurologic Dysfunction (NCHS))) THEN “SEIZ” SHALL = “Y” ELSE “N”	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Seizure or Serious Neurologic Dysfunction (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
SURF	Y	N	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	Newborn given surfactant replacement therapy: Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency either due to preterm birth or pulmonary injury resulting in decreased lung compliance (respiratory distress). Includes both artificial and extracted natural surfactant.	IF (Labor and Delivery Summary Newborn Delivery Information Medications Administered Coded Product Name Coded Product Name CONTAINS ValueSet (Newborn Receiving Surfactant Replacement Therapy (NCHS))), THEN "SURF" SHALL = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Newborn Receiving Surfactant Replacement Therapy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11
NOA54	Y	N	Abnormal conditions of the newborn: None of the above	None of the listed abnormal conditions of the newborn.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
DNA54	Y	N	Abnormal conditions of the newborn: Pending	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((AVEN1 = "U") OR (AVEN6 = "U") OR (NICU = "U") OR (SURF = "U") OR (ANTI = "U") OR (SEIZ = "U") OR (BINJ = "U")), THEN "DNA54" SHALL = "1" ELSE "DNA54" SHALL = "0"	See: AVEN1, AVEN6, NICU, SURF, ANTI, SEIZ, BINJ	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
APGAR5	Y	N	Apgar Score: 5 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. Enter the infant's Apgar score at 5 minutes.	If (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Result Type CONTAINS ValueSet (5 Min Apgar Score (NCHS))), THEN "APGAR5" = (Result Value)	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 Result Type ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	5 Min Apgar Score (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 Result ValueClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
APGAR10	Y	N	Apgar Score: 10 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes.	If ("APGAR5" <6), AND (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Result Type CONTAINS ValueSet (10 Min Apgar Score (NCHS)), THEN "APGAR10" = (Result Value)	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 Result Type ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	10 Min Apgar Score (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 Result Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ATTENDN	Y	Y	Attendant's name	The name of the attendant (the person responsible for delivering the child), their title, and their National Provider Identification (NPI) Number.	"ATTENDN" **SHALL** be populated using Procedures and Interventions using Provider Name WHERE Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID contains ValueSet (Delivery (NCHS)) where the provider is the person responsible for delivering the child	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Name 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/assignedPerson/name	
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
ATTEND	Y	Y	Attendant's title:	The title of the person (attendant) responsible for delivering the child. The	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions	Labor and Delivery Summary Labor and Delivery	Physician (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery. Titles include: M.D. (doctor of medicine); D.O. (doctor of osteopathy); CNM/CM (certified nurse midwife/certified midwife); Other midwife (midwife other than a CNM/CM); and Other (specify)	Procedure ID CONTAINS ValueSet (Delivery (NCHS)), THEN IF Provider Type CONTAINS ValueSet (Physician (NCHS)), THEN "ATTEND" **SHALL** = "1", ELSE IF Provider Type CONTAINS ValueSet (Doctor of Osteopathic Medicine (NCHS)), THEN "ATTEND" **SHALL** = "2", ELSE IF 4.04 Provider Type CONTAINS ValueSet (Certified Midwife (NCHS)), THEN "ATTEND" **SHALL** = "3", ELSE IF Provider Type CONTAINS ValueSet (Midwife (NCHS)), THEN "ATTEND" **SHALL** = "4", ELSE IF Provider Type NOT NULL THEN "ATTEND" **SHALL** = "5", ELSE "ATTEND" **SHALL** = "9"	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Type 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/code	Doctor of Osteopathic Medicine (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16 Certified Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17 Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ATTENDS	Y	Y	Attendant: Other specified	The specific title of the person (attendant) responsible for delivering the child if not included in the list of provided titles. Examples include nurse, father, police officer, and EMS technician. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID CONTAINS ValueSet (Delivery (NCHS)) AND "ATTEND" = "5", THEN ATTENDS SHALL = Provider Type	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Type 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/code	
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NPI	Y	Y	Attendant's NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.	"NPI" **SHALL** be populated using the Provider ID of the Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID contains ValueSet (Delivery (NCHS)) where the Procedure ID is expressed as the National Provider Identifier (NPI)	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider ID (NPI) 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/performer/assignedEntity/id	
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BWG	Y	N	Birth weight (Infant's)	Infant's birthweight in grams.	IF Newborn Delivery Information Coded Detailed Physical Examination Coded Vital Signs Result Type = 3141-9 where Result methodCode CONTAINS ValueSet (Birth Weight (NCHS)), THEN "BWG" **SHALL** = Result Value WHERE Result Value Units are expressed in grams	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result type, Result methodCode ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code	Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Method Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BWO	Y	N	Birth weight (Infant's)	Infant's birthweight in ounces.	The preferred measure is in grams rather than ounces. Refer to BWG	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Type, Result methodCodeClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BWP	Y	N	Birth weight (Infant's)	Infant's birthweight in pounds.	The preferred measure is in grams rather than pounds. Refer to BWG	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result type, methodCode 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	
ANTB	Y	N	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	Antibiotics received by the mother during labor. Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin,	IF (Labor and Delivery Summary Medications Administered Coded Product Name CONTAINS ValueSet Antibiotics (NCHS))) AND (Route CONTAINS ValueSet IM Medication Administration Route (NCHS)) OR ValueSet (IV Medication Administration Route	Labor and Delivery Summary Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Antibiotics (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				Cefataxine, and Ceftriaxone. Information about the course of labor and delivery.	(NCHS))) AND (Administration Time >=procedure effectiveTime(low AND Administration Time <= procedure effectiveTime (high)) WHERE Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID CONTAINS ValueSet (Delivery (NCHS) THEN “ANTI” SHALL = “Y” ELSE “N”	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Route 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode	IV Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4 IM Medication Administration Route (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Administration Time 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/effectiveTme(low)	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Effective Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/effectiveTime(low)	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
AUGL	Y	N	Characteristics of labor and delivery: Augmentation of labor	Augmentation of labor: Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun). Information about the course of labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Augmentation of Labor - Procedure (NCHS)) OR (Coded Product Name CONTAINS (Augmentation of Labor - Medication (NCHS))), THEN “AUGL” SHALL =“Y” ELSE “N”	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Augmentation of Labor - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Augmentation of Labor - Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23
CHOR	Y	N	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Any recorded maternal temperature at or above 38oC (100.4oF) or clinical diagnosis of chorioamnionitis during labor made by the delivery attendant (usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, or fetal tachycardia). Information about the course of labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Active Problems Problem Code CONTAINS ValueSet ((Chorioamnionitis During Labor (NCHS)) OR (Fever Greater Than 100.4 (NCHS)) THEN "CHOR" SHALL = "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Chorioamnionitis During Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24 Fever Greater Than 100.4 (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25
ESAN	Y	N	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[du	Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a	IF (Labor and Delivery Summary Medications Administered Coded Product Name	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	Epidural Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			ring labor]	limited space with the distribution of the analgesic effect limited to the lower body. Information about the course of labor and delivery.	CONTAINS ValueSet (Epidural Anesthesia - Medication (NCHS)) OR ValueSet (Spinal Anesthesia – Medication (NCHS)) OR(Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code Procedure ID CONTAINS (Epidural Anesthesia - Procedure (NCHS)) OR (Spinal Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29)) THEN “ESAN” SHALL be “Y” ELSE “N”	Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Spinal Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29
						Labor and Delivery Summary Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Epidural Anesthesia - Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26
							Spinal Anesthesia – Medication (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FINT	Y	N	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	Fetal intolerance of labor was such that one or more of the following actions was taken: In utero resuscitative measures, further fetal assessment, or operative delivery. Includes any of the following: Maternal position change; Oxygen Administration to the mother; Intravenous fluids administered to the mother; Amnioinfusion; Support of maternal blood pressure; Administration of uterine relaxing agents. Further fetal assessment including any of the following: scalp pH, scalp stimulation, acoustic stimulation. Operative delivery to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.	IF (Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Fetal Intolerance of Labor (NCHS)) AND (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (In-utero Resuscitation (NCHS)) OR ValueSet (Further Fetal Assessment (NCHS)) OR ValueSet (Operative Delivery (NCHS))), THEN “FINT” **SHALL** = “Y” ELSE “N”	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Fetal Intolerance of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	In-utero Resuscitation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31
							Operative Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
							Further Fetal Assessment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
INDL	Y	N	Characteristics of labor and delivery: Induction of labor	Induction of labor: Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun). Information about the course of labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Induction of Labor (NCHS)) THEN "INDL" **SHALL** = "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Induction of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34
MECS	Y	N	Characteristics of labor and delivery: Meconium staining	Moderate or heavy meconium staining of the amniotic fluid Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery that is more than enough to cause a greenish color change of an otherwise clear fluid. Information about the course of labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Codedications administered Event Outcomes Observation Code CONTAINS ValueSet (Meconium Staining (NCHS)) THEN "MECS" **SHALL** = "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Meconium Staining (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
STER	Y	N	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Steroids (glucocorticoids): For fetal lung maturation received by the mother before delivery. Includes: Betamethasone dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Does not include: Steroid medication given to the mother as an anti-inflammatory treatment before or after delivery. Information about the course of labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Medications Administered Coded Product Name CONTAINS ValueSet (Glucocortico Steroids (NCHS))) AND (Administration Time < Procedure Time(low)) WHERE Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID CONTAINS ValueSet (Delivery (NCHS) THEN “STER” **SHALL** =“Y”ELSE “N”	Labor and Delivery Summary Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Glucocortico Steroids (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38
						Labor and Delivery Summary Medications Administered Administration Time 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/effectiveTime(low)	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
NOA04	Y	N	Characteristics of labor and delivery: None of the above	None of the listed characteristics of labor and delivery that provide information about the course of labor and delivery.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
DNA04	Y	N	Characteristics of labor and delivery: Pending	If the data are not available when the characteristics of labor and delivery are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((INDL = “U”) OR (AUGL = “U”) OR (NVPR = “U”) OR (STER = “U”) OR (ANTB = “U”) OR (CHOR = “U”) OR (MECS = “U”) OR (FINT = “U”) OR (ESAN = “U”)), THEN “DNA04” **SHALL** = “1” ELSE “DNA04” **SHALL** = “0”	See INDL, AUGL, NVPR, STER, ANTB, CHOR, MECS, FINT, ESAN	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
IDOB_YR	Y	N	Child: Date of Birth: Year	The infant's date (year) of birth.	"IDOB_YR" SHALL be populated using Child's Metadata Entry: Date of Birth using the Year part of Date of Birth WHERE the Year is represented using 4-digits	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ birthTime	
IDOB_MO	Y	N	Child: Date of Birth: Month	The infant's date (month) of birth.	"IDOB_MO" SHALL be populated using Child's Metadata Entry: Date of Birth using the Month part of Date of Birth WHERE the Month is represented using 2-digits	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/subject/*related Subject*/code[@code='NCHILD' AND id=idOfTheChild]/ birthTime	
IDOB_DY	Y	N	Child: Date of Birth: Day	The infant's date (day) of birth.	"IDOB_DY" SHALL be populated using Child's Metadata Entry: Date of Birth using the Day part of Date of Birth WHERE the Day is represented using 2-digits	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ birthTime	
KIDFNAME	Y	Y	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	The legal name (first) of the child as provided by the parents.	"KIDFNAME" SHALL be populated using Child's Metadata Entry: Person Name, using the First Name part of Person Name	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ subject/name	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
KIDMNAME	Y	Y	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	The legal name (middle) of the child as provided by the parents.	"KIDMNAME" SHALL be populated using Child's Metadata Entry: Person Name, using the Middle Name part of Person Name	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ subject/name	
KIDLNAME	Y	Y	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	The legal name (last) of the child as provided by the parents.	"KIDLNAME" SHALL be populated using Child's Metadata Entry: Person Name, using the Last Name part of Person Name	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ subject/name	
KIDSUFFX	Y	Y	Child's Last Name Suffix:	The legal name (suffix) of the child as provided by the parents.	"KIDSUFFX" SHALL be populated using HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.05 Person Name	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/following-sibling::subject/name	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BFED	Y	N	Child: Infant being breastfed?	Information on whether the infant was being breast-fed during the period between birth and discharge from the hospital.	If Labor and Delivery Summary Newborn Delivery Information Active Problems Observation Code CONTAINS ValueSet (Breastfed Infant (NCHS)) THEN BFED SHALL be “Y”.	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems 1.3.6.1.4.1.19376.1.5.3.1.3.6 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Breastfed Infant (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ILIV	Y	N	Child: Infant living at time of report?	Information on the infant's survival. Check "Yes" if the infant is living. Check "Yes" if the infant has already been discharged to home care. Check "No" if it is known that the infant has died. If the infant was transferred but the status is known, indicate the known status.	IF NOT Labor and Delivery Summary Newborn Delivery Information Code Coded Event Outcomes Observation Code CONTAINS ValueSet(Neonatal Death (NCHS)) THEN "ILIV" SHALL = 'Y' ELSE 'N'	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Neonatal Death (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.149
IRECNUM	Y	N	Child: Newborn Medical Record Number	The medical record number assigned to the newborn.	"IRECNUM" **SHALL** = Child's newborn medical record number	Labor and Delivery Summary ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ClinicalDocument/componentOf/id	
ISEX	Y	N	Child: (infant) Sex -	The sex of the infant.	IF Labor and Delivery recordTarget/patientRole/patient/	Labor and Delivery Summary	Male Gender (NCHS) 1.3.6.1.4.1.193

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					administrativeGenderCode CONTAINS ValueSet(Male Gender (NCHS)) THEN “ISEX” SHALL =’M’ ELSE IF Labor and Delivery recordTarget/patientRole/patient/ administrativeGenderCode CONTAINS ValueSet(Female Gender (NCHS)) THEN “ISEX” SHALL =’F’ ELSE THEN “ISEX” SHALL =’N’	ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ClinicalDocument/componentOf/administrativeGenderCode	76.1.7.3.1.1.13.8.42 Female Gender (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.43

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ITRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	Transfer status of the infant within 24 hours after delivery.	Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Patient Transfer Observation Code CONTAINS ValueSet (Transfer to (NCHS)) and (Coded Event Outcomes Patient Transfer effectiveTime (High) – Child date of birth) <= 24 hours THEN ITRAN **SHALL** = "Y" ELSE ITRAN **SHALL** = "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Patient Transfer Entry 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/code	Transfer to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Patient Transfer Entry 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/effectiveTime[high]	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Child Date Of Birth /ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/birthTime	
FTRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility		If Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Patient Transfer Entry Observation Code CONTAINS ValueSet (Institution Referred to (NCHS)) and (Observation effectiveTime (High) – Child Date of Birth) <= 24 hours THEN FTRAN **SHALL** = Observation Value	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Patient Transfer Entry Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/code	Institution Referred to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.191

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Patient Transfer Entry Observation Value ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Patient Transfer Entry Observation effectiveTime ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/component/section[templateId[@root= 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1]]/entry/act/entryRelationship/observation/effectiveTime	
						Labor and Delivery Summary Child Date Of Birth /ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/birthTime	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
TB	Y	N	Child: Time of Birth	The infant's time of birth.	"TB" **SHALL** = Time part of Child's date of birth	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChildbirthTime	
ANEN	Y	Y	Congenital anomalies of the Newborn: Anencephaly	Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain .Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination Nervous System Observation Code CONTAINS ValueSet (Anencephaly of the Newborn (NCHS)) THEN "ANEN" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Nervous System1.3.6.1.4.1.19376.1.5.3.1.1.9.35 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.35]]/entry/act/entryRelationship/observation/code	Anencephaly of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CCHD	Y	Y	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Congenital heart defects that cause cyanosis.	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination Heart Observation Code CONTAINS ValueSet (Cyanotic Congenital Heart Disease (NCHS)) THEN "CCHD" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Heart 1.3.6.1.4.1.19376.1.5.3.1.1.9.29 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.29]]/entry/act/entryRelationship/observation/code	Cyanotic Congenital Heart Disease (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CDH	Y	Y	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.	If (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet (Congenital Diaphragmatic Hernia (NCHS))THEN "CDH" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Congenital Diaphragmatic Hernia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55
CDIC	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal	Suspected chromosomal disorder karyotype confirmed	If ((Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	Karyotype Confirmed (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			disorder karyotype confirmed		Observation Code CONTAINS ValueSet (Karyotype Confirmed (NCHS)) AND ((Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet(Suspected Chromosomal Disorder (NCHS))) THEN "CDIC" **SHALL** = "Y" ELSE "N".	Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Suspected Chromosomal Disorder (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
CDIS	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.	IF (NOT(Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet (Karyotype Confirmed (NCHS)) AND (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16	Karyotype Confirmed (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Appearance Observation Code CONTAINS ValueSet (Suspected Chromosomal Disorder (NCHS))) THEN "CDIS" **SHALL** = "Y" ELSE "N"	ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Suspected Chromosomal Disorder (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
‘CDIP	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Suspected chromosomal disorder karyotype pending.	If (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet (Suspected Chromosomal Disorder (NCHS)) AND Procedure Contains (Karyotype Determination (NCHS)) AND act classCode='ACT' moodCode='INT' AND NOT Result Type (Karyotype Result (NCHS)) THEN “CDIP” **SHALL** = “Y” ELSE “N”.	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Suspected Chromosomal Disorder (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Karyotype Determination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28 ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']]subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]//entry/act/entryRelationship/observation/code	Karyotype Result (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CL	Y	Y	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Coded Detailed Physical Examination Nervous System Observation Code CONTAINS ValueSet (Cleft Lip with or without Cleft Palate (NCHS))) "CL" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Nervous System 1.3.6.1.4.1.19376.1.5.3.1.1.9.35 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.35]]/entry/act/entryRelationship/observation/code	Cleft Lip with or without Cleft Palate (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CP	Y	Y	Congenital anomalies of the Newborn: Cleft Palate alone	Cleft palate refers to incomplete fusion of the palatal shelves. This may be limited to the soft palate or may also extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without cleft Palate" category, rather than here.	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Coded Detailed Physical Examination Nervous System Observation Code CONTAINS ValueSet (Cleft Palate Alone (NCHS))) THEN "~~CL~~CP" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Nervous System 1.3.6.1.4.1.19376.1.5.3.1.1.9.35 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.35]]/entry/act/entryRelationship/observation/code	Cleft Palate Alone (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189
DOWC	Y	Y	Congenital anomalies of the Newborn: Down Karyotype	Down Karyotype confirmed	IF ((Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	Karyotype Confirmed (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			confirmed		Appearance Observation Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet (Karyotype Confirmed (NCHS)) AND (Observation Code CONTAINS ValueSet (Downs Syndrome (NCHS))) THEN "DOWC" **SHALL** = "Y" ELSE "N"	Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Downs Syndrome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOWN	Y	Y	Congenital anomalies of the Newborn: Down Syndrome	Down Syndrome: Trisomy 21	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Problem Code CONTAINS ValueSet (Downs Syndrome (NCHS))) THEN "DOWN" SHALL = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Downs Syndrome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOWP	Y	Y	Congenital anomalies of the Newborn: Down Karyotype pending	Down Karyotype pending	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination General Appearance Observation Code CONTAINS ValueSet (Downs Syndrome (NCHS)) AND Procedure Contains (Karyotype Determination (NCHS)) AND act classCode='ACT' moodCode='INT' AND NOT Result Type (Karyotype Result (NCHS)) THEN "~~DOWC~~DOWP" **SHALL** = "Y" ELSE "N"	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.General Appearance 1.3.6.1.4.1.19376.1.5.3.1.1.9.16 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.16]]/entry/act/entryRelationship/observation/code	Downs Syndrome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure Code1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Karyotype Determination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28 ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']] subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/ /entry/act/entryRelationship/observation/code	Karyotype Result (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GAST	Y	Y	Congenital anomalies of the Newborn: Gastroschisis	An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.	IF (Labor and Delivery Summary Coded Detailed Physical Examination Digestive System Observation Code CONTAINS ValueSet (Gastroschisis of the Newborn (NCHS))) THEN "GAST" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.Abdomen 1.3.6.1.4.1.19376.1.5.3.1.1.9.31 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.31]]/entry/act/entryRelationship/observation/code	Gastroschisis of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HYPO	Y	Y	Congenital anomalies of the Newborn: Hypospadias	Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree – on the glans ventral to the tip, second degree – in the coronal sulcus, and third degree – on the penile shaft.	If (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination Reno-urogenital System Observation Code CONTAINS ValueSet (Hypospadias (NCHS))) THEN "HYPO" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.Genitalia 1.3.6.1.4.1.19376.1.5.3.1.1.9.36 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.36]]/entry/act/entryRelationship/observation/code	Hypospadias (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
LIMB	Y	Y	Congenital anomalies of the Newborn: Limb reduction defect	Limb reduction defect: (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.	IF (Coded Detailed Physical Examination Musculoskeletal System Observation Code CONTAINS ValueSet (Limb Reduction Defect (NCHS)) THEN "LIMB" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.Musculoskeletal System 1.3.6.1.4.1.19376.1.5.3.1.1.9.34 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.34]]/entry/act/entryRelationship/observation/code	Limb Reduction Defect (NCHS) 6.1.4.1.19376.1.7.3.1.1.13.8.64

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
MNSB	Y	Y	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination Nervous System Observation Code CONTAINS ValueSet (Meningomyelocele/Spina Bifida - Newborn (NCHS)) THEN "~~ANEN~~MNSB" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.Neurologic System 1.3.6.1.4.1.19376.1.5.3.1.1.9.35 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.35]]/entry/act/entryRelationship/observation/code	Meningomyelocele/Spina Bifida - Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
OMPH	Y	Y	Congenital anomalies of the Newborn: Omphalocele	A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.	IF (Labor and Delivery Summary Newborn Delivery Information Coded Detailed Physical Examination Digestive System Observation Code CONTAINS ValueSet (Omphalocele of the Newborn (NCHS)) THEN "OMPH" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.Abdomen 1.3.6.1.4.1.19376.1.5.3.1.1.9.31 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.31]]/entry/act/entryRelationship/observation/code	Omphalocele of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66
NOA55	Y	Y	Congenital anomalies of the Newborn: None of the anomalies listed above	None of the listed congenital anomalies of the newborn or fetus.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DNA55	Y	Y	Congenital anomalies of the Newborn: Pending	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((ANEN = "N") OR (MNSB = "N") OR (CCHD = "N") OR (CDH = "N") OR (OMPF = "N") OR (GAST = "N") OR (LIMB = "N") OR (CL = "N") OR (CP = "N") OR (DOWN = "N") OR (DOWC = "N") OR (DOWP = "N") OR (CDIS = "N") OR (CDIC = "N") OR (CDIP = "N") OR (HYPO = "N")), THEN "DNA55" **SHALL** = "1", ELSE "DNA55" **SHALL** = "0".	See ANEN, MNSB, CCHD, CDH, OMPF, GAST, LIMB, CL, CP, DOWN, DOWC, DOWP, CDIS, CDIC, CDIP, HYPO	
YLLB	Y	Y	Date of last live birth:	The year of birth of the last live-born infant.	Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Live Birth (NCHS)), THEN (IF Observation Value NOT NULL THEN "YLLB" SHALL = the Year part of Result Value WHERE Observation Value is expressed as Date AND WHERE the Year is represented using 4-digits ELSE "YLLB" SHALL = '8888') ELSE "YLLB" SHALL = '9999'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
MLLB	Y	Y	Date of last live birth:	The month of birth of the last live-born infant.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Live Birth (NCHS)), THEN (IF Result Value NOT NULL THEN "MLLB" SHALL = the Month part of Observation Value WHERE Observation Value is expressed as Date AND WHERE the Month is represented using 2-digits ELSE "MLLB" SHALL = '88') ELSE "YLLB" SHALL = '99' .	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
DLMP_DY	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Menses (NCHS)), THEN "~~CM_DLNM~~ DLMP_DY" SHALL = Day part of Observation Value WHERE Observation Value is expressed as Date	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
DLMP_MO	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Menses (NCHS)), THEN "~~CM_DLNM~~ DLMP_MO" SHALL = Month part of Observation Value WHERE ResObservationult Value is expressed as Date	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
DLMP_YR	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Menses (NCHS)), THEN "~~CM_DLNM~~DLMP_YR" SHALL = Year part of Observation Value WHERE Observation Value is expressed as Date	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
YOPO	Y	Y	Date of Last Other Pregnancy Outcome: Year	The date (year) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Other Pregnancy Outcome (NCHS)), THEN (IF Observation Value NOT NULL THEN “YOPO” SHALL = the Year part of Observation Value WHERE Observation Value is expressed as Date AND WHERE the Year is represented using 4-digits ELSE YOPO” SHALL = ‘8888’) ELSE “YOPO” SHALL = ‘9999’	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
MOPO	Y	Y	Date of Last Other Pregnancy Outcome: Month	The date (month) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Date of Last Other Pregnancy Outcome (NCHS)), THEN (IF Observation Value NOT NULL THEN “MOPO” SHALL = the Month part of Observation Value WHERE Observation Value is expressed as Date AND WHERE the Month is represented using 2-digits ELSE MOPO” SHALL = ‘88’) ELSE “MOPO” SHALL = ‘99’	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	
ADDRESS_D	Y	Y	Facility Address		"Facility Address" SHALL be populated using the Child's facility address	Metadata Entry: Child's facility address ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ClinicalDocument/componentOf/ encompassingEncounter/location/healthCareFacility/**location**/addr	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FNAME	Y	Y	Facility Name (if Not institution, give street and number)	The name of the facility where the delivery took place.	"FNAME" SHALL be populated using the Child's Facility Name	ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]ClinicalDocument/componentOf/ encompassingEncounter/ location/healthCareFacility/**location/**name	
FNPI	Y	Y	Facility National Provider Identifier	National Provider Identifier.	"FNPI" SHALL be populated using the Child Facility's NPI Id	ClinicalDocument/recordTarget[N]/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ClinicalDocument/componentOf/ encompassingEncounter/ location/healthCareFacility/**location/**id	
CHAM	Y	Y	Infections present and treated during this pregnancy: Chlamydia	Chlamydia: A positive test for Chlamydia trachomatis. Infections present at the time of the pregnancy diagnosis or a	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet	Labor and Delivery Summary Active Problems Problem Code	Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	(Chlamydia (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Chlamydia (NCHS))) THEN "CHAM" **SHALL** = "Y" ELSE "N".	1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1]]/entry/act/entryRelationship/observation/code	Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GON	Y	Y	Infections present and treated during this pregnancy: Gonorrhea	Gonorrhea: A positive test/culture for Neisseria gonorrhea. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Gonorrhea (NCHS)) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Gonorrhea (NCHS))) THEN "GON" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Gonorrhea (NCHS) 2.16.840.1.114 222.4.11.6071
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1]]/entry/act/entryRelationship/observation/code	Gonorrhea (NCHS) 2.16.840.1.114 222.4.11.6071

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HEPB	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis B	Hepatitis B (HBV, serum hepatitis): A positive test for the hepatitis B virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Hepatitis B (NCHS)) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Hepatitis B (NCHS))) THEN "HEPB" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1]]/entry/act/entryRelationship/observation/code	Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HEPC	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis C	Hepatitis C (non-A, non-B hepatitis (HCV)): A positive test for the hepatitis C virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Hepatitis C (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Hepatitis C (NCHS))) THEN "HEPC" **SHALL** = "Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1]]/entry/act/entryRelationship/observation/code	Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
SYPH	Y	Y	Infections present and treated during this pregnancy: Syphilis	Syphilis (also called lues) A positive test for Treponema pallidum. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Syphilis (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Syphilis (NCHS))) THEN "SYPH" **SHALL** ="Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1]]/entry/act/entryRelationship/observation/code	Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
NOA02	Y	Y	Infections present and treated during this pregnancy: None of the above	None of the listed infections were present and treated during this pregnancy.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AINT	Y	Y	Maternal Morbidity: - Admission to Intensive care [unit]	Admission to intensive care unit: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation CONTAINS ValueSet (ICU Care (NCHS)) THEN "AINT" SHALL be "Y" ELSE "N".	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	ICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188
MTR	Y	Y	Maternal Morbidity: Maternal Transfusion	Maternal transfusion: Includes infusion of whole blood or packed red blood cells within the period specified. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Transfusion Whole Blood or Packed Red Bld (NCHS)) THEN "MTR" **SHALL** be "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Transfusion Whole Blood or Packed Red Bld (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PLAC	Y	Y	Maternal Morbidity: [Third or fourth degree] perineal laceration	Third or fourth degree perineal laceration: 3rd degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4th degree laceration is all of the above with extension through the rectal mucosa. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Third Degree Perineal Laceration (NCHS)) OR (Fourth Degree Perineal Laceration (NCHS)) THEN "PLAC" **SHALL** be "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation CodeClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Third Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100 Fourth Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101
RUT	Y	Y	Maternal Morbidity: Ruptured Uterus	Ruptured Uterus: Tearing of the uterine wall. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Active Coded Event Outcomes Observation Code CONTAINS ValueSet (Ruptured Uterus (NCHS)) THEN "RUT" **SHALL** be "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Ruptured Uterus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
UHYS	Y	Y	Maternal Morbidity: Unplanned hysterectomy	Unplanned hysterectomy: Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet(Unplanned Hysterectomy (NCHS))) THEN "UHYS" **SHALL** be "Y" ELSE "N"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Unplanned Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103
UOPR	Y	Y	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Unplanned operating room procedure following delivery: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations. Serious complications experienced by the mother associated with labor and delivery.	IF (Labor and Delivery Summary Labor and Delivery Procedure Code CONTAINS ValueSet (Unplanned Operation (NCHS)) AND (Mother's facility location CONTAINS ValueSet (Facility Location OR (NCHS)) AND (Mother's facility location effectiveTime (low) > Procedure Date/Time (high) WHERE Procedure ID CONTAINS (Delivery (NCHS))) "UOPR" **SHALL** be "Y" ELSE "N"	Labor and Delivery Summary Mother's Metadata Entry: Mother's facility location *recordTarget/patientRole/providerOrganization/addr*	Facility Location OR (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104
						Labor and Delivery Summary Mother's Metadata Entry: Mother's facility location *recordTarget/patientRole/providerOrganization/*effectiveTime	
						Labor and Delivery Summary Labor and Delivery	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Unplanned Operation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Date/Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NOA05	Y	Y	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	None of the listed serious complications experienced by the mother associated with labor and delivery.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
PRES	Y	Y	Method of Delivery: Fetal presentation [at birth]: Cephalic	The physical process by which the complete delivery of the fetus was affected. Fetal presentation at birth - Cephalic: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP); Breech: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech; Other: Any other presentation not listed above.	IF (Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Fetal Presentation at Birth- Cephalic (NCHS)) THEN "PRES" **SHALL** = "1" ELSE IF (Observation Code CONTAINS ValueSet (Fetal Presentation at Birth- Breech (NCHS)) THEN "PRES" **SHALL** = "2" ELSE IF (Observation Code CONTAINS ValueSet (Fetal Presentation at Birth- Other (NCHS)) THEN "PRES" **SHALL** = "3" ELSE "PRES" **SHALL** = "9"	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes Observation Code 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Fetal Presentation at Birth- Breech (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.108 Fetal Presentation at Birth- Cephalic (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.109 Fetal Presentation at Birth- Other (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.110
ROUT	Y	Y	Method of Delivery: [Final]Route and method of delivery	The physical process by which the complete delivery of the fetus was affected. Includes: Vaginal/spontaneous: delivery of the entire fetus through the	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	Route and Method of Delivery - Spontaneous (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.111

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				vagina by the nature force of labor with or without manual assistance from the delivery attendant; Vaginal/forceps Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head; Vaginal/vacuum Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head; or Cesarean: Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.	(Route and Method of Delivery - Spontaneous (NCHS)) THEN "ROUT" SHALL = "1" ELSE IF Procedure Code CONTAINS ValueSet (Route and Method of Delivery - Forceps (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112) THEN "ROUT" SHALL = "2" ELSE IF Procedure Code CONTAINS ValueSet (Route and Method of Delivery - Vacuum (NCHS)) THEN "ROUT" SHALL = "3" ELSE IF Procedure Code CONTAINS ValueSet (Route and Method of Delivery - Cesarean (NCHS)) THEN "ROUT" SHALL = "4" ELSE "ROUT" **SHALL** = "9".	Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Route and Method of Delivery - Forceps (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112 Route and Method of Delivery - Vacuum (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113 Route and Method of Delivery - Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
TLAB	Y	Y	Method of Delivery: Trial of labor attempted	If cesarean, indicate if a trial of labor was attempted (labor was allowed, augmented, or induced with plans for a vaginal delivery).	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS Procedure Code CONTAINS CONTAINS ValueSet (Route and Method of Delivery - Cesarean (NCHS)) THEN (IF (Procedure Code CONTAINS ValueSet (Route Method of Delivery - Trial of	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/compone	Route Method of Delivery - Trial of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115 Route and Method of Delivery - Scheduled C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Labor (NCHS)) THEN “TLAB” **SHALL** be “Y”.IF NOT Procedure Code CONTAINS ValueSet (Route and Method of Delivery - Scheduled C (NCHS)) THEN “TLAB” SHALL NOT be available for data entry. SHALL = “X” ELSE IF =NULL THEN “U”) ELSE “N”.	nt/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Route and Method of Delivery - Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
MFNAME	Y	Y	Mother's Current Legal Name: First Name	The current legal first name of the mother.	“MFNAME” **SHALL** be populated using Mother’s Metadata Entry: Mother’s Name using the First Name part of Mother’s Name	Mother’s Metadata Entry: Mother’s Name /ClinicalDocument/recordTarget[0]/patientRole/patient/name	
MMNAME	Y	Y	Mother's Current Legal Name: Middle Name	The current legal middle name of the mother.	“MMNAME” **SHALL** be populated using Mother’s Metadata Entry: Mother’s Name using the Middle Name part of part of Mother’s Name	Labor and Delivery Summary Mother’s Metadata Entry: Mother’s Name /ClinicalDocument/recordTarget[0]/patientRole/patient/name	
MLNAME	Y	Y	Mother's Current Legal Name: Last Name	The current legal last name of the mother.	“MLNAME” **SHALL** be populated using Mother’s Metadata Entry: Mother’s Name using the Last Name part of part of Mother’s Name	Labor and Delivery Summary Mother’s Metadata Entry: Mother’s Name /ClinicalDocument/recordTarget[0]/patientRole/patient/name	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
MSUFF	Y	Y	Mother's Current Legal Name: suffix	The current legal name suffix of the mother.	"MSUFF" **SHALL** be populated using Mother's Metadata Entry: Mother's Name the Last Name Suffix part of part of Mother's Name	Labor and Delivery Summary Mother's Metadata Entry: Mother's Name /ClinicalDocument/recordTarget[0]/patientRole/patient/name	
HFT	Y	Y	Mother's Height: Feet	Mother's height feet	IF (Mother's) Labor and Delivery Summary Coded Detailed Physical Examination Coded Vital Signs Section Result Type CONTAINS ValueSet (Height (NCHS)), THEN "HFT" **SHALL** = feet part of Result Value WHERE Result Value Units are expressed in Feet and Inches	(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Type ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code	Height (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2 Result Value ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.2 Result Value Units 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/units	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HIN	Y	Y	Mother's Height: Inches	Mother's height inches	IF Mother's Labor and Delivery Summary Coded Detailed Physical Examination Coded Vital Signs Section Result Type CONTAINS ValueSet (Height (NCHS)), THEN "HIN" **SHALL** = Inches part of Result Value WHERE Result Value Units are expressed in Feet and Inches	(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Type ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code	Height (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2 Result Value Units ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/units	
MRECNUM	Y	Y	Mother's medical record number	The mother's medical record number for this facility admission	"MRECNUM" **SHALL** be populated using Mother's Metadata Entry: Mother's Person ID using Mother's Person ID Where Person ID represents the Mother's Medical Record Number	(Mother's) Labor and Delivery Summary /ClinicalDocument/recordTarget[0]/patientRole/patient/id	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PWGT	Y	Y	Mother's pre-pregnancy weight	The mother's prepregnancy weight	IF Mother's Labor and Delivery Summary Coded Detailed Physical Examination Coded Vital Signs Section : Result Type = 3141-9 where methodCode CONTAINS ValueSet (Pre-Pregnancy Weight (NCHS)), THEN "PWGT" **SHALL** = Result Value	(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Type methodCode 1.3.6.1.4.1.19376.1.5.3.1.3.28 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	Pre-Pregnancy Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	
NFACL	Y	Y	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Indicates the name of the facility the mother was transferred from if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	IF Labor and Delivery Summary Mother's Encounter Admission Source is value set (Transfer In (NCHS)) and Labor and Delivery Summary Labor and Delivery Active Problems Problem Code is value set (Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)), THEN	(Mother's) Labor and Delivery Summary Mother's Encounter 2.16.840.1.113883.10.20.1.21 Referring Facility Name encompassingEncounter/participant[@typeCode='ORG']/name	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					NFACL SHALL = Referring Facility Name ELSE **NFACL SHALL** = NULL'	(Mother's) Labor and Delivery Summary Mother's Encounter 2.16.840.1.113883.10.20.1.21 Admission Source encompassingEncounter/participant[@typeCode='ORG']/code	Transfer In (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177
						(Mother's) Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
TRAN	Y	Y	Mother transferred for maternal medical or fetal indications for delivery?	Indicates if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	If Labor and Delivery Summary Mother's Encounter Admission Source is value set (Transfer In (NCHS)) and Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code is value set (Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)), THEN "**TRAN" SHALL** = "Y" ELSE IF 16.06 NOT NULL, THEN TRAN **SHALL** = "N" ELSE TRAN **SHALL** = "U".	(Mother's) Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes Observation Code 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176
						Mother's Encounter 2.16.840.1.113883.10.20.1.21 Admission Source encompassingEncounter/participant[@typeCode='ORG']/code	Transfer In (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DWGT	Y	Y	Mother's weight at delivery	The mother's weight at the time of delivery.	(Mother's) Coded Labor and Delivery Summary Coded Detailed Physical Examination Coded Vital Signs Section Result Type=3141-9 where Result methodCode CONTAINS ValueSet (Mothers Delivery Weight (NCHS)), THEN "DWGT" **SHALL** = Result Value	(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Type methodCode ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	Mothers Delivery Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						(Mother's) Labor and Delivery Summary Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs Section 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Value ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
POPO	Y	Y	Number of other pregnancy outcomes	Total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Previous Other Pregnancy Outcomes (NCHS)), THEN "~~POBO~~POPO" **SHALL** = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Previous Other Pregnancy Outcomes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PLBD	Y	Y	Number of previous live births now dead (do not include this child)	The total number of previous live-born infants now dead.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Number of Previous Live Births Now Dead (NCHS)), THEN "PLBD" **SHALL** = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PLBL	Y	Y	Number of previous live births now living (do not include this child)	The total number of previous live-born infants now living.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Number of Previous Live Births Now Living (NCHS)), THEN "PLBL" **SHALL** = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
OWGEST	Y	Y	Obstetric Estimate of Gestation	The best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Obstetric Estimate of Gestation (NCHS)), THEN "OWGEST" **SHALL** = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CERV	Y	N	Obstetric procedures: Cervical cerclage	Cervical cerclage: Circumferential banding or suture of the cervix to prevent or treat dilation. Includes: MacDonald's suture; Shirodkar procedure; and Abdominal cerclage via laparotomy. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Section Procedure Code CONTAINS ValueSet (Cervical Cerclage (NCHS)), THEN "CERV" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Cervical Cerclage (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125
ECVF	Y	N	Obstetric procedures: Failed External cephalic Version	Failed External cephalic version: Failed attempt to convert a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Section Procedure ID CONTAINS ValueSet (External Cephalic Version (NCHS)) as Intent and Negation=TRUE, THEN "ECVF" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	External Cephalic Version (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ECVS	Y	N	Obstetric procedures: Successful External cephalic version	Successful External cephalic version: Successful conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Section Procedure Code CONTAINS ValueSet (External Cephalic Version (NCHS)), AND **NOT (Intent and Negation)=TRUE**, THEN "ECVS" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	External Cephalic Version (NCHS)
TOC	Y	N	Obstetric procedures: Tocolysis	Tocolysis: Administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Medications: Magnesium sulfate (for preterm labor); Terbutaline; Indocin (for preterm labor). Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Section Procedure Code CONTAINS ValueSet Tocolysis (NCHS)), THEN "TOC" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Tocolysis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128
NOA03	Y	N	Obstetric procedures:	None of the listed obstetric procedures were performed for	This SHALL require data entry and SHALL NOT be a result of a		

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			None of the above	medical treatment or invasive/manipulative procedures during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	default from the other attributes in the list	Data Entry Required	
PROM	Y	N	Onset of labor: Premature Rupture	Premature Rupture of the Membranes (prolonged≥12 hours): Spontaneous tearing of the amniotic sac, (natural breaking of the "bag of waters"), 12 hours or more before labor begins. Serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Premature Rupture (NCHS)), THEN "PROM" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PROM" SHALL = 'U" ELSE "PROM" SHALL = 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Premature Rupture (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PRIC	Y	N	Onset of labor: Precipitous Labor	Precipitous labor (<3hours): Labor that progresses rapidly and lasts for less than 3 hours. Serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Precipitous Labor (NCHS)), THEN "PRIC" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PRIC" SHALL = 'U" ELSE "PRIC" SHALL = 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Precipitous Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130
PROL	Y	N	Onset of labor: Prolonged Labor	Prolonged labor (≥ 20 hours): Labor that progresses slowly and lasts for 20 hours or more. Serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Summary Labor and Delivery Coded Event Outcomes Observation Code CONTAINS ValueSet (Prolonged Labor (NCHS)), THEN "PROL" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PROL" SHALL = 'U" ELSE "PROL" SHALL = 'N'	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Prolonged Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131
NOA05	Y	N	Onset of labor: None of the above	None of the listed serious complications experienced by	This SHALL require data entry and SHALL NOT be a result of a	Data Entry Required	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			NOTE: NOA05 is also used for Maternal Morbidity	the mother associated with labor and delivery.	default from the other attributes in the list		
SFN	Y	Y	Place where birth occurred: State Facility Number		"SFN" SHALL be populated using the Child's Facility State Identifier f	ClinicalDocument/recordTarget[N]/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ClinicalDocument/componentOf/ encompassingEncounter/ location/healthCareFacility/location/id	
FLOC	Y	Y	Place where birth occurred: Facility City/Town		"FLOC" SHALL = City/Town part of Metadata Entry: Birth Place taken from the newborn's record	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] /relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ addr/county	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CNAME	Y	Y	Place where birth occurred: County Name		"CNAME" SHALL = County name part of Metadata Entry: Birth Place taken from the newborn's record	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] / subject/relatedSubject/code[@code='NCHILD AND id=idOfTheChild']/addr/county	
CNTYO	Y	Y	Place where birth occurred: County Code		"CNTYO" SHALL = County Code part of Metadata Entry: Birth Place taken from the newborn's record	ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] / subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ addr/county	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BPLACE	Y	N	Place where birth occurred: Birth Place		IF Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Observation Code CONTAINS ValueSet (Birthplace Setting (NCHS)) THEN IF Observation Value CONTAINS ValueSet (Birthplace Hospital (NCHS)) THEN BPLACE SHALL = '1' ELSE IF Observation Value CONTAINS ValueSet (Birth Place Freestanding Birthing Center (NCHS)) THEN BPLACE SHALL = '2' ELSE IF Observation Value CONTAINS ValueSet (Birth Place Home Intended (NCHS)) THEN BPLACE SHALL = '3' ELSE IF Observation Value CONTAINS ValueSet (Birth Place Home	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Birthplace Setting (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Unintended (NCHS)) THEN BPLACE SHALL = '4' ELSE IF Observation Value CONTAINS ValueSet (Birth Place Home Unknown Intention (NCHS)) THEN BPLACE SHALL = '5' ELSE IF Observation Value CONTAINS ValueSet (Birthplace Clinic Office (NCHS)) THEN BPLACE SHALL = '6' ELSE BPLACE SHALL = '7'	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/value	Birthplace Hospital (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192 Birth Place Home Intended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193 Birth Place Home Unintended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194 Birth Place Home Unknown Intention (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195 Birthplace Clinic Office (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197 Birth Place Freestanding Birthing Center (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PLUR	Y	Y	Plurality	The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy. ("Reabsorbed" fetuses, those which are not "delivered" (expulsed or extracted from the mother) should not be counted.)	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Birth Plurality of Delivery (NCHS)), THEN "PLUR" SHALL = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Birth Plurality of Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOFP_MO	Y	Y	Prenatal care visits: Date of first prenatal care visit: Month	The month a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (First Prenatal Care Visit (NCHS)) THEN (IF Observation Value NOT NULL THEN "~~DOLP~~DOFP_MO" SHALL = the Month part of Observation Value WHERE the Month is represented using 2-digits ELSE ~~DOLP~~DOFP_MO" SHALL = '88') ELSE "~~DOLP~~DOFP_MO" SHALL = '99'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOFP_DY	Y	Y	Date of first prenatal care visit: Day	The day a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation CONTAINS ValueSet (First Prenatal Care Visit (NCHS)) THEN (IF Observation Value NOT NULL THEN "DOFP_DY" SHALL CONTAINS the Day part of Observation Value WHERE the Day is represented using 2-digits ELSE DOFP_DY" SHALL = '88') ELSE "DOFP_DY" SHALL = '99'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOFP_YR	Y	Y	Date of first prenatal care visit: Year	The year a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation CONTAINS ValueSet (First Prenatal Care Visit (NCHS)), THEN (IF Observation Value NOT NULL THEN “DOFP_YR” SHALL = the Year part of Observation Value WHERE the Year is represented using 4-digits ELSE DOFP_YR” SHALL = ‘8888’) ELSE “DOFP_YR” SHALL = ‘9999’	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOLP_MO	Y	Y	Prenatal care visits: Date of last prenatal care visit: Month	The month of the last prenatal care visit recorded in the records.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Last Prenatal Care Visit (NCHS)), THEN (IF Result Value NOT NULL THEN "DOLP_MO" SHALL = the Month part of Observation Value WHERE Result Value is expressed as Date AND WHERE the Month is represented using 2-digits for the MAX Observation Value ELSE DOLP_MO" SHALL = '88') ELSE "DOLP_MO" SHALL = '99'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Last Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOLP_DY	Y	Y	Prenatal care visits: Date of last prenatal care visit: Day	The day of the last prenatal care visit recorded in the records.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Last Prenatal Care Visit (NCHS)), THEN (IF Result Value NOT NULL THEN "DOLP_DY" SHALL = the Day part of Observation Value WHERE Result Value is expressed as Date AND WHERE the Day is represented using 2-digits for the MAX Observation Value ELSE DOLP_DY" SHALL = '88') ELSE "DOLP_DY" SHALL = '99' .	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Last Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DOLP_YR	Y	Y	Prenatal care visits: Date of last prenatal care visit: Year	The year of the last prenatal care visit recorded in the records.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Last Prenatal Care Visit (NCHS)), THEN (IF Result Value NOT NULL THEN "DOLP_DY" SHALL = the Year part of Observation Value WHERE Result Value is expressed as Date AND WHERE the Year is represented using 4-digits for the MAX Observation Value ELSE DOLP_YR" SHALL = '8888') ELSE "DOLP_YR" SHALL = '9999' .	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Last Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value (Timestamp) ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NPREV	Y	Y	Prenatal care visits: Total number of prenatal visits for this pregnancy	The total number of visits recorded in the record.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Number Prenatal Care Visits (NCHS)), THEN "NPREV" **SHALL** = Observation Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Number Prenatal Care Visits (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PAY	Y	N	Principal source of payment for this delivery	The principal source of payment at the time of delivery: Includes: Private insurance (Blue Cross/Blue Shield, Aetna, etc.); Medicaid (or a comparable State program); Self-pay (no third party identified); Other (Indian Health Service, CHAMPUS/ TRICARE, other government [Federal, State, local]); Unknown	NOTE: The US-Specific codes associated with this value set are not yet mapped to the form data from HITSP selected ANSI X12 Values. Until such time as these codes are mapped, this attribute will require implementation-specific mapping.	Payers 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7 Coverage Entry 1.3.6.1.4.1.19376.1.5.3.1.4.17	
PDIAB	Y	Y	Risk factors in this pregnancy: Prepregnancy Diabetes	Prepregnancy Diabetes (diagnosis of glucose intolerance requiring treatment before this pregnancy).	IF History of Past Illness Problem Code CONTAINS ValueSet (Prepregnancy Diabetes (NCHS)), THEN “PDIAB” **SHALL** = ‘Y’ ELSE IF Problem Code = ‘NULL’ THEN “PDIAB” SHALL = ‘U” ELSE “PDIAB” SHALL = ‘N’	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Prepregnancy Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GDIAB	Y	Y	Risk factors in this pregnancy: Gestational Diabetes	Gestational Diabetes (diagnosis of glucose intolerance requiring treatment during this pregnancy).	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Gestational Diabetes (NCHS)), THEN "GDIAB" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "GDIAB" SHALL = 'U" ELSE "GDIAB" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Gestational Diabetes (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.137
PHYPE	Y	Y	Risk factors in this pregnancy: Prepregnancy Hypertension	Prepregnancy (Chronic) Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis prior to the onset of this pregnancy. Does not include gestational (pregnancy induced) hypertension (PIH).)	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Prepregnancy Hypertension (NCHS)) AND NOT Problem Code CONTAINS (Gestational Hypertension (NCHS)) THEN "PHYPE" SHALL = 'Y' ELSE IF Problem Code = 'NULL' THEN "PHYPE" SHALL = 'U" ELSE "PHYPE" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Prepregnancy Hypertension (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.138 Gestational Hypertension (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.139

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GHYPE	Y	Y	Risk factors in this pregnancy: Gestational Hypertension	Gestational Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis in this pregnancy (pregnancy-induced hypertension or preeclampsia).	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Gestational Hypertension (NCHS))AND NOT Problem Code CONTAINS (Prepregnancy Hypertension (NCHS)) THEN "GHYPE" SHALL = 'Y' ELSE IF Problem Code = 'NULL' THEN "GHYPE" SHALL = 'U" ELSE "GHYPE" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Gestational Hypertension (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.139 Prepregnancy Hypertension (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.138
EHYPE	Y	Y	Risk factors in this pregnancy: Eclampsia	Eclampsia Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with proteinuria with generalized seizures or coma. May include pathologic edema.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Eclampsia (NCHS)), THEN "EHYPE" SHALL = 'Y' ELSE IF Problem Code = 'NULL' THEN "EHYPE" SHALL = 'U" ELSE "EHYPE" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Eclampsia (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.140

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PPB	Y	Y	Risk factors in this pregnancy: Previous preterm births	History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet(Preterm Birth (NCHS)) OR (Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Number of Preterm Births (NCHS)) AND Pregnancy History Observation Value >0) THEN “PPB” **SHALL** = ‘Y’ ELSE IF Problem Code = ‘NULL’ THEN “PPB” SHALL = ‘U” ELSE “PPB” SHALL = ‘N’	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Preterm Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141 Number of Preterm Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PPO	Y	Y	Risk factors in this pregnancy: Poor pregnancy outcomes	History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: Perinatal death (including fetal and neonatal deaths); Small for gestational age; Intrauterine-growth-restricted birth.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Poor Pregnancy Outcome History (NCHS))THEN "PPO" **SHALL** = 'Y' ELSE IF 7.04 Problem Code = 'NULL' THEN "PPO" SHALL = 'U" ELSE "PPO" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Poor Pregnancy Outcome History (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142
INFT	Y	Y	Risk factors in this pregnancy: Infertility treatment	Any assisted reproductive treatment used to initiate the pregnancy. Includes: Drugs (such as Clomid, Pergonal); Artificial insemination; Technical procedures (such as in-vitro fertilization).	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Infertility Treatment (NCHS))THEN "INFT" **SHALL** = 'Y' ELSE IF Procedure Code = 'NULL' THEN "INFT" SHALL = 'U" ELSE "INFT" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Infertility Treatment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
INFT_DRG	Y	Y	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Fertility-enhancing drugs, artificial insemination or intrauterine insemination Any fertility enhancing drugs (e.g., Clomid, Pergonal), artificial insemination or intrauterine insemination used to initiate the pregnancy.	IF Labor and Delivery Summary Admission Medication History Medications AdministeredSection Coded Product Name CONTAINS ValueSet (Fertility Enhancing Drugs Medications (NCHS))THEN "INFT_DRG" **SHALL** = 'Y' ELSE IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS (Artificial or Intrauterine Insemination (NCHS)) THEN "INFT_DRG" SHALL = 'Y' ELSE (IF (Coded Product Name = 'NULL') AND (Procedure Code = 'NULL') THEN "INFT_DRG" SHALL = 'U") ELSE "INFT_DRG" SHALL = 'N'	Labor and Delivery Summary Admission Medication History 1.3.6.1.4.1.19376.1.5.3.1.3.20 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code	Fertility Enhancing Drugs Medications (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Artificial or Intrauterine Insemination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
INFT_ART	Y	Y	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer GIFT)) Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Assistive Reproductive Technology (NCHS))THEN "INFT_ART" **SHALL** = 'Y' ELSE IF Procedure Code = 'NULL' THEN "INFT_ART" SHALL = 'U" ELSE "INFT_ART" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 Observation Code ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Assistive Reproductive Technology (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146
PCES	Y	Y	Risk factors in this pregnancy: Previous cesarean	Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Previous Cesarean (NCHS))THEN "PCES" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PCES" SHALL = 'U" ELSE "PCES" SHALL = 'N'	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Observation Code 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Previous Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NPCES	Y	Y	Risk factors in this pregnancy: Number of previous cesareans	Number of previous deliveries extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	IF Labor and Delivery Summary Pregnancy History Observation Code CONTAINS ValueSet (Number of Previous Cesareans (NCHS)), THEN "NPCES" **SHALL** = Result Value	Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Observation Code 1.3.6.1.4.1.19376.1.5.3.1.4.13.5 ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/code	Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148
						Labor and Delivery Summary Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Observation Value ClinicalDocument/recordTarget[0]/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.4.13.5]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NOA01	Y	Y	Risk factors in this pregnancy: None of the above	The patient had none of the listed risk factors in this pregnancy.	This attribute SHALL NOT be determined by default. If there are no other risk factors identified through other attributes, the form manager SHALL require data entry to assure the accuracy of the data.		
SORD	Y	Y	Set Order	Order this infant was delivered in the set.	If Labor and Delivery Summary Labor and Delivery Coded Event Outcome Multiple Birth =’Y’ THEN “SORD” **SHALL** be populated using Birth Order AND using ‘99’ where not known ELSE IF Multiple Birth =’N’ “SORD” **SHALL** = ‘88’	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Multiple Birth Indication Coded Event Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	
FSEX	Y	N	Child: (infant) Sex -	The sex of the infant.	IF Labor and Delivery recordTarget/patientRole/patient/administrativeGenderCode CONTAINS ValueSet(Male Gender (NCHS)) THEN “FSEX”	Labor and Delivery Summary recordTarget/patientRole/patient/administrativeGenderCode	Male Gender (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					SHALL ='M' ELSE IF Labor and Delivery recordTarget/patientRole/patient/administrativeGenderCode CONTAINS ValueSet(Female Gender (NCHS)) THEN "FSEX" SHALL ='F' ELSE THEN "FSEX" SHALL ='N'		Female Gender (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
FDOD_YR	N	Y		Date of Delivery (Fetus) Year	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Delivery (NCHS)) THEN "FDOD_YR" **SHALL** = Year part of Procedure Date/Time	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FDOD_MO	N	Y		Date of Delivery (Fetus) Month	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Delivery (NCHS)) THEN “FDOD_MO” **SHALL** = Month part of Procedure Date/Time	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
FDOD_DY	N	Y		Date of Delivery (Fetus) Day	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Delivery (NCHS)) THEN “FDOD_DYYR” **SHALL** = Day part of Procedure Date/Time	Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ETIME	N	Y	Estimated Time of Fetal Death	Item to indicate when the fetus died with respect to labor and assessment.	IF Newborn Delivery Information Coded Event Outcomes Observation Code CONTAINS ValueSet (Time of Death (NCHS)), THEN "ETIME" **SHALL** = Observation Value WHERE Result Value contains ValueSet (Fetal Death Time Point (NCHS) - 2.16.840.1.114222.4.11.7112)	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Time of Death (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.185

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/*relatedSubject*/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/value	Fetal Death Time Point (NCHS) - 2.16.840.1.114222.4.11.7112

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
LIVEB	Y	N	Not single birth - specify number of infants in this delivery born alive.	Specify the number of infants in this delivery born alive	IF Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Observation Code CONTAINS ValueSet (Number of Live Births (NCHS)), THEN **SHALL** = Observation Value	Labor and Delivery Summary (Mother's) Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Number of Live Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
						Labor and Delivery Summary (Mother's) Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FDTH	N	Y	Number of fetal deaths	Specify the number of fetal deaths in this delivery	IF Labor and Delivery Summary Newborn Delivery Information Coded Event Outcomes Observation CONTAINS ValueSet (Number of Fetal Deaths This Delivery (NCHS)), THEN **SHALL** = Observation Value	Labor and Delivery Summary (Mother's) Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/code	Number of Fetal Deaths This Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164
						Labor and Delivery Summary (Mother's) Coded Event Outcomes 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Observation Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.7.3.1.1.13.7]]/entry/act/entryRelationship/observation/value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HYST	N	Y	Method of Delivery: Hysterotomy/Hysterectomy?	Hysterotomy/Hysterectomy was the physical process by which the complete delivery of the fetus was affected. Hysterotomy: Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy: Surgical removal of the uterus. May be performed abdominally or vaginally.	IF Labor and Delivery Procedures and Interventions Procedure ID CONTAINS ValueSet (Hysterotomy Hysterectomy (NCHS)), THEN "HYST" **SHALL** = Result Value	Labor and Delivery Summary (Mother's) Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Hysterotomy Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150
TD	N	Y	Time of delivery	Hour and minute fetus was delivered.	IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet (Delivery (NCHS)), THEN "TD" **SHALL** = Result Value (TS)	Labor and Delivery Summary (Mother's) Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AUTOP	N	Y	Was an autopsy performed?	Information on whether or not an autopsy was performed	IF (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure Code CONTAINS ValueSet CONTAINS ValueSet (Fetal Autopsy (NCHS)) THEN "AUTOP" SHALL = "Y" ELSE "N".	Labor and Delivery Summary (Mother's) Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure Code 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Fetal Autopsy (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.153
FWO	N	Y	Weight of Fetus (in ounces)	Fetus' weight in ounces.	The preferred measure is in grams rather than ounces. Refer to FWG		
FWG	N	Y	Weight of Fetus (grams preferred, specify unit)	Fetus' weight in grams.	IF Newborn Delivery Information Coded Detailed Physical Examination Coded Vital Signs Result Type = 3141-9 where Result methodCode CONTAINS ValueSet (Birth Weight (NCHS)) THEN "FWG" **SHALL** = Result Value WHERE units are specified in Grams	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result methodCode 1.3.6.1.4.1.19376.1.5.3.1.3.28	Birth Weight (NCHS) 1.3.6.1.4.1.193 76.1.7.3.1.1.13.8.20

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FWP	N	Y	Weight of Fetus (in pounds)	Fetus' weight in pounds.	The preferred measure is in grams rather than ounces. Refer to FWG	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2 Result type, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/code	Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result type, Result methodCode ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/methodCode	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Detailed Physical Examination 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2Result Value ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2]]/entry/act/entryRelationship/observation/value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
LM	N N	Y	Infections present and treated during this pregnancy: Listeria	Listeria: A diagnosis of or positive test for Listeria monocytogenes. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Listeria (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet Listeria (NCHS))) THEN THEN “LM” SHALL = “Y” ELSE “N”.	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GBS		Y	Infections present and treated during this pregnancy: Group B Streptococcus	Group B Streptococcus: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Group B Streptococcus (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Group B Streptococcus (NCHS))) THEN THEN "GBS" SHALL = "Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
CMV	N	Y	Infections present and treated during this pregnancy: Cytomeglovirus	Cytomegalovirus (CMV): A diagnosis of or positive test for Cytomegalovirus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Cytomegalovirus (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Cytomegalovirus (NCHS))) THEN THEN "CMV" SHALL = "Y" ELSE "N".	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
B19	N	Y	Infections present and treated during this pregnancy: Parvovirus	Parvovirus: A diagnosis of or positive test for Parvovirus B19. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Parvovirus (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Parvovirus (NCHS))) THEN THEN “B19” SHALL = “Y” ELSE “N”.	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation	Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
HISTOP	N	Y	Was a Histological Placental Examination performed?	Information on whether or not a histological placental examination was performed	IF (Labor and Delivery Summary Newborn Delivery Information Procedures and Interventions Procedure ID CONTAINS ValueSet (Histological Placental Examination (NCHS))) OR (Labor and Delivery Summary Labor and Delivery Procedures and Interventions Procedure ID CONTAINS ValueSet (Histological Placental Examination (NCHS))) THEN THEN “HISTOP” SHALL = “Y” ELSE “N”.	Labor and Delivery Summary Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19 ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138
						Labor and Delivery Summary Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code	Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
TOXO	N	Y	Infections present and treated during this pregnancy: Toxoplasmosis	Toxoplasmosis: A diagnosis of or positive test for Toxoplasma gondii.	IF (Labor and Delivery Summary Active Problems Problem Code CONTAINS ValueSet (Toxoplasmosis (NCHS))) OR (Labor and Delivery Summary Coded History of Infection Problem Concern Observation CONTAINS ValueSet (Toxoplasmosis (NCHS))) THEN THEN “TOXO” SHALL = “Y” ELSE “N”.	Labor and Delivery Summary Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6 ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
						Labor and Delivery Summary Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Problem Concern 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 Observation ClinicalDocument/recordTarget/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code	Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

4.I.2.1.2 Form Data Element Mappings to Output Content Document

This section identifies the mapping of the data elements defined for this form and the specified template for the output CDA Document.

Table 4.I.2.1.2-1: Form Data Elements Data Mapped to Output Content Document Modules for Birth

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn [Observation: templateId 2.16.840.1.113883.10.20.26.13]	IF ANTI = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName=' Abnormal conditions of the Newborn' AND /value@code= Code='434621000124103', CodsSystemName='SNOMED CT', DisplayName=' Antibiotics Received for Suspected Neonatal Sepsis'
AVEN1	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF AVEN1 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='PHC1250', CodeSystemName= 'PHIN VS (CDC Local Coding System)', DisplayName=' Assisted ventilation required immediately following Delivery'
AVEN6	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF AVEN6 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='PHC1251', CodeSystemName= 'PHIN VS (CDC Local Coding System)', DisplayName='Assisted ventilation required for more than six hours'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BINJ	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF BINJ = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code=' 56110009', CodeSystemName= 'SNOMED CT', DisplayName='Birth trauma of fetus'
NICU	Abnormal conditions of the newborn: Admission to NICU	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF NICU = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='405269005', CodeSystemName= 'SNOMED CT', DisplayName=' Neonatal intensive care unit'
SEIZ	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF SEIZ = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code=' 91175000', CodeSystemName= 'SNOMED CT', DisplayName='Seizure'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
SURF	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF SURF = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='43470100012410', CodeSystemName= 'SNOMED CT', DisplayName=' Surfactant replacement therapy'
NOA54	Abnormal conditions of the newborn: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF NOA54 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='260413007', CodeSystemName= 'SNOMED CT', DisplayName='None'
DNA54	Abnormal conditions of the newborn: Pending	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF DNA54 = 'Y' then NULL

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
APGAR5	Apgar Score: 5 Minute	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.11]	Vital Signs Observation [Observation: templateId 2.16.840.1.113883.10.20.22.4.27]	/code@code= Code=' 9274-2', CodeSystemName= 'LOINC', DisplayName=' Score^5M post birth' AND /value@value= APGAR5
APGAR10	Apgar Score: 10 Minute	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.11]	Vital Signs Observation [Observation: templateId 2.16.840.1.113883.10.20.22.4.27]	/code@code= Code='9271-8', CodeSystemName= 'LOINC', DisplayName=' Score^10M post birth' AND /value@value= APGAR10
ATTENDN	Attendant's name	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/name = ATTENDN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ATTEND	Attendant's title:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/code = ATTEND
ATTENDS	Attendant: Other specified	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/name = ATTENDS
NPI	Attendant's NPI	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/id = NPI

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BWG	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Newborn's Vital Signs Observation [templateId: 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWG(PQ) /value/@unit= 'gm'
BWO	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWO(PQ) /value/@unit= 'oz' NOTE: Preferred measure of weight is in Grams.

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BWP	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWP(PQ) /value/@unit= 'lb' NOTE: Preferred measure of weight is in Grams.
ANTB	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF ANTB = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code=' 634771000124114', CodeSystemName= 'SNOMED CT', DisplayName='Antibiotics received during labor'
AUGL	Characteristics of labor and delivery: Augmentation of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF AUGL = 'Y' then) /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='237001001', CodeSystemName= 'SNOMED CT', DisplayName= 'Augmentation of labor'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF CHOR = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='11612004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chorioamnionitis'
ESAN	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF ESAN = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code=' 231064003', CodeSystemName= 'SNOMED CT', DisplayName= 'Intrathecal injection of local anesthetic agent'
FINT	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF FINT = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='130955003', CodeSystemName= 'SNOMED CT', DisplayName= 'Fetal distress'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
INDL	Characteristics of labor and delivery: Induction of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF INDL = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code=' 236958009', CodeSystemName= 'SNOMED CT', DisplayName= 'Induction of labor'
MECS	Characteristics of labor and delivery: Meconium staining	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF MECS = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='249135009', CodeSystemName= 'SNOMED CT', DisplayName= 'Meconium stained liquor'
STER	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF STER = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='634621000124113', CodeSystemName= 'SNOMED CT', DisplayName= 'Steroids (glucocorticoids) for fetal lung maturation (procedure)'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NOA04	Characteristics of labor and delivery: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF NOA04 = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code=' 260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
DNA04	Characteristics of labor and delivery: Pending	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	NULL
IDOB_YR	Child: Date of Birth: Year	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/birthtime contains IDOB_YR/IDOB_MO/IDOB_DY

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
IDOB_MO	Child: Date of Birth: Month	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/birthtime contains IDOB_YR/IDOB_MO/IDOB_DY
IDOB_DY	Child: Date of Birth: Day	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/birthtime contain IDOB_YR/IDOB_MO/IDOB_DY
KIDFNAME	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name contains KIDFNAME
KIDMNAME	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name contains KIDMNAME

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
KIDLNAME	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name contains KIDLNAME
KIDSUFFX	Child's Last Name Suffix:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name contains KIDSUFFX
BFED	Child: Infant being breastfed?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Infant Breastfed (templateId: 2.16.840.1.113883.10.20.26.27)	/code@code= Code='3756-9', CodeSystemName= 'LOINC', DisplayName=' Infant is being breastfed at discharge' AND /value@value= Boolean form of BFED
ILIV	Child: Infant living at time of report?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Infant Living (templateId: 2.16.840.1.113883.10.20.26.28)	/code@code= Code='73757-7', CodeSystemName= 'LOINC', DisplayName='Infant living at time of report' AND /value@value= Boolean form of ILIV

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
IRECNUM	Child: Newborn Medical Record Number	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/sDTCId = IRECNUM
ISEX	Child: (infant) Sex -	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/administrativeGenderCode = ISEX
ITRAN	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	infant Transfer (templateId: 2.16.840.1.113883.10.20.26.29)	/code@code= Code='73758-5', CodeSystemName= 'LOINC', DisplayName= 'Infant was transferred within 24 hours of delivery' AND /value@value= Boolean form of ITRAN
FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	infant Transfer (templateId: 2.16.840.1.113883.10.20.26.29)	/participant/participantRole/name = FTRAN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
TB	Child: Time of Birth	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/birthTime = TB
ANEN	Congenital anomalies of the Newborn: Anencephaly	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF ANEN = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code=’ 89369001’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Anencephalus’
CCHD	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CCHD = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code=’12770006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Cyanotic congenital heart disease’
CDH	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDH = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code=’17190001’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Congenital diaphragmatic hernia’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
CDIC	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'
CDIS	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIS = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
'CDIP	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code='312948004', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype determination'
CL	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CL = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '80281008', CodeSystemName= 'SNOMED CT', DisplayName= 'Cleft lip'
CP	Congenital anomalies of the Newborn: Cleft Palate alone	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '87979003', CodeSystemName= 'SNOMED CT', DisplayName= 'Cleft palate'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DOWC	Congenital anomalies of the Newborn: Down Karyotype Confirmed	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'
DOWN	Congenital anomalies of the Newborn: Down Syndrome	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWN = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DOWP	Congenital anomalies of the Newborn: Down Karyotype Pending	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code='312948004', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype determination'
GAST	Congenital anomalies of the Newborn: Gastroschisis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF GAST = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '72951007', CodeSystemName= 'SNOMED CT', DisplayName= 'Gastroschisis'
HYPO	Congenital anomalies of the Newborn: Hypospadias	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF HYPO = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '416010008', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypospadias'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
LIMB	Congenital anomalies of the Newborn: Limb reduction defect	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF LIMB = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '67341007', CodeSystemName= 'SNOMED CT', DisplayName= 'Longitudinal deficiency of limb'
MNSB	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF MNSB = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '67341007', CodeSystemName= 'SNOMED CT', DisplayName= 'Longitudinal deficiency of limb'
OMPH	Congenital anomalies of the Newborn: Omphalocele	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF OMPH = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '18735004', CodeSystemName= 'SNOMED CT', DisplayName= 'Congenital omphalocele'
NOA55	Congenital anomalies of the Newborn: None of the anomalies listed above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF NOA55= 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DNA55	Congenital anomalies of the Newborn: Pending	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	NULL
YLLB	Date of last live birth:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= YLLB
MLLB	Date of last live birth:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= MLLB
DLMP_DY	Date last Normal Menses began:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_DY

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DLMP_MO	Date last Normal Menses began:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_MO
DLMP_YR	Date last Normal Menses began:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_YR
YOPO	Date of Last Other Pregnancy Outcome: Year	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains YOPO
MOPO	Date of Last Other Pregnancy Outcome: Month	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains MOPO

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ADDRESS_D	Facility Address	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr = ADDRESS_D
FNAME	Facility Name (if Not institution, give street and number)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/playingEntity/name = FNAME
FNPI	Facility National Provider Identifier	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = FNPI

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
CHAM	Infections present and treated during this pregnancy: Chlamydia	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present - Live Birth (templateId: 2.16.840.1.113883.10.20.26.30)	IF CHAM = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '105629000', CodeSystemName= 'SNOMED CT', DisplayName= 'Chlamydia infection'
GON	Infections present and treated during this pregnancy: Gonorrhea	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF GON = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '1562800', CodeSystemName= 'SNOMED CT', DisplayName= 'Gonorrhea'
HEPB	Infections present and treated during this pregnancy: Hepatitis B	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPB = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '66071002', CodeSystemName= 'SNOMED CT', DisplayName= 'Type B viral hepatitis'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
HEPC	Infections present and treated during this pregnancy: Hepatitis C	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPC = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '50711007', CodeSystemName= 'SNOMED CT', DisplayName= 'Viral hepatitis C'
SYPH	Infections present and treated during this pregnancy: Syphilis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF SYPH = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '76272004', CodeSystemName= 'SNOMED CT', DisplayName= 'Syphilis'
NOA02	Infections present and treated during this pregnancy: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF NOA02 = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
AINT	Maternal Morbidity: - Admission to Intensive care [unit]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF AINT = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '309904001', CodeSystemName= 'SNOMED CT', DisplayName= 'Intensive care unit'
MTR	Maternal Morbidity: Maternal Transfusion	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF MTR = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '116859006', CodeSystemName= 'SNOMED CT', DisplayName= 'Maternal Transfusion'
PLAC	Maternal Morbidity: [Third or fourth degree] perineal laceration	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF PLAC = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '398019008', CodeSystemName= 'SNOMED CT', DisplayName= 'Perineal laceration during delivery'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
RUT	Maternal Morbidity: Ruptured Uterus	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF RUT = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '34430009', CodeSystemName= 'SNOMED CT', DisplayName= 'Rupture of uterus'
UHYS	Maternal Morbidity: Unplanned hysterectomy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UHYS = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '625654015', CodeSystemName= 'SNOMED CT', DisplayName= 'Emergency cesarean hysterectomy'
UOPR	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UOPR = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '177217006', CodeSystemName= 'SNOMED CT', DisplayName= 'Immediate repair of obstetric laceration'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NOA05	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF NOA05 = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PRES	Method of Delivery: Fetal presentation [at birth]: Cephalic	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF PRES = '1' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘6096002’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Breech presentation’ ELSE IF PRES = '2' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘70028003’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Vertex Presentation’ ELSE IF PRES = '3' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘394841004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Other category’ ELSE IF PRES = '9' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘261665006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Unknowncategory’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ROUT	Method of Delivery: [Final]Route and method of delivery	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF ROUT = '1' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘48782003’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Delivery normal’ ELSE IF ROUT = '2' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘302383004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Forceps delivery’ ELSE IF ROUT = '3' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘61586001’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Delivery by vacuum extraction’ ELSE IF ROUT = '4' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘11466000’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Cesarean section’ ELSE IF ROUT = '9' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘261665006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Unknown category’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
TLAB	Method of Delivery: Trial of labor attempted	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF TLAB = 'Y' then /code@code= Code= '72149-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery method' AND entryRelationship /code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND /entryRelationship/value@code= Code= '11466000, CodeSystemName= 'SNOMED CT', DisplayName= 'Cesarean section' AND /entryRelationship/entryRelationship/code@code= Code= '73760-1', CodeSystemName= 'LOINC', DisplayName= 'If cesarean, a trial of labor was attempted' AND /entryRelationship /entryRelationship/value@code= Boolean form of TLAB
MFNAME	Mother's Current Legal Name: First Name	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]		/recordtarget/patientRole/patient/name contains MFNAME
MMNAME	Mother's Current Legal Name: Middle Name	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]		/recordtarget/patientRole/patient/name contains MMNAME

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
MLNAME	Mother's Current Legal Name: Last Name	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]		/recordtarget/patientRole/patient/name contains MLNAME
MSUFF	Mother's Current Legal Name: suffix	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]		/recordtarget/patientRole/patient/name contains MSUFF
HFT	Mother's Height: Feet	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Mother's Vital Signs Observation (templateId: 2.16.840.1.113883.10.20.26.46)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HFT(PQ) /value/@unit= 'ft'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
HIN	Mother's Height: Inches	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Mother's Vital Signs Observation (templateId: 2.16.840.1.113883.10.20.26.46)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HIN(PQ) /value/@unit= 'in'
MRECNUM	Mother's medical record number	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]		recordTarget/patientRole/id = MRECNUM
PWGT	Mother's pre-pregnancy weight	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Mother's Vital Signs Observation (templateId: 2.16.840.1.113883.10.20.26.46)	/code@code= Code='56077-1', CodeSystemName= 'LOINC', DisplayName= 'Body weight -- pre current pregnancy' AND /value@value= PWGT(PQ) /value/@unit= 'lb'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31)	Maternal Transfer [Observation: templateId 2.16.840.1.113883.10.20.26.35]	/participant/participantRole/scopingEntity/name = NFACL
TRAN	Mother transferred for maternal medical or fetal indications for delivery?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31)	Maternal Transfer [Observation: templateId 2.16.840.1.113883.10.20.26.35]	/code@code= Code=’73763-5’, CodeSystemName= ‘LOINC’, DisplayName=’ Mother was transferred for maternal medical or fetal indications for delivery’ AND /value@value= Boolean form of TRAN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DWGT	Mother's weight at delivery	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Mother's Vital Signs Observation (templateId: 2.16.840.1.113883.10.20.26.46)	/code@code= Code='69461-2', CodeSystemName= 'LOINC', DisplayName= 'Body weight mother -- at delivery' AND /value@value= DWGT(PQ) /value/@unit= 'lb'
POPO	Number of other pregnancy outcomes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName= 'Other pregnancy outcomes' AND /value@value= POPO(int)
PLBD	Number of previous live births now dead (do not include this child)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Live Births now Dead (templateId: 2.16.840.1.113883.10.20.26.38)	/code@code= Code='68496-9', CodeSystemName= 'LOINC', DisplayName= 'Live births now dead' AND /value@value= PLBD(int)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PLBL	Number of previous live births now living (do not include this child)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Births Now Living (templateId: 2.16.840.1.113883.10.20.26.36)	/code@code= Code='11638-4', CodeSystemName= 'LOINC', DisplayName= 'Births still living' AND /value@value= PLBL(int)
OWGEST	Obstetric Estimate of Gestation	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Estimate of Gestation (templateId: 2.16.840.1.113883.10.20.26.21)	/code@code= Code='11884-4', CodeSystemName= 'LOINC', DisplayName= 'Gestational age Estimated' AND /value@value= OWGEST(int)
CERV	Obstetric procedures: Cervical cerclage	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF CERV = 'Y' then /code@code= Code= '265636007', CodeSystemName= 'SNOMED CT', DisplayName= 'Cerclage of cervix' /@negationInd = false

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ECVF	Obstetric procedures: Failed External cephalic Version	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	PENDING
ECVS	Obstetric procedures: Successful External cephalic version	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF ECVS = 'Y' then /code@code= Code= ‘240278000’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘External Cephalic Version’ /@negationInd = false

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
TOC	Obstetric procedures: Tocolysis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF TOC = 'Y' then /code@code= Code= '103747003', CodeSystemName= 'SNOMED CT', DisplayName= 'Tocolysis' /@negationInd = false
NOA03	Obstetric procedures: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF NOA03 = 'Y' then /code@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None' /@negationInd = false
PROM	Onset of labor: Premature Rupture	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PROM = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '44223004', CodeSystemName= 'SNOMED CT', DisplayName= 'Premature rupture of membranes'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PRIC	Onset of labor: Precipitous Labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PRIC = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '51920004', CodeSystemName= 'SNOMED CT', DisplayName= 'Precipitate labor'
PROL	Onset of labor: Prolonged Labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PROL = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '53443007', CodeSystemName= 'SNOMED CT', DisplayName= Prolonged labor'
NOA05	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF NOA05 = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
SFN	Place where birth occurred: State Facility Number	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = SFN
FLOC	Place where birth occurred: Facility City/Town	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains FLOC
CNAME	Place where birth occurred: County Name	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNAME

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
CNTYO	Place where birth occurred: County Code	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNTYO

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BPLACE	Place where birth occurred: Birth Place	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	IF BPLACE = '1' then /participant/participantRole/code@code = Code= ‘22232009’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Hospital’ ELSE IF BPLACE = '2' then /participant/participantRole/code@code = Code= ‘91154008’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Free-standing birthing center’ ELSE IF BPLACE = '3' then (/participant/participantRole/code@code = Code= ‘169813005’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Home birth’ AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= ‘73765-0’, CodeSystemName= ‘LOINC’, DisplayName= ‘Home birth’ /value@code = '1') ELSE IF BPLACE = ‘4’ then (/participant/participantRole/code@code = Code= ‘169813005’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Home birth’ AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= ‘73765-0’, CodeSystemName= ‘LOINC’, DisplayName= ‘Home birth’ /value@code = '0') ELSE IF BPLACE = ‘5’ then (/participant/participantRole/code@code = Code= ‘169813005’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Home birth’ AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= ‘73765-0’, CodeSystemName=

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PLUR	Plurality	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.10]	Plurality [Observation: templateId 2.16.840.1.113883.10.20.26.41]	/code@code= Code='57722-1', CodeSystemName= 'LOINC', DisplayName= 'Birth plurality' AND /value@value= PLUR(int)
DOFP_MO	Prenatal care visits: Date of first prenatal care visit: Month	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]
DOFP_DY	Date of first prenatal care visit: Day	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DOFP_YR	Date of first prenatal care visit: Year	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]
DOLP_MO	Prenatal care visits: Date of last prenatal care visit: Month	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]
DOLP_DY	Prenatal care visits: Date of last prenatal care visit: Day	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3] Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DOLP_YR	Prenatal care visits: Date of last prenatal care visit: Year	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]
NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/entryRelationship/observation/code@code= Code='68493-6', CodeSystemName= 'LOINC', DisplayName= 'Prenatal visits for this pregnancy' AND /value@value= NPREV(int)
PAY	Principal source of payment for this delivery	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	entryRelationship/observation/ code@code= Code= '68461-3', CodeSystemName= 'LOINC', DisplayName= 'Payment source' AND /value@code = PAY using Value Set 'Birth and Fetal Death Financial Class (NCHS) (2.16.840.1.114222.4.11.7163)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PDIAB	Risk factors in this pregnancy: Prepregnancy Diabetes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '73211009', CodeSystemName= 'SNOMED CT', DisplayName= 'Diabetes mellitus'
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '11687002', CodeSystemName= 'SNOMED CT', DisplayName= 'Gestational diabetes mellitus'
PHYPE	Risk factors in this pregnancy: Prepregnancy Hypertension	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '38341003', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypertensive disorder, systemic arterial'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
GHYPE	Risk factors in this pregnancy: Gestational Hypertension	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '48194001', CodeSystemName= 'SNOMED CT', DisplayName= 'Pregnancy-induced hypertension'
EHYPE	Risk factors in this pregnancy: Eclampsia	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF EHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '15938005', CodeSystemName= 'SNOMED CT', DisplayName= 'Eclampsia'
PPB	Risk factors in this pregnancy: Previous preterm births	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '161765003', CodeSystemName= 'SNOMED CT', DisplayName= 'History of - premature delivery'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PPO	Risk factors in this pregnancy: Poor pregnancy outcomes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPO = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '271903000', CodeSystemName= 'SNOMED CT', DisplayName= 'History of – pregnancy'
INFT	Risk factors in this pregnancy: Infertility treatment	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '65046005', CodeSystemName= 'SNOMED CT', DisplayName= 'Infertility Therapy'
INFT_DRG	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT_DRG = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '58533008', CodeSystemName= 'SNOMED CT', DisplayName= 'Artificial insemination'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
INFT_ART	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean'
PCES	Risk factors in this pregnancy: Previous cesarean	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NPCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean'
NPCES	Risk factors in this pregnancy: Number of previous cesareans	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean' /entryRelationship/observation/code@code= Code= '68497-7', CodeSystemName= 'LOINC', DisplayName= 'Previous cesarean deliveries' AND /value@value= NPCES(int)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NOA01	Risk factors in this pregnancy: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NOA01 = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
SORD	Set Order	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Birth Order (templateId: 2.16.840.1.113883.10.20.26.16)	/code@code= Code='73771-8', CodeSystemName= 'LOINC', DisplayName= 'Birth order' AND /value@value= SORD(int)
FSEX	Child: (infant) Sex -	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.6]		/subject/relatedSubject/subject/administrativeGender = FSEX
FDOD_YR		NA	NA	
FDOD_MO		NA	NA	

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
FDOD_DY		NA	NA	
ETIME	Estimated Time of Fetal Death	NA	NA	
LIVEB	Not single birth - specify number of infants in this delivery born alive.	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.10]	Number of Infants Born Alive (templateId: 2.16.840.1.113883.10.20.26.37)"	/code@code= Code='73773-4', CodeSystemName= 'LOINC', DisplayName= 'Number of infants in this delivery born alive' AND /value@value= LIVEB(int)
FDTH	Number of fetal deaths	NA	NA	
HYST	Method of Delivery: Hysterotomy/Hysterectomy?	NA	NA	
TD	Time of delivery	NA	NA	
AUTOP	Was an autopsy performed?	NA	NA	
FWO	Weight of Fetus (in ounces)	NA	NA	
FWG	Weight of Fetus (grams preferred, specify unit)	NA	NA	
FWP	Weight of Fetus (in pounds)	NA	NA	
LM	Infections present and treated during this pregnancy: Listeria	NA	NA	

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
GBS	Infections present and treated during this pregnancy: Group B Streptococcus	NA	NA	
CMV	Infections present and treated during this pregnancy: Cytomeglovirus	NA	NA	
B19	Infections present and treated during this pregnancy: Parvovirus	NA	NA	
HISTOP	Was a Histological Placental Examination performed?	NA	NA	
TOXO	Infections present and treated during this pregnancy: Toxoplasmosis	NA	NA	

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Table 4.I.2.1.2-2: Form Data Elements Data Mapped to Output Content Document Modules for Fetal Death

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	NA	NA	NA
AVEN1	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	NA	NA	NA
AVEN6	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	NA	NA	NA
BINJ	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	NA	NA	NA
NICU	Abnormal conditions of the newborn: Admission to NICU	NA	NA	NA
SEIZ	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
SURF	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	NA	NA	NA
NOA54	Abnormal conditions of the newborn: None of the above	NA	NA	NA
DNA54	Abnormal conditions of the newborn: Pending	NA	NA	NA
APGAR5	Apgar Score: 5 Minute	NA	NA	NA
APGAR10	Apgar Score: 10 Minute	NA	NA	NA
ATTENDN	Attendant's name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/name = ATTENDN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ATTEND	Attendant's title:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/code = ATTEND
ATTENDS	Attendant: Other specified	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/assignedPerson/name = ATTENDS
NPI	Attendant's NPI	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/performer/assignedEntity/id = NPI
BWG	Birth weight (Infant's)	NA	NA	NA
BWO	Birth weight (Infant's)	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
BWP	Birth weight (Infant's)	NA	NA	NA
ANTB	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	NA	NA	NA
AUGL	Characteristics of labor and delivery: Augmentation of labor	NA	NA	NA
CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	NA	NA	NA
ESAN	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FINT	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	NA	NA	NA
INDL	Characteristics of labor and delivery: Induction of labor	NA	NA	NA
MECS	Characteristics of labor and delivery: Meconium staining	NA	NA	NA
STER	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	NA	NA	NA
NOA04	Characteristics of labor and delivery: None of the above	NA	NA	NA
DNA04	Characteristics of labor and delivery: Pending	NA	NA	NA
IDOB_YR	Child: Date of Birth: Year	NA	NA	NA
IDOB_MO	Child: Date of Birth: Month	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
IDOB_DY	Child: Date of Birth: Day	NA	NA	NA
KIDFNAME	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name contains KIDFNAME
KIDMNAME	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name contains KIDMNAME
KIDLNAME	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name contains KIDLNAME
KIDSUFFX	Child's Last Name Suffix:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name contains KIDSUFFX

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
BFED	Child: Infant being breastfed?	NA	NA	NA
ILIV	Child: Infant living at time of report?	NA	NA	NA
IRECNUM	Child: Newborn Medical Record Number	NA	NA	NA
ISEX	Child: (infant) Sex -	NA	NA	NA
ITRAN	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	NA	NA	NA
FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility	NA	NA	NA
TB	Child: Time of Birth	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ANEN	Congenital anomalies of the Newborn: Anencephaly	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF ANEN = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code=' 89369001', CodeSystemName= 'SNOMED CT', DisplayName= 'Anencephalus'
CCHD	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CCHD = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='12770006', CodeSystemName= 'SNOMED CT', DisplayName= 'Cyanotic congenital heart disease'
CDH	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDH = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='17190001', CodeSystemName= 'SNOMED CT', DisplayName= 'Congenital diaphragmatic hernia'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CDIC	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'
CDIS	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIS = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
'CDIP	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code='312948004', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype determination'
CL	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CL = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '80281008', CodeSystemName= 'SNOMED CT', DisplayName= 'Cleft lip'
CP	Congenital anomalies of the Newborn: Cleft Palate alone	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '87979003', CodeSystemName= 'SNOMED CT', DisplayName= 'Cleft palate'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DOWC	Congenital anomalies of the Newborn: Down Karyotype Confirmed	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'
DOWN	Congenital anomalies of the Newborn: Down Syndrome	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWN = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DOWP	Congenital anomalies of the Newborn: Down Karyotype Pending	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code='312948004', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype determination'
GAST	Congenital anomalies of the Newborn: Gastroschisis	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF GAST = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '72951007', CodeSystemName= 'SNOMED CT', DisplayName= 'Gastroschisis'
HYPO	Congenital anomalies of the Newborn: Hypospadias	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF HYPO = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '416010008', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypospadias'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
LIMB	Congenital anomalies of the Newborn: Limb reduction defect	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF LIMB = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '67341007', CodeSystemName= 'SNOMED CT', DisplayName= 'Longitudinal deficiency of limb'
MNSB	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF MNSB = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '67341007', CodeSystemName= 'SNOMED CT', DisplayName= 'Longitudinal deficiency of limb'
OMPH	Congenital anomalies of the Newborn: Omphalocele	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF OMPH = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '18735004', CodeSystemName= 'SNOMED CT', DisplayName= 'Congenital omphalocele'
NOA55	Congenital anomalies of the Newborn: None of the anomalies listed above	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF NOA55= 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DNA55	Congenital anomalies of the Newborn: Pending			NULL
YLLB	Date of last live birth:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= YLLB
MLLB	Date of last live birth:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= MLLB
DLMP_DY	Date last Normal Menses began:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_DY
DLMP_MO	Date last Normal Menses began:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_MO

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DLMP_YR	Date last Normal Menses began:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_YR
YOPO	Date of Last Other Pregnancy Outcome: Year	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains YOPO
MOPO	Date of Last Other Pregnancy Outcome: Month	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains MOPO
ADDRESS_D	Facility Address	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr = ADDRESS_D

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FNAME	Facility Name (if Not institution, give street and number)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/playingEntity/name = FNAME
FNPI	Facility National Provider Identifier	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = FNPI
CHAM	Infections present and treated during this pregnancy: Chlamydia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF CHAM = 'Y' then /code@code= Code= ‘72519-2’, CodeSystemName= ‘LOINC’, DisplayName= ‘Infections present and or treated during this pregnancy for live birth’ AND /value@code= Code= ‘105629000’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Chlamydia infection’
GON	Infections present and treated during this pregnancy: Gonorrhea	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF GON = 'Y' then /code@code= Code= ‘72519-2’, CodeSystemName= ‘LOINC’, DisplayName= ‘Infections present and or treated during this pregnancy for live birth’ AND /value@code= Code= ‘1562800’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Gonorrhea’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
HEPB	Infections present and treated during this pregnancy: Hepatitis B	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPB = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '66071002', CodeSystemName= 'SNOMED CT', DisplayName= 'Type B viral hepatitis'
HEPC	Infections present and treated during this pregnancy: Hepatitis C	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPC = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '50711007', CodeSystemName= 'SNOMED CT', DisplayName= 'Viral hepatitis C'
SYPH	Infections present and treated during this pregnancy: Syphilis	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF SYPH = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '76272004', CodeSystemName= 'SNOMED CT', DisplayName= 'Syphilis'
NOA02	Infections present and treated during this pregnancy: None of the above	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF NOA02 = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
AINT	Maternal Morbidity: - Admission to Intensive care [unit]	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF AINT = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘309904001’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Intensive care unit’
MTR	Maternal Morbidity: Maternal Transfusion	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF MTR = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘116859006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Maternal Transfusion’
PLAC	Maternal Morbidity: [Third or fourth degree] perineal laceration	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF PLAC = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘398019008’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Perineal laceration during delivery’
RUT	Maternal Morbidity: Ruptured Uterus	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF RUT = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘34430009’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Rupture of uterus’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
UHYS	Maternal Morbidity: Unplanned hysterectomy	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UHYS = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘625654015’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Emergency cesarean hysterectomy’
UOPR	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UOPR = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘177217006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Immediate repair of obstetric laceration’
NOA05	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF NOA05 = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘260413007’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘None’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
PRES	Method of Delivery: Fetal presentation [at birth]: Cephalic	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF PRES = '1' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘6096002’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Breech presentation’ ELSE IF PRES = '2' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘70028003’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Vertex Presentation’ ELSE IF PRES = '3' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘394841004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Other category’ ELSE IF PRES = '9' then entryRelationship/code@code= Code= ‘73761-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Fetal presentation at birth’ AND entryRelationship/value@code= Code= ‘261665006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Unknowncategory’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ROUT	Method of Delivery: [Final]Route and method of delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF ROUT = '1' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘48782003’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Delivery normal’ ELSE IF ROUT = '2' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘302383004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Forceps delivery’ ELSE IF ROUT = '3' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘61586001’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Delivery by vacuum extraction’ ELSE IF ROUT = '4' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘11466000’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Cesarean section’ ELSE IF ROUT = '9' then entryRelationship/code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND entryRelationship/value@code= Code= ‘261665006’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Unknown category’

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
TLAB	Method of Delivery: Trial of labor attempted	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF TLAB = 'Y' then /code@code= Code= ‘72149-8’, CodeSystemName= ‘LOINC’, DisplayName= ‘Delivery method’ AND entryRelationship /code@code= Code= ‘73762-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Final route and method of delivery’ AND /entryRelationship/value@code= Code= ‘11466000, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Cesarean section’ AND /entryRelationship/entryRelationship/code@code= Code= ‘73760-1’, CodeSystemName= ‘LOINC’, DisplayName= ‘If cesarean, a trial of labor was attempted’ AND /entryRelationship /entryRelationship/value@code= Boolean form of TLAB
MFNAME	Mother's Current Legal Name: First Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name contains MFNAME
MMNAME	Mother's Current Legal Name: Middle Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name contains MMNAME

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
MLNAME	Mother's Current Legal Name: Last Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name contains MLNAME
MSUFF	Mother's Current Legal Name: suffix	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name contains MSUFF
HFT	Mother's Height: Feet	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Height (templateId: 2.16.840.1.113883.10.20.26.25)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HFT(PQ) /value/@unit= 'ft'
HIN	Mother's Height: Inches	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Height (templateId: 2.16.840.1.113883.10.20.26.25)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HIN(PQ) /value/@unit= 'in'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
MRECNUM	Mother's medical record number	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		recordTarget/patientRole/id = MRECNUM
PWGT	Mother's pre-pregnancy weight	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	Pre-pregnancy Body Weight [Observation: templateId 2.16.840.1.113883.10.20.26.43]	/code@code= Code='56077-1', CodeSystemName= 'LOINC', DisplayName= 'Body weight -- pre current pregnancy' AND /value@value= PWGT(PQ) /value/@unit= 'lb'
NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Transfer templateId: 2.16.840.1.113883.10.20.26.35)	/participant/participantRole/scopingEntity/name = NFACL
TRAN	Mother transferred for maternal medical or fetal indications for delivery?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Transfer templateId: 2.16.840.1.113883.10.20.26.35)	/code@code= Code='73763-5', CodeSystemName= 'LOINC', DisplayName=' Mother was transferred for maternal medical or fetal indications for delivery' AND /value@value= Boolean form of TRAN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DWGT	Mother's weight at delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Body Weight at Delivery (templateId: 2.16.840.1.113883.10.20.26.17)	/code@code= Code='69461-2', CodeSystemName= 'LOINC', DisplayName= 'Body weight mother -- at delivery' AND /value@value= DWGT(PQ) /value/@unit= 'lb'
POPO	Number of other pregnancy outcomes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName= 'Other pregnancy outcomes' AND /value@value= POPO(int)
PLBD	Number of previous live births now dead (do not include this child)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Live Births now Dead (templateId: 2.16.840.1.113883.10.20.26.38)	/code@code= Code='68496-9', CodeSystemName= 'LOINC', DisplayName= 'Live births now dead' AND /value@value= PLBD(int)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
PLBL	Number of previous live births now living (do not include this child)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Births Now Living (templateId: 2.16.840.1.113883.10.20.26.36)	/code@code= Code='11638-4', CodeSystemName= 'LOINC', DisplayName= 'Births still living' AND /value@value= PLBL(int)
OWGEST	Obstetric Estimate of Gestation	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Estimate of Gestation (templateId: 2.16.840.1.113883.10.20.26.21)	/code@code= Code='11884-4', CodeSystemName= 'LOINC', DisplayName= 'Gestational age Estimated' AND /value@value= OWGEST(int)
CERV	Obstetric procedures: Cervical cerclage	NA	NA	IF CERV = 'Y' then /code@code= Code= '265636007', CodeSystemName= 'SNOMED CT', DisplayName= 'Cerclage of cervix' /@negationInd = false
ECVF	Obstetric procedures: Failed External cephalic Version	NA	NA	PENDING
ECVS	Obstetric procedures: Successful External cephalic version	NA	NA	NA

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
TOC	Obstetric procedures: Tocolysis	NA	NA	NA
NOA03	Obstetric procedures: None of the above	NA	NA	NA
PROM	Onset of labor: Premature Rupture	NA	NA	NA
PRIC	Onset of labor: Precipitous Labor	NA	NA	NA
PROL	Onset of labor: Prolonged Labor	NA	NA	NA
NOA05	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	NA	NA	NA
SFN	Place where birth occurred: State Facility Number	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = SFN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FLOC	Place where birth occurred: Facility City/Town	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains FLOC
CNAME	Place where birth occurred: County Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNAME
CNTYO	Place where birth occurred: County Code	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNTYO
BPLACE	Place where birth occurred: Birth Place	NA	NA	NA
PLUR	Plurality	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Plurality [Observation: templateId 2.16.840.1.113883.10.20.26.41]	/code@code= Code='57722-1', CodeSystemName= 'LOINC', DisplayName= 'Birth plurality' AND /value@value= PLUR(int)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DOFP_MO	Prenatal care visits: Date of first prenatal care visit: Month	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]
DOFP_DY	Date of first prenatal care visit: Day	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]
DOFP_YR	Date of first prenatal care visit: Year	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime[low]
DOLP_MO	Prenatal care visits: Date of last prenatal care visit: Month	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DOLP_DY	Prenatal care visits: Date of last prenatal care visit: Day	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3] Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]
DOLP_YR	Prenatal care visits: Date of last prenatal care visit: Year	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime [high]
NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/entryRelationship/observation/code@code= Code='68493-6', CodeSystemName= 'LOINC', DisplayName= 'Prenatal visits for this pregnancy' AND /value@value= NPREV(int)
PAY	Principal source of payment for this delivery	NA	NA	NA
PDIAB	Risk factors in this pregnancy: Prepregnancy Diabetes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '73211009', CodeSystemName= 'SNOMED CT', DisplayName= 'Diabetes mellitus'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '11687002', CodeSystemName= 'SNOMED CT', DisplayName= 'Gestational diabetes mellitus'
PHYPE	Risk factors in this pregnancy: Prepregnancy Hypertension	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '38341003', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypertensive disorder, systemic arterial'
GHYPE	Risk factors in this pregnancy: Gestational Hypertension	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '48194001', CodeSystemName= 'SNOMED CT', DisplayName= 'Pregnancy-induced hypertension'
EHYPE	Risk factors in this pregnancy: Eclampsia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF EHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '15938005', CodeSystemName= 'SNOMED CT', DisplayName= 'Eclampsia'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
PPB	Risk factors in this pregnancy: Previous preterm births	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '161765003', CodeSystemName= 'SNOMED CT', DisplayName= 'History of - premature delivery'
PPO	Risk factors in this pregnancy: Poor pregnancy outcomes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPO = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '439221000124101', CodeSystemName= 'SNOMED CT', DisplayName= 'History of poor pregnancy outcome'
INFT	Risk factors in this pregnancy: Infertility treatment	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '65046005', CodeSystemName= 'SNOMED CT', DisplayName= 'Infertility Therapy'
INFT_DRG	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT_DRG = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '58533008', CodeSystemName= 'SNOMED CT', DisplayName= 'Artificial insemination'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
INFT_ART	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= ‘73775-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Risk factors in this pregnancy’ AND /value@code= Code= ‘200144004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Deliveries by cesarean’
PCES	Risk factors in this pregnancy: Previous cesarean	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NPCES = 'Y' then /code@code= Code= ‘73775-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Risk factors in this pregnancy’ AND /value@code= Code= ‘200144004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Deliveries by cesarean’
NPCES	Risk factors in this pregnancy: Number of previous cesareans	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= ‘73775-9’, CodeSystemName= ‘LOINC’, DisplayName= ‘Risk factors in this pregnancy’ AND /value@code= Code= ‘200144004’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Deliveries by cesarean’ /entryRelationship/observation/code@code= Code= ‘68497-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Previous cesarean deliveries’ AND /value@value= NPCES(int)

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
NOA01	Risk factors in this pregnancy: None of the above	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NOA01 = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
SORD	Set Order	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Birth Order (templateId: 2.16.840.1.113883.10.20.26.16)	/code@code= Code='73771-8', CodeSystemName= 'LOINC', DisplayName= 'Birth order' AND /value@value= SORD(int)
FSEX	Child: (infant) Sex -	NA	NA	NA
FDOD_YR		Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Fetal Delivery Time (templateId: 2.16.840.1.113883.10.20.26.23)	/code@code='11778-8' CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value contains FDOD_YR
FDOD_MO		Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Fetal Delivery Time (templateId: 2.16.840.1.113883.10.20.26.23)	/code@code='11778-8' CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value contains FDOD_MO

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FDOD_DY		Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Fetal Delivery Time (templateId: 2.16.840.1.113883.10.20.26.23)	/code@code='11778-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value contains FDOD_DY
ETIME	Estimated Time of Fetal Death	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Fetal Death Occurrence [Observation: templateId 2.16.840.1.113883.10.20.26.22]	code@code=' 73811-2', CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value = ETIME
LIVEB	Not single birth - specify number of infants in this delivery born alive.	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.10]	NA	
FDTH	Number of fetal deaths	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	PENDING	PENDING

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
HYST	Method of Delivery: Hysterotomy/Hysterectomy?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery (templateId: 2.16.840.1.113883.10.20.26.45)	/entryrelationship/code@code='73759-3;, CodeSystemName= 'LOINC', DisplayName= 'Hysterotomy or hysterectomy was performed at delivery; /value@value = HYST
TD	Time of delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	Fetal Delivery Time [Observation: templateId 2.16.840.1.113883.10.20.26.23]	/code@code='11778-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value contains TD
AUTOP	Was an autopsy performed?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Autopsy Performance (templateId: 2.16.840.1.113883.10.20.26.15)	/code@code= '73768-4', CodeSystemName= 'LOINC', DisplayName= 'Autopsy was performed' /value@value = AUTOP
FWO	Weight of Fetus (in ounces)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= FWO(PQ) /value/@unit= 'oz' NOTE: Preferred measure of weight is in Grams.

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FWG	Weight of Fetus (grams preferred, specify unit)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= FWG(PQ) /value/@unit= 'gm' NOTE: Preferred measure of weight is in Grams.
FWP	Weight of Fetus (in pounds)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= FWP(PQ) /value/@unit= 'lb' NOTE: Preferred measure of weight is in Grams.
LM	Infections present and treated during this pregnancy: Listeria	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF LM = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '4241002', CodsSystemName='SNOMED CT', DisplayName='Listeriosis'
GBS	Infections present and treated during this pregnancy: Group B Streptococcus	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF GBS = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '426933007', CodsSystemName='SNOMED CT', DisplayName= 'Streptococcus agalactiae infection'

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CMV	Infections present and treated during this pregnancy: Cytomeglovirus	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF CMV = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '28944009', CodsSystemName='SNOMED CT', DisplayName= 'Cytomegalovirus infection'
B19	Infections present and treated during this pregnancy: Parvovirus	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF B19 = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '186748004', CodsSystemName='SNOMED CT', DisplayName= 'Parovirus infection'
HISTOP	Was a Histological Placental Examination performed?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Autopsy Performance (templateId: 2.16.840.1.113883.10.20.26.15)	/entryRelationship/code@code= '73767-6', CodeSystemName= 'LOINC', DisplayName= 'Histological placental examination was performed' /value@value = HISTOP
TOXO	Infections present and treated during this pregnancy: Toxoplasmosis	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF TOXO = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '187192000', CodsSystemName='SNOMED CT', DisplayName= 'Toxoplasmosis'

4.I.2.1.3 Form Data Element Mappings to Output HL7 Message

This section identifies the mapping of the data elements defined for this form and the specified output HL7 Message.

Table 4.I.2.1.3-1: Form Data Elements Data Mapped to Output Message Segments

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 434621000124103^ Antibiotics given for suspected neonatal sepsis	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||434621000124103^ Antibiotics given for suspected neonatal sepsis^SNM ||||||F
AVEN1	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain PHC1250^Assisted ventilation required immediately following delivery	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||PHC1250^ Assisted ventilation required immediately following delivery^CDCPHINVS ||||||F
AVEN6	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain PHC1251^Assisted ventilation required for more than six hours	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||PHC1251^ Assisted ventilation required for more than six hours ^CDCPHINVS ||||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
BINJ	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 56110009^Birth trauma of fetus	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||56110009^Birth trauma of fetus^SNM ||||||F
NICU	Abnormal conditions of the newborn: Admission to NICU	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 405269005^Neonatal intensive care unit	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||405269005^ Neonatal intensive care unit^SNM ||||||F
SEIZ	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 91175000^Seizure	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||91175000^ Seizure^SNM ||||||F
SURF	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 434701000124101^Surfactant replacement therapy	OBX|1|CNE|73812-0^Abnormal conditions of the Newborn ^LN||434701000124101^ Surfactant replacement therapy ^SNM ||||||F
NOA54	Abnormal conditions of the newborn: None of the above	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 260413007 None (qualifier value)	OBX|31|CNE|73812-0^Abnormal conditions of the Newborn ^LN||260413007^None (qualifier value)^SNM ||||||F
APGAR5	Apgar Score: 5 Minute	OBX-2 SHALL contain NM OBX-3 SHALL contain 9274-2^Score^5M post birth OBX-5 SHALL contain the 5-minute Apgar Score	OBX|1|NM|9274-2^ Score^5M post birth ^LN||4

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
APGAR10	Apgar Score: 10 Minute	OBX-2 SHALL contain NM OBX-3 SHALL contain 9271-8^Score^10M post birth OBX-5 SHALL contain the 10-minute Apgar Score	OBX|1|NM|9271-8|^ Score^10M post birth ^LN||8
ATTENDN	Attendant's name	ROL-2 SHALL contain LI ROL-3 SHALL contain ATT ROL-4 SHALL contain the attendant's Name, practice location, and NPI	ROL||LI|ATT|888-003^Xxwalshingham^Albert^DR^^Good Health Hospital^^^NPI
ATTEND	Attendant's title:	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73764-3^Birth Attendant Title OBX-5 SHALL contain a value selected from value the set Birth Attendant Title (Birth Attendant Titles) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7111	OBX|1|CNE|73764-3^Birth Attendant^LN||76231001^ Osteopath^SNM |||||F
ATTENDS	Attendant: Other specified	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73764-3^Attendants's TitleOBX-5 SHALL contain 394841004^ Other category (qualifier value) OBX-5 SHALL contain the Text Description of the Attendant's Title in Alternate Text 73764-3^ Birth attendant title	OBX|3|CNE|73764-3^Attendants's Title^LN||394841004^ Other category (qualifier value) ^SNM^^Chief Birthing Specialist|||||F
NPI	Attendant's NPI	ROL-2 SHALL contain LI ROL-3 SHALL contain ATT ROL-4 SHALL contain the attendant's Name, and NPI	ROL||LI|ATT| 1234^Admit^Alan^A^III^Dr^^^&2.16.840.1.113883.19.4.6&ISO^ ^^^EI^&2.16.840.1.113883.19.4.6&ISO^^^^^^^MD|

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
BWG	Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Body weight^at birth OBX-5 SHALL contain the birthweight in Grams OBX-6 SHALL indicate grams using UCUM units: SHALL contain gm	OBX|24|NM|8339-4 ^ Body weight^at birth^LN||1200|gm
BWO	Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Body weight^at birth OBX-5 SHALL contain the birthweight in Ounces OBX-6 SHALL indicate ounces using UCUM units: SHALL contain oz NOTE: it is preferred to send in grams (see BWG)	OBX|24|NM|8339-4 ^Body weight^at birth^LN||1200|oz
BWP	Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^ Body weight^at birth OBX-5 SHALL contain the birthweight in Pounds OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb NOTE: it is preferred to send in grams (see BWG)	OBX|24|NM|8339-4 ^Body weight^at birth ^LN||1200|lb
ANTB	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 281789004^Antibiotics received during labor	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||281789004^ Antibiotics received during labor^SNM|||||F
AUGL	Characteristics of labor and delivery: Augmentation of labor	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 237001001^Augmentation of Labor	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||237001001^ Augmentation of Labor^SNM|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 11612004^ Chorioamnionitis	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||11612004^ Chorioamnionitis^SNM|||||F
ESAN	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 231064003^ Intrathecal injection of local anesthetic agent	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||231064003^ Intrathecal injection of local anesthetic agent^SNM|||||F
FINT	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 130955003^Fetal distress	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||130955003^Fetal distress^SNM|||||F
INDL	Characteristics of labor and delivery: Induction of labor	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 236958009^Induction of labor	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||236958009^Induction of labor^SNM|||||F
MECS	Characteristics of labor and delivery: Meconium staining	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 249135009^Meconium stained liquor	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||249135009^Meconium stained liquor^SNM|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
STER	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 434611000124106 ^Maternal antenatal administration of corticosteroids for fetal lung maturation	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||434611000124106 ^Maternal antenatal administration of corticosteroids for fetal lung maturation ^SNM|||||F
NOA04	Characteristics of labor and delivery: None of the above	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 260413007^ None (qualifier value)	OBX|23|CNE|73813-8^Characteristics of labor and delivery^LN||260413007^ None (qualifier value)^SNM|||||F
DNA04	Characteristics of labor and delivery: Pending	PENDING (see open issues surrounding 'Pending flag')	
IDOB_YR	Child: Date of Birth: Year	PID-7 SHALL contain the Newborn's date and time of birth, or (for fetal death reporting) the delivery date and time of delivery of the fetus.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
IDOB_MO	Child: Date of Birth: Month	PID-7 SHALL contain the Newborn's date and time of birth, or (for fetal death reporting) the delivery date and time of delivery of the fetus.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
IDOB_DY	Child: Date of Birth: Day	PID-7 SHALL contain the Newborn's date and time of birth, or (for fetal death reporting) the delivery date and time of delivery of the fetus.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
KIDFNAME	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
KIDMNAME	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
KIDLNAME	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
KIDSUFFX	Child's Last Name Suffix:	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
BFED	Child: Infant being breastfed?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73756-9^Infant is being breastfed at discharge OBX-5 SHALL contain a value selected from HL7 Table 0532 – Expanded Yes/No Indicator (HL7 Defined)	OBX|34|CE|73756-9^Infant is being breastfed at discharge^LN||Y^Yes^HL70532|||||F
ILIV	Child: Infant living at time of report?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73757-7^Infant living at time of report OBX-5 SHALL contain a value selected from HL7 Table 0532 – Expanded Yes/No Indicator (HL7 Defined)	OBX|59|CE|73757-7^Infant living at time of report^LN||Y^Yes^HL70532|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
IRECNUM	Child: Newborn Medical Record Number	PID-3	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
ISEX	Child: (infant) Sex -	PID-8	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
ITRAN	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	OBX-2 SHALL contain CE OBX-3 SHALL contain 73758-5^Infant was transferred within 24 hours of delivery OBX-5 SHALL contain a value selected from value the set from HL7 Table 0532 – Expanded Yes/No Indicator (HL7 Defined)	OBX|32|CE|73758-5^ Infant was transferred within 24 hours of delivery ^LN||N^No^HL70532||||||F
FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility	OBX-2 SHALL contain CE OBX-3 SHALL contain 73770-0^ Name of facility infant transferred to OBX-5 SHALL contain the name of the facility the infant was transferred to. (Only value if the infant was transferred within 24 hours of delivery.)	OBX|32|CE|73770-0^ Name of facility infant transferred to^LN||N^No^HL70532|||||F
TB	Child: Time of Birth	PID-7 SHALL contain the Newborn's date and time of birth, or (for fetal death reporting) the delivery date and time of delivery of the fetus.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
ANEN	Congenital anomalies of the Newborn: Anencephaly	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 89369001^Anencephalus	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||89369001^Anencephalus^SNM |||||F
CCHD	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 12770006^Cyanotic congenital heart disease	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||12770006^Cyanotic congenital heart disease^SNM ||||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
CDH	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 17190001^Congenital diaphragmatic hernia	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||17190001^Congenital diaphragmatic hernia^SNM ||||||F
CDIS	Congenital anomalies of the Newborn: Suspected chromosomal disorder	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM ||||||F
CDIC	Congenital anomalies of the Newborn: Suspected chromosomal Disorder karyotype confirmed	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder (disorder) AND a second OBX segment WHERE: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73778-3^Suspected chromosomal disorder karyotype status OBX-5 SHALL contain 442124003^Karyotype evaluation abnormal	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM ||||||F OBX|27|CNE|73778-3 ^Suspected chromosomal disorder karyotype status^LN||442124003^Karyotype evaluation abnormal^SNM ||||||F
'CDIP	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder (disorder) AND a second OBX segment WHERE: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73778-3^Suspected chromosomal disorder karyotype status OBX-5 SHALL contain 312948004^ Karyotype determination	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM ||||||F OBX|27|CNE|73778-3^Suspected chromosomal disorder karyotype ^LN||312948004^ Karyotype determination^SNM ||||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
CL	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 80281008^Cleft lip	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||80281008^Cleft lip^SNM ||||||F
CP	Congenital anomalies of the Newborn: Cleft Palate alone	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 87979003^ Cleft palate	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||87979003^ Cleft palate^SNM ||||||F
DOWC	Congenital anomalies of the Newborn: Down Karyotype Confirmed	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 70156005^Anomaly of chromosome pair 21 (disorder) AND a second OBX segment WHERE: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73779-1^Down syndrome karyotype status OBX-5 SHALL contain 442124003^Karyotype evaluation abnormal (finding)	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||70156005^Anomaly of chromosome pair 21^SNM ||||||F OBX|27|CNE|73779-1^Down syndrome karyotype status ^LN||442124003^Karyotype evaluation abnormal (finding)^SNM ||||||F
DOWN	Congenital anomalies of the Newborn: Down Syndrome	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 70156005^Anomaly of chromosome pair 21	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||70156005^Anomaly of chromosome pair 21^SNM ||||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
DOWP	Congenital anomalies of the Newborn: Down Karyotype Pending	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 70156005^Anomaly of chromosome pair 21 AND a second OBX segment WHERE: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73779-1^Down syndrome karyotype status OBX-5 SHALL contain 312948004^ Karyotype determination	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||70156005^Anomaly of chromosome pair 21 (disorder)^SNM |||||F OBX|27|CNE|73779-1^ Down syndrome karyotype status ^LN||^312948004^ Karyotype determination^SNM |||||F
GAST	Congenital anomalies of the Newborn: Gastroschisis	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 72951007^Gastroschisis	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||72951007^Gastroschisis^SNM |||||F
HYPO	Congenital anomalies of the Newborn: Hypospadias	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 416010008^Hypospadias	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||416010008^Hypospadias^SNM |||||F
LIMB	Congenital anomalies of the Newborn: Limb reduction defect	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 67341007^Longitudinal deficiency of limb	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||67341007^Longitudinal deficiency of limb^SNM |||||F
MNSB	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 67531005^Spina bifida	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||67531005^Spina bifida^SNM |||||F
OMPH	Congenital anomalies of the Newborn: Omphalocele	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 18735004^Congenital omphalocele	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||17190001^18735004^Congenital omphalocele^SNM |||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
NOA55	Congenital anomalies of the Newborn: None of the anomalies listed above	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|27|CNE|73780-9^Congenital anomalies of the Newborn ^LN||260413007^None (qualifier value)^SNM |||||F
DNA55	Characteristics of labor and delivery: Pending	PENDING (see open issues surrounding 'Pending flag')	
YLLB	Date of last live birth:	OBX-2 SHALL contain TS OBX-3 SHALL contain 68499-3^Date last live birth OBX-5 SHALL contain the date of birth of the last live-born infant (month and year) excluding this delivery. Includes live-born infants now living and now dead. If this was a multiple delivery, include all live born infants who preceded the live born infant in this delivery. If first born, do not include this infant. If second born, include the first born. (Month and year should be provided.)	OBX|14|TS|68499-3^Date last live birth^LN||20090926
MLLB	Date of last live birth:	OBX-2 SHALL contain TS OBX-3 SHALL contain 68499-3^Date last live birth OBX-5 SHALL contain the date of birth of the last live-born infant (month and year) excluding this delivery. Includes live-born infants now living and now dead. If this was a multiple delivery, include all live born infants who preceded the live born infant in this delivery. If first born, do not include this infant. If second born, include the first born. (Month and year should be provided.)	OBX|14|TS|68499-3^Date last live birth^LN||20090926
DLMP_DY	Date last Normal Menses began:	OBX-2 SHALL contain TS OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|TS|8665-2^ Date last menstrual period ||20100418

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
DLMP_MO	Date last Normal Menses began:	OBX-2 SHALL contain TS OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|TS|8665-2^ Date last menstrual period ||20100418
DLMP_YR	Date last Normal Menses began:	OBX-2 SHALL contain TS OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|TS|8665-2^ Date last menstrual period ||20100418
YOPO	Date of Last Other Pregnancy Outcome: Year	OBX-2 SHALL contain TS OBX-3 SHALL contain 68500-8^Date last other pregnancy outcome OBX-5 SHALL contain the date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. (month and year)	OBX|16|TS|68500-8^Date last other pregnancy outcome||20100418
MOPO	Date of Last Other Pregnancy Outcome: Month	OBX-2 SHALL contain TS OBX-3 SHALL contain 68500-8^Date last other pregnancy outcome OBX-5 SHALL contain the date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. (month and year)	OBX|16|TS|68500-8^Date last other pregnancy outcome||20100418
ADDRESS_D	Facility Address	OBX-2 SHALL contain TS OBX-3 SHALL contain 68500-8^Date last other pregnancy outcome OBX-5 SHALL contain the date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. (month and year)	OBX|16|TS|68500-8^Date last other pregnancy outcome||20100418
FNAME	Facility Name (if Not institution, give street and number)	ROL-4	ROL||AD|FAC|Good Health Hospital|||||||300 Main St^^Metropolis^Rhode Island^03443^B
FNPI	Facility National Provider Identifier	ROL-4	ROL||AD|FAC|Good Health Hospital|||||||300 Main St^^Metropolis^Rhode Island^03443^B

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
CHAM	Infections present and treated during this pregnancy: Chlamydia	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 105629000^Chlamydial infection For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 105629000^Chlamydial infection	For Live Birth: OBX|20|CNE|72519-2^Infections present and treated during this pregnancy for live birth^LN||105629000^Chlamydial infection ^SNM|||||F For Fetal Death: OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||105629000^Chlamydial infection ^SNM |||||F
GON	Infections present and treated during this pregnancy: Gonorrhea	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 15628003^Gonorrhea For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 15628003^Gonorrhea	For Live Birth: OBX|20|CNE|72519-2^Infections present and treated during this pregnancy for live birth^LN||15628003^Gonorrhea ^SNM|||||F For Fetal Death: OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN|15628003^Gonorrhea^SNM |||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
HEPB	Infections present and treated during this pregnancy: Hepatitis B	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 66071002^ Type B viral hepatitis For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 66071002^ Type B viral hepatitis	For Live Birth: OBX|20|CE|72519-2^Infections present and treated during this pregnancy for live birth^LN||66071002^ Type B viral hepatitis ^SNM|||||F For Fetal Death: OBX|19|CE|73769-2^Infections present treated during the pregnancy for fetal death^LN|66071002^ Type B viral hepatitis ^SNM |||||F
HEPC	Infections present and treated during this pregnancy: Hepatitis C	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 50711007^Viral hepatitis C For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 50711007^Viral hepatitis C	For Live Birth: OBX|20|CNE|72519-2^Infections present and treated during this pregnancy for live birth^LN||50711007^Viral hepatitis C^SNM|||||F For Fetal Death: OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN|50711007^Viral hepatitis C^SNM |||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
SYPH	Infections present and treated during this pregnancy: Syphilis	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 76272004^Syphilis For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 76272004^Syphilis	For Live Birth: OBX|20|CNE|72519-2^Infections present and treated during this pregnancy for live birth^LN||76272004^Syphilis ^SNM|||||F For Fetal Death: OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN|76272004^Syphilis^SNM |||||F
NOA02	Infections present and treated during this pregnancy: None of the above	For Live Birth: OBX-2 SHALL contain CNE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 76272004^Syphilis (disorder) For Fetal Death: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 260413007^None (qualifier value)	For Live Birth: OBX|20|CNE|72519-2^Infections present and treated during this pregnancy for live birth^LN||260413007^None (qualifier value)^SNM|||||F For Fetal Death: OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN|260413007^None (qualifier value)^SNM |||||F
AINT	Maternal Morbidity: - Admission to Intensive care [unit]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 309904001^Intensive care unit	OBX|23|CNE|73781-7^Maternal Morbidity ^LN||309904001^Intensive care unit^SNM|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
MTR	Maternal Morbidity: Maternal Transfusion	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 116859006^Transfusion of blood product (procedure)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||116859006^Transfusion of blood product^SNM|||||F
PLAC	Maternal Morbidity: [Third or fourth degree] perineal laceration	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 398019008^Perineal laceration during delivery (disorder)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||398019008^Perineal laceration during delivery (disorder)^SNM|||||F
RUT	Maternal Morbidity: Ruptured Uterus	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 34430009^Rupture of uterus (disorder)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||34430009^Rupture of uterus (disorder)^SNM|||||F
UHYS	Maternal Morbidity: Unplanned hysterectomy	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 625654015^Emergency cesarean hysterectomy (procedure)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||625654015^Emergency cesarean hysterectomy (procedure)^SNM|||||F
UOPR	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 177217006^Immediate repair of obstetric laceration (procedure)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||177217006^Immediate repair of obstetric laceration (procedure)^SNM|||||F
NOA05	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|22|CNE|73781-7^Maternal Morbidity ^LN||260413007^None (qualifier value)^SNM|||||F
PRES	Method of Delivery: Fetal presentation [at birth]: Cephalic	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 70028003^Vertex presentation (finding)	OBX|24|CNE|73761-9^Fetal presentation at Birth^LN||70028003^Cephalic^SNM|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
ROUT	Method of Delivery: [Final]Route and method of delivery: Breech	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 6096002^Breech Presentation	OBX|20|CNE|73761-9^Fetal presentation at Birth^LN||6096002^Breech Presentation^SNM|||||F
ROUT	Method of Delivery: [Final]Route and method of delivery: Other	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 394841004^Other category (qualifier value)	OBX|20|CNE|73761-9^Fetal presentation at Birth^LN||6096002^Breech Presentation^SNM|||||F
TLAB	Method of Delivery: Trial of labor attempted	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73760-1^If cesarean, a trial of labor was attempted OBX-5 SHALL contain boolean indication using HL7 0532 Expanded yes/no indicator (NCHS of whether a trial of labor was attempted when the final route and method of delivery is a cesarean.	OBX|24|CE|73761-9^Fetal presentation at Birth^LN|| N^No^HL70532|||||F
MFNAME	Mother's Current Legal Name: First Name	NK1-2	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||||9876546688^^^^MRN
MMNAME	Mother's Current Legal Name: Middle Name	NK1-2	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||||9876546688^^^^MRN
MLNAME	Mother's Current Legal Name: Last Name	NK1-2	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||||9876546688^^^^MRN
MSUFF	Mother's Current Legal Name: suffix	NK1-2	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||||9876546688^^^^MRN

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
HFT	Mother's Height: Feet	OBX-2 SHALL contain NM OBX-3 SHALL contain 3137-7^Body height OBX-5 SHALL contain the Mother's Height in Inches OBX-6 SHALL indicate grams using UCUM units: SHALL contain ft	OBX|9|NM|73776-7^Body height^LN||6|ft
HIN	Mother's Height: Inches	OBX-2 SHALL contain NM OBX-3 SHALL contain 3137-7^Body height OBX-5 SHALL contain the Mother's Height in Inches OBX-6 SHALL indicate grams using UCUM units: SHALL contain in	OBX|9|NM|73776-7^Body height^LN||58|in
MRECNUM	Mother's medical record number	NK1-33	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||||9876546688^^^^MRN
PWGT	Mother's pre-pregnancy weight	OBX-2 SHALL contain NM OBX-3 SHALL contain 56077-1^Body weight ^ pre current pregnancy OBX-5 SHALL contain the mother's weight before becoming pregnant OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb	OBX|10|NM|56077_1^Body weight-pre current pregnancy^LN||94lb
NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	PV1-6	PV1||I||^^^^^^^^Simple Birth Clinic||||||||||||PI

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
TRAN	Mother transferred for maternal medical or fetal indications for delivery?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73763-5^ Mother was transferred for maternal medical or fetal indications for delivery OBX-5 SHALL contain boolean indication of whether a trial of labor was attempted using HL7 0532 Expanded yes/no indicator (NCHS) when the final route and method of delivery is a cesarean.)	OBX|4|CE|73763-5^Mother transferred for maternal medical or fetal indications for delivery?^LN||N^No^HL70532|||||F
DWGT	Mother's weight at delivery	OBX-2 SHALL contain NM OBX-3 SHALL contain 69461-2^ Body weight at delivery OBX-5 SHALL contain the mother's weight at the time of delivery OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb	OBX|10|NM|69461-2^ Body weight at delivery^LN||124lb
POPO	Number of other pregnancy outcomes	OBX-2 SHALL contain NM OBX-3 SHALL contain 69043-8^Other pregnancy outcomes OBX-5 SHALL contain the total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. For multiple deliveries include all previous pregnancy losses before this infant in this pregnancy and in previous pregnancies.	OBX|15|NM|69043-8^Other pregnancy outcomes||1
PLBD	Number of previous live births now dead (do not include this child)	OBX-2 SHALL contain NM OBX-3 SHALL contain 68496-9^Live births.now dead OBX-5 SHALL contain the total number of previous live-born infants now dead. For multiple deliveries include all live-born infants before this infant in the pregnancy who are now dead. If the first born, do not include this infant	OBX|15|NM|68496-9^Live births.now dead||1
PLBL	Number of previous live births now living (do not include this child)	OBX-2 SHALL contain NM OBX-3 SHALL contain 11638-4^Births.still living OBX-5 SHALL contain the total number of previous live-born infants now living. For multiple deliveries include all live-born infants before this infant in the pregnancy. If the first born, do not include this infant.	OBX|12|NM|11638-4^Births.still living^LN||2

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
OWGEST	Obstetric Estimate of Gestation	OBX-2 SHALL contain NM OBX-3 SHALL contain 11884-4^Obstetric estimate of gestation OBX-5 SHALL contain the best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred. Do not complete solely based on the infant's date of birth and the mothers date of last menstrual period.	OBX|25|NM|11884-4^Obstetric estimate of gestation^LN||39|wk
CERV	Obstetric procedures: Cervical cerclage	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 265636007^Cerclage of cervix (procedure)	OBX|21|CNE|73814-6^Obstetric procedures^LN||265636007^Cerclage of cervix (procedure)^SNM|||||F
ECVF	Obstetric procedures: Failed External cephalic Version	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 240278000^External cephalic version (procedure) AND OBX-2 SHALL contain CNE OBX-3 SHALL contain 73820-3^Successful external cephalic version OBX-5 SHALL contain boolean indication (No)	OBX|21|CNE|73814-6^Obstetric procedures^LN||240278000^ External cephalic version (procedure)^SNM|||||F OBX|21|CNE|73820-3^Successful external cephalic version ^LN|| N^No^HL70532|||||F
ECVS	Obstetric procedures: Successful External cephalic version	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 240278000^External cephalic version (procedure) AND OBX-2 SHALL contain CNE OBX-3 SHALL contain 73820-3^Successful external cephalic version OBX-5 SHALL contain boolean indication (Yes)	OBX|21|CNE|73814-6^Obstetric procedures^LN||240278000^ External cephalic version (procedure)^SNM|||||F OBX|21|CNE|73820-3^Successful external cephalic version ^LN|| Y^Yes^HL70532|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
TOC	Obstetric procedures: Tocolysis	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 103747003^Tocolysis (procedure)	OBX|21|CNE|73814-6^Obstetric procedures^LN||103747003^Tocolysis (procedure)^SNM|||||F
NOA03	Obstetric procedures: None of the above	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|21|CE|73814-6^Obstetric procedures^LN||260413007^None (qualifier value)^SNM|||||F
PROM	Onset of labor: Premature Rupture	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 44223004^Premature Rupture of membranes (disorder)	OBX|22|CE|73774-2^Onset of labor||44223004^Premature Rupture of membranes (disorder)^SNM|||||F
PRIC	Onset of labor: Precipitous Labor	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 51920004^Precipitate labor (disorder)	OBX|22|CE|73774-2^Onset of labor||51920004^Precipitate labor (disorder)^SNM|||||F
PROL	Onset of labor: Prolonged Labor	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 53443007^Prolonged labor (disorder)	OBX|22|CE|73774-2^Onset of labor||53443007^Prolonged labor (disorder)^SNM|||||F
NOA05	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|22|CNE|73774-2^Onset of labor||53443007^260413007^None (qualifier value)^SNM|||||F
SFN	Place where birth occurred: State Facility Number	ROL-11	ROL||AD|FAC|Good Health Hospital||||||300 Main St^^Metropolis^Rhode Island^03443^B
FLOC	Place where birth occurred: Facility City/Town	ROL-11	ROL||AD|FAC|Good Health Hospital||||||300 Main St^^Metropolis^Rhode Island^03443^B

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
CNAME	Place where birth occurred: County Name	ROL-11	ROL||AD|FAC|Good Health Hospital||||||300 Main St^^Metropolis^Rhode Island^03443^B
CNTYO	Place where birth occurred: County Code	ROL-11	ROL||AD|FAC|Good Health Hospital||||||300 Main St^^Metropolis^Rhode Island^03443^B
BPLACE	Place where birth occurred: Birth Place: Hospital	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 22232009^Hospital	OBX|1|CE|73766-8^Birth/delivery location type^LN||22232009^Hospital^SNM|||||F
BPLACE	Place where birth occurred: Birth Place: Clinic/Doctor's Office	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 67190003^Free-standing clinic	OBX|1|CNE|73766-8^Birth/delivery location type^LN||67190003^Free-standing clinic ^SNM|||||F
BPLACE	Place where birth occurred: Birth Place: Freestanding Birth Center	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 91154008^Free-standing birthing center	OBX|1|CNE|73766-8^Birth/delivery location type^LN||91154008^Free-standing birthing center ^SNM|||||F
BPLACE	Place where birth occurred: Birth Place: Home Birth	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 169813005^Home birth	OBX|1|CNE|73766-8^Birth/delivery location type^LN||169813005^Home birth^SNM|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
BPLACE	Place where birth occurred: Birth Place: Other category	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 394841004^Other category	OBX|1|CNE|73766-8^Birth/delivery location type^LN||394841004^Other category^SNM|||||F
BPLACE	Place where birth occurred: Birth Place: Unknown	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CNE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 261665006^Unknown	OBX|1|CNE|73766-8^Birth/delivery location type^LN||261665006^Unknown^SNM|||||F
PLUR	Plurality	OBX-2 SHALL contain NM OBX-3 SHALL contain 57722-1^Birth plurality OBX-5 SHALL contain the number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy	OBX|30|NM|57722-1^Birth plurality^LN||1
DOFP_MO	Prenatal care visits: Date of first prenatal care visit: Month	OBX-2 SHALL contain TS OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|TS|69044-6^Date first prenatal visit^LN||20100528|||||F
DOFP_DY	Date of first prenatal care visit: Day	OBX-2 SHALL contain TS OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|TS|69044-6^Date first prenatal visit^LN||20100528|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
DOFP_YR	Date of first prenatal care visit: Year	OBX-2 SHALL contain TS OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|TS|69044-6^Date first prenatal visit^LN||20100528|||||F
DOLP_MO	Prenatal care visits: Date of last prenatal care visit: Month	OBX-2 SHALL contain TS OBX-3 SHALL contain 68492-8^Date last prenatal visit OBX-5 SHALL contain the date of the last prenatal care visit recorded in the records. The precision of reporting will be to the day (including month, day and year).	OBX|7|TS|68492-8^Date last prenatal visit^LN||20100624|||||F
DOLP_DY	Prenatal care visits: Date of last prenatal care visit: Day	OBX-2 SHALL contain TS OBX-3 SHALL contain 68492-8^Date last prenatal visit OBX-5 SHALL contain the date of the last prenatal care visit recorded in the records. The precision of reporting will be to the day (including month, day and year).	OBX|7|TS|68492-8^Date last prenatal visit^LN||20100624|||||F
DOLP_YR	Prenatal care visits: Date of last prenatal care visit: Year	OBX-2 SHALL contain TS OBX-3 SHALL contain 68492-8^Date last prenatal visit OBX-5 SHALL contain the date of the last prenatal care visit recorded in the records. The precision of reporting will be to the day (including month, day and year).	OBX|7|TS|68492-8^Date last prenatal visit^LN||20100624|||||F
NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy	OBX-2 SHALL contain TS OBX-3 SHALL contain 68492-8^Date last prenatal visit OBX-5 SHALL contain the total number of visits recorded in the record.	OBX|8|NM|68492-8^Prenatal visits for this pregnancy^LN||10
PAY	Principal source of payment for this delivery	PV1-20 SHALL contain PAY using the HL7 Table 0064 – Financial Class value set	PV1||I||^^^^^^^^Simple Birth Clinic|||||||||||55

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
PDIAB	Risk factors in this pregnancy: Prepregnancy Diabetes	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 73211009^Diabetes mellitus (disorder)	OBX|17|CNE|73775-9^Risk factors in this pregnancy^LN||73211009^Diabetes mellitus (disorder)^SNM||||||F
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 11687002^Gestational diabetes mellitus (disorder)	OBX|17|CNE|11687002^Gestational diabetes mellitus (disorder)^LN||73211009^Diabetes mellitus (disorder)^SNM||||||F
PHYPE	Risk factors in this pregnancy: Prepregnancy Hypertension	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 38341003^Hypertensive disorder, systemic arterial (disorder)	OBX|17|CNE|11687002^Gestational diabetes mellitus (disorder)^LN||38341003^Hypertensive disorder, systemic arterial (disorder)^SNM||||||F
GHYPE	Risk factors in this pregnancy: Gestational Hypertension	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 48194001^Pregnancy-induced hypertension (disorder)	OBX|17|CNE|73775-9^Risk factors in this pregnancy^LN||48194001^ Pregnancy-induced hypertension (disorder)^SNM||||||F
EHYPE	Risk factors in this pregnancy: Eclampsia	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 15938005^Eclampsia (disorder)	OBX|17|CNE|73775-9^Risk factors in this pregnancy^LN||15938005^Eclampsia (disorder)^SNM||||||F
PPB	Risk factors in this pregnancy: Previous preterm births	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 161765003^History of - premature delivery (situation)	OBX|17|CNE|73775-9^Risk factors in this pregnancy^LN||161765003^History of - premature delivery (situation)^SNM||||||F
PPO	Risk factors in this pregnancy: Poor pregnancy outcomes	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 439221000124101^ History of poor pregnancy outcome	OBX|17|CNE|73775-9^Risk factors in this pregnancy^LN||439221000124101^ History of poor pregnancy outcome^SNM||||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
INFT	Risk factors in this pregnancy: Infertility treatment	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 65046005^ Infertility Therapy (procedure)	OBX|18|CNE|73775-9^Risk factors in this pregnancy^LN||65046005^ Infertility Therapy (procedure)^SDM|||||F
INFT_DRG	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 58533008^Artificial insemination (procedure)	OBX|19|CNE|73775-9^Risk factors in this pregnancy^LN||58533008^Artificial insemination (procedure)^SNM|||||F
INFT_ART	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 63487001^Assisted fertilization (procedure)	OBX|19|CNE|73775-9^Risk factors in this pregnancy^LN||63487001^Assisted fertilization (procedure)^SNM|||||F
PCES	Risk factors in this pregnancy: Previous cesarean	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 200144004^Deliveries by cesarean (finding)	OBX|19|CNE|73775-9^Risk factors in this pregnancy^LN||200144004^Deliveries by cesarean (finding)^SNM|||||F
NPCES	Risk factors in this pregnancy: Number of previous cesareans	OBX-2 SHALL contain NM OBX-3 SHALL contain 68497-7^Previous cesarean deliveries OBX-5 SHALL contain The number of previous cesarean deliveries	OBX|8|NM|68497-7^Previous cesarean deliveries^LN||1
NOA01	Risk factors in this pregnancy: None of the above	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|19|CNE|73775-9^Risk factors in this pregnancy^LN||260413007^None (qualifier value)^SNM|||||F
SORD	Set Order	PID-25	PID|1||987645432^^^^MRN||~^^^^^^U||20110530234 9M|||||||||||N

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
FSEX	Child: (infant) Sex -	PID-8	PID|1||987645432^^^^MRN||~^^^^^^U||20110530234 9|M|||||||||||N
FDOD_YR		PID-7	PID|1||987645432^^^^MRN||~^^^^^^U||20110530234 9|M|||||||||||N
FDOD_MO		PID-7	PID|1||987645432^^^^MRN||~^^^^^^U||20110530234 9|M|||||||||||N
FDOD_DY		PID-7	PID|1||987645432^^^^MRN||~^^^^^^U||20110530234 9|M|||||||||||N
ETIME	Estimated Time of Fetal Death	OBX-2 SHALL contain CE OBX-3 SHALL contain 73811-2^Estimated time of fetal death OBX-5 SHALL contain a value selected from value the set Fetal Death Time Points (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7112	OBX|19|CE|73811-2^Estimated time of fetal death ^LN||58533008^Artificial insemination (procedure)^SNM|||||F
LIVEB	Not single birth - specify number of infants in this delivery born alive.	OBX-2 SHALL contain NM OBX-3 SHALL contain 73773-4^Number of infants in this delivery born alive OBX-5 SHALL specify the number of live born in this delivery	OBX|8|NM|73773-4^Number of infants in this delivery born alive ^LN||1
FDTH	Number of fetal deaths	OBX-2 SHALL contain NM OBX-3 SHALL contain 73772-6^ Number of fetal deaths delivered OBX-5 SHALL specify the number of fetal deaths in this delivery	OBX|8|NM|73772-6^ Number of fetal deaths delivered^LN||1
HYST	Method of Delivery: Hysterotomy/Hysterectomy?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73759-3^ Hysterotomy or hysterectomy was performed at delivery OBX-5 SHALL contain boolean indication (Yes/No/Unknown/Not Applicable) of whether a hysterotomy or hysterectomy was performed using HL7 0532 Expanded yes/no indicator (NCHS)	OBX|21|CE|73759-3^ Hysterotomy or hysterectomy was performed at delivery^LN|| N^No^HL70532|||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
TD	Time of delivery	PID-7	
AUTOP	Was an autopsy performed?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73768-4^Autopsy was performed OBX-5 SHALL contain a value selected from value the set Autopsy Examination (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7137	OBX|19|CE|73768-4^Autopsy was performed ^LN||44551000009109^ Autopsy not performed ^SNM|||||F
FWO	Weight of Fetus (in ounces)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams converted from Ounces OBX-6 SHALL indicate ounces using UCUM units: SHALL contain oz NOTE: it is preferred to send in grams (see FWG)	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|oz
FWG	Weight of Fetus (grams preferred, specify unit)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams OBX-6 SHALL indicate grams using UCUM units: SHALL contain gm	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|gm
FWP	Weight of Fetus (in pounds)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams converted from Pounds OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb NOTE: it is preferred to send in grams (see FWG)	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|lb
LM	Infections present and treated during this pregnancy: Listeria	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 4241002^ Listeriosis (disorder)	OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||4241002^ Listeriosis (disorder)^SNM |||||F

Form Data Element <Use Data Element Label from V1 X.7>	Form Data Element Name	Segment and Location within the Segment	Example
GBS	Infections present and treated during this pregnancy: Group B Streptococcus	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 426933007^Streptococcus agalactiae infection (disorder)	OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||426933007^Streptococcus agalactiae infection (disorder)^SNM |||||F
CMV	Infections present and treated during this pregnancy: Cytomeglovirus	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 28944009^Cytomegalovirus infection (disorder)	OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||28944009^Cytomegalovirus infection (disorder)^SNM |||||F
B19	Infections present and treated during this pregnancy: Parvovirus	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 186748004^Parvovirus	OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||186748004^Parvovirus^SNM |||||F
HISTOP	Was a Histological Placental Examination performed?	OBX-2 SHALL contain CE OBX-3 SHALL contain 73767-6^Histological placental examination was performed OBX-5 SHALL contain a value selected from value the set Histological Placental Examination (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7138	OBX|19|CE|73767-6^Histological placental examination was performed ^LN||262008008^ Not Performed^SNM|||||F
TOXO	Infections present and treated during this pregnancy: Toxoplasmosis	OBX-2 SHALL contain CNE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 187192000^ Toxoplasmosis (disorder)	OBX|19|CNE|73769-2^Infections present treated during the pregnancy for fetal death^LN||187192000^ Toxoplasmosis (disorder)^SNM |||||F

