



5 **IHE Quality, Research and Public Health
Technical Framework Supplement**

10 **Birth and Fetal Death Reporting-Labor and
Delivery Summary for Vital Records
(BFDR-LDS-VR)**

15 **Revision 1.1 – Trial Implementation**

20 Date: October 26, 2021
Author: QRPH Technical Committee
Email: qrph@ihe.net

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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

30 This is a supplement to the IHE Quality, Research and Public Health (QRPH) Technical Framework. 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 October 26, 2021 for trial implementation and may be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the Quality, Research
35 and Public Health Technical Framework. Comments are invited and can be submitted at http://www.ihe.net/QRPH_Public_Comments.

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

<i>Amend Section X.X by the following:</i>
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40 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.

45 General information about IHE can be found at www.ihe.net.

Information about the IHE QRPH domain can be found at http://www.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://www.ihe.net/IHE_Process and <http://www.ihe.net/Profiles>.

50 The current version of the IHE QRPH Technical Framework can be found at http://www.ihe.net/Technical_Frameworks.

CONTENTS

55	Introduction to this Supplement.....	6
	Open Issues and Questions	6
	Closed Issues	7
	IHE Technical Frameworks General Introduction.....	10
	9 Copyright Licenses	10
60	10 Trademark.....	10
	IHE Technical Frameworks General Introduction Appendices.....	11
	Appendix A – Actors	11
	Appendix B – Transactions.....	11
	Appendix D – Glossary.....	12
65	Volume 1 – Profiles	13
	Domain-specific additions	13
	X Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR) Profile	13
	X.1 Actors, Transactions, and Content Modules	14
70	X.1.1 Actor Descriptions and Actor Profile Requirements.....	15
	X.1.1.1 Content Creator.....	15
	X.1.1.2 Content Consumer	15
	X.2 Actor Options	15
	X.3 BFDR-LDS-VR Required Actor Groupings	15
75	X.4 BFDR-LDS-VR Overview	16
	X.4.1 Concepts	16
	X.4.2 Use Cases	17
	X.4.2.1 Use Case #1: Forms Data Capture with Messaging	17
	X.4.2.1.1 Use Case Description.....	17
80	X.4.2.1.2 Processing Steps	17
	X.4.2.1.2.1 Pre-conditions	17
	X.4.2.1.2.2 Main Flow	17
	X.4.2.1.2.3 Post-conditions.....	17
	X.4.2.1.3 Process Flow	18
85	X.4.2.2 Use Case #2: Forms Data Capture with Document Submission	18
	X.4.2.2.1 Use Case Description.....	19
	X.4.2.2.2 Processing Steps	19
	X.4.2.2.2.1 Pre-conditions	19
	X.4.2.2.2.2 Main Flow	19
90	X.4.2.2.2.3 Post-conditions.....	19
	X.4.2.2.3 Process Flow	19
	X.4.2.3 Use Case #3: Native Forms Data Capture	20
	X.4.2.3.1 Use Case Description.....	20
	X.4.2.3.2 Processing Steps	21

95	X.4.2.3.2.1 Pre-conditions	21
	X.4.2.3.2.2 Main Flow	21
	X.4.2.3.2.3 Post-conditions	21
	X.4.2.3.3 Process Flow	21
	X.5 Security Considerations	22
100	X.6 Cross Profile Considerations	23
	X.6.1 RFD –Retrieve Form for Data Capture	23
	X.6.2 XD*– Cross Enterprise Document Sharing.b, Cross Enterprise Document Media Interchange, or Cross Enterprise Document Reliable Interchange.....	23
	X.6.3 Sharing Value Sets (SVS)	24
105	Volume 3 – Content Modules.....	25
	5 Namespaces and Vocabularies	25
	6 CDA Content Modules	26
	6.3.1 CDA Document Templates	26
	6.3.1.D1 Labor and Delivery Summary for Vital Records (LDS-VR) Document.....	26
110	6.3.1.D1.1 Format Code	26
	6.3.1.D1.2 Parent Template(s)	26
	6.3.1.D1.3 Referenced Standards	26
	6.3.1.D1.4 Data Element Mapping to CDA.....	26
	6.3.1.D1.5 Content Module Specifications.....	27
115	6.3.1.D1.5.1 Document Constraints.....	27
	6.3.1.D1.5.2 Header – Further Vocabulary or Conditional Constraints	30
	6.3.1.D1.5.2.1 documentationOf/encompassingEncounter.....	30
	6.3.1.D1.5.3 Body - Further Vocabulary or Conditional Constraints.....	31
	6.3.1.D1.5.3.1 Admission Medication History	31
120	6.3.1.D1.5.3.2 Coded History of Infection.....	31
	6.3.1.D1.5.3.3 Pregnancy History	32
	6.3.1.D1.5.3.4 Active Problems	35
	6.3.1.D1.5.3.5 Coded Detailed Physical Examination.....	37
	6.3.1.D1.5.3.6 Coded Detailed Physical Examination.Coded Vital Signs.....	37
125	6.3.1.D1.5.3.7 Medications Administered	38
	6.3.1.D1.5.3.8 Labor and Delivery Events.....	39
	6.3.1.D1.5.3.9 Labor and Delivery Events.Procedures and Interventions	39
	6.3.1.D1.5.3.10 Labor and Delivery Events.Coded Event Outcomes.....	42
	6.3.1.D1.5.3.11 Newborn Delivery Information.....	44
130	6.3.1.D1.5.3.12 Newborn Delivery Information.Coded Physical Detailed Examination.....	45
	6.3.1.D1.5.3.13 Newborn Delivery Information.Coded Detailed Physical Examination.Coded Vital Signs	49
	6.3.1.D1.5.3.14 Newborn Delivery Information.Coded Detailed Physical Examination.General Appearance.....	50
135	6.3.1.D1.5.3.15 Newborn Delivery Information.Active Problems	52

	6.3.1.D1.5.3.16 Newborn Delivery Information.Procedures and Interventions	53
	6.3.1.D1.5.3.17 Newborn Delivery Information.Medications Administered ..	54
140	6.3.1.D1.5.3.18 Newborn Delivery Information.Coded Event Outcomes	55
	6.3.1.D1.5.3.19 Newborn Delivery Information.Coded Results.....	59
	6.3.1.D1.5.3.20 Payers	59
	6.3.1.D1.6 Document Example.....	60
	6.3.2 CDA Header Templates	60
145	6.3.3 CDA Section Templates	60
	6.3.4 CDA Entry Content Module Templates	60
	6.4 Section not applicable	61
	6.5 Value Sets	61
	6.5.1 Value Sets used by this profile	61
150	6.5.2 Value Sets Defined by this profile	76
	Appendices to Volume 3.....	77
	Appendix A – LDS-VR Document Quick Reference.....	77
	A.1 LDS-VR Document Template and LOINC Code Quick Reference	77
	Volume 3 Namespace Additions	83
155	Volume 4 – National Extensions	85
	4 National Extensions	85
	4.I National Extensions for IHE USA.....	85

160 Introduction to this Supplement

This supplement is written for trial implementation. It is written as an addition to the Quality, Research and Public Health Technical Framework.

This supplement also references the following documents¹. The reader should review these documents as needed:

- 165 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](#)
- 170 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 (4/2004; 3/2005; Updated 7/2012)
9. Natality 2003 Revision – File In-Processing Documentation (14 Dec 2010)
- 175 10. Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Report of Fetal Death.
11. International Classification of Diseases, Tenth Revision (ICD-10)
12. Reference: Making Every Baby Count Audit and review of stillbirths and neonatal deaths
 <http://apps.who.int/iris/bitstream/10665/249523/1/9789241511223-eng.pdf?ua=1>
- 180 12.1 This document contains WHO statistics for prenatal data, labor and delivery data, and some newborn data, the latter being focused on stillborn and newborn deaths.

Open Issues and Questions

Open Issue List:

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.

Item Count	Issue Description	Status
1	May consider requesting specific SNOMED Codes to address External Cephalic Version successful/failed. If we have new SNOMED Codes, it will involve updates to the derivation rules and mapping for the Form manager and LDS-VR specifications for representing this information.	Additional request to be submitted to SNOMED for failed external cephalic version codes.
2	Medication list is used for augmentation but not for induction. There may be overlap if we were to create a separate	Value set exists for Augmentation but may need review by expert panel. No medication value set is used for induction of labor.
3	Glucocorticosteroids received by the mother prior to delivery may need to be checked in antepartum	Referenced in definitions only.
4	The concept of Packs of Cigarettes/day may be eliminated	
5	The value set for Antibiotics Received During Labor Finding (NCHS) 2.16.840.1.114222.4.11.7535 is not published in PHIN-VADS.	This value set is available but needs clinician validation. Request for interim publication by PHIN VADS pending.

185

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	LDS specification needs to be updated to allow for Intake and Output to represent coded observations	Resolved by using ProblemObservation to gather breastfeeding observation.
4	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.	We already got a new LOINC code for HW. Suggest using that same code and add as an OR. John supports adding. Section for LOINC question with entry from Lisa. Now in HW in Social Hx, not good fit for VR. We could have modeled with LOINC, there isn't a good place in LDS to add this approach. No change to document.
5	Infant living at time of report: approach to use the LOINC question/answer observation as done in the BFDR CDA	Two places to look: Deceased indicator OR Coded Event Outcomes Subject of the newborn delivery information section.

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Item	Issue Description	Status
6	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	Resolved. This is acceptable since we are modeling for data mining whereas the HL7 IG is modeling for reporting purposes.
7	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. NOTE: Date of Last Prenatal Care Visit has been removed from data requirements.	Resolved. This is acceptable since we are modeling for data mining whereas the HL7 IG is modeling for reporting purposes.
8	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	Added 73773-4 code to the existing value set for Number of Live Births (NCHS)
9	Apgar5 and Apgar10 need to be updated to reflect new PCC modeling for Apgar once PCC work is completed Initial CP taken on by Lisa Nelson to clarify that Apgar is to be in Coded Detailed Physical Exam/General. Longer term effort may consider a more global concept for assessments.	PCC decided not to make this proposed change. No changes needed.
10	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	No change needed. Already have value sets that includes concepts for autopsy and hysterectomy/hysterotomy unplanned.
11	Vocabulary – Unplanned Operation seems there should be a better code than selected '177217006' Immediate repair of obstetric laceration (procedure)	No change needed. The value set for unplanned operation has been modified to include additional codes based on feedback from the VRVC (Vital Records Vocabulary Committee)
12	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	Updates were added to the profile as follows: 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.
13	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)	Resolved by adding observation that can verify if the pregnancy resulted from fertility enhancing drugs.

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Item	Issue Description	Status
14	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?	No change needed.
15	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.	Nonpersuasive. Naming already implemented in PHIN VADS and acceptable by clinical reviewers and vocabulary experts.
16	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'	We are looking for a finding in the general appearance section.
17	Direct submission from EMR considerations: Some jurisdictions may require human sign-off before submitting a message	This is an implementation issue and does not require revisions to the profile.
18	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.	Considered and resolved to continue to use Admission Source following discussion with PCC and QRPH. Issue closed.
19	Review in progress to use SNOMED vocabularies for International Applicability to replace current value set content for international codes (SNOMED). Updates should be to the value set rather than changes to the name/OID.	Unless changed by other national extensions, SNOMED has been utilized throughout the profile.
20	No SNOMED codes are available to Hospital admission transfer from other facility rather than the UB04 codeset. May consider new code requests.	Has been changed to use HL7 Admit Source HL7 vocabulary codes. Work complete.

IHE Technical Frameworks General Introduction

- 190 The [IHE Technical Framework General Introduction](#) is shared by all of the IHE domain technical frameworks. Each technical framework volume contains links to this document where appropriate.

9 Copyright Licenses

- 195 IHE technical documents refer to, and make use of, a number of standards developed and published by several standards development organizations. Please refer to the IHE Technical Frameworks General Introduction, [Chapter 9 - Copyright Licenses](#) for copyright license information for frequently referenced base standards. Information pertaining to the use of IHE International copyrighted materials is also available there.

10 Trademark

- 200 IHE® and the IHE logo are trademarks of the Healthcare Information Management Systems Society in the United States and trademarks of IHE Europe in the European Community. Please refer to the IHE Technical Frameworks General Introduction, [Chapter 10 - Trademark](#) for information on their use.

IHE Technical Frameworks General Introduction Appendices

- 205 The [IHE Technical Framework General Introduction Appendices](#) are components shared by all of the IHE domain technical frameworks. Each technical framework volume contains links to these documents where appropriate.

- 210 *Update the following appendices to the General Introduction as indicated below. Note that these are **not** appendices to this domain's Technical Framework (TF-1, TF-2, TF-3 or TF-4) but rather, they are appendices to the IHE Technical Frameworks General Introduction located [here](#).*

[Appendix A](#) – Actors

215

*Add the following **new or modified** actors to the [IHE Technical Frameworks General Introduction Appendix A](#):*

Actor	Definition
None	

[Appendix B](#) – Transactions

220

*Add the following **new or modified** transactions to the [IHE Technical Frameworks General Introduction Appendix B](#):*

Transaction	Definition
None	

225

230 **Appendix D – Glossary**

*Add the following **new or modified** glossary terms to the [IHE Technical Frameworks General Introduction Appendix D](#):*

235

Term	Definition
No new terms	

Volume 1 – Profiles

Domain-specific additions

240 Not applicable

<i>Add Section X</i>

245 **X Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR) Profile**

Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR) Profile provides a means to capture and communicate information needed to report births and fetal deaths for vital registration purposes. BFDR-LDS-VR builds upon the earlier Birth and Fetal Death Reporting (BFDR) Profile that utilizes actors and transactions defined in the ITI
250 Retrieve Form for Data Capture (RFD) Profile or the Mobile Retrieve Form for Data Capture (mRFD) Profile to capture structured data using digital forms.

BFDR-LDS-VR 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 according to specified pre-population rules.
255 BFDR-LDS-VR 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-LDS-VR also defines a FHIR query and associated pre-population rules to be used with
260 mRFD to pre-populate the provider report form.

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

BFDR-LDS-VR also defines a mechanism to transform form submission data and transmit it as a standard HL7 v2 message. The BFDRFeed [QRPH-37] transaction adapts the HL7 V2.6 BFDR
270 Message for this purpose. BFDR-LDS-VR defines the BFDRFeed transaction to transmit this message.

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-LDS-VR Profile defines three ways to exchange data required for birth and fetal death reporting in an electronic form. First, creation of a BFDR Provider Live Birth FHIR Report Document and a BFDR Provider Fetal Death Report 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 from a Labor and Delivery Summary Document (LDS) 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 FHIR Document, the BFDR Fetal Death FHIR Document, or the BFDR message format.

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



Figure X.1-1: BFDR-LDS-VR Actor Diagram

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

Actors (see Note 1 and Note 2)	Transactions	Optionality	TF Reference
Content Creator	NA	NA	NA
Content Consumer	NA	NA	NA

Table X.1-2: BFDR-LDS-VR Profile - Actors and Content Modules

Actors	Content Modules	Optionality	Reference
Content Creator	LDS-VR Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1)	R	QRPH TF-3: 6.3.1.D3.5
Content Consumer	LDS-VR Document (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1)	R	QRPH TF-3: 6.3.1.D3.5

X.1.1 Actor Descriptions and Actor Profile Requirements

295 X.1.1.1 Content Creator

The Content Creator SHALL be able to create a valid BFDR-LDS-VR according to the detailed roles fully defined in

Detailed rules for the BFDR Provider Live Birth Composition Bundle are fully defined in QRPH TF-3: 6.3.

300 X.1.1.2 Content Consumer

The Content Consumer SHALL consume a valid BFDR-LDS-VR Document which is fully defined in QRPH TF-3: 6.3. For this profile content, this would typically be accomplished in the context of pre-populating a form when grouped with ITI-RFD Form Manager.

X.2 Actor Options

305 Options that may be selected for each actor in this profile, if any, are listed in Table X.2-1. Dependencies between options when applicable are specified in notes.

Table X.2-1: BFDR-LDS-VR - Actors and Options

Actor	Option Name	TF Reference
Content Creator	None	
Content Consumer	View ^{Note 1}	PCC TF-2: 3.1.1
	Document Import ^{Note 1}	PCC TF-2: 3.1.2
	Discrete Data Import ^{Note 1}	PCC TF-2: 3.1.4

Note 1: At least one of these options SHALL be supported.

310 X.3 BFDR-LDS-VR Required Actor Groupings

An actor from this profile (Column 1) shall implement all of the required transactions and/or content modules in this profile *in addition to* all of the transactions required for the grouped actor (Column 2).

315 Section X.5 describes some optional groupings that may be of interest for security considerations and Section X.6 describes some optional groupings in other related profiles.

Table X.3-1: BFDR-LDS-VR - Required Actor Groupings

BFDR-LDS-VR Actor	Actor to be grouped with	Reference	Content Bindings Reference
Content Creator with Antepartum Import Option	PCC APS Content Consumer with Discrete Data Import Option	QRPH TF-1: X.2.4	PCC TF Antepartum Profiles Trial Implementation Supplement, Vol 1, Sec X PCC TF-2: 3.1.4 ^{Note 1}
Content Consumer	Form Manager	--	--
	Form Processor	ITI-TF-1:17.2	

X.4 BFDR-LDS-VR Overview

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. 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 (EMR). 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.

The national statistics agencies have a long and enduring history that serves to provide essential data on births and deaths. Within the United States, for instance, this 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. This profile specifies the clinical content required to determine the information that is supplied in the reporting to vital records.

X.4.1 Concepts

Some jurisdictions have established detailed specifications for collecting and reporting the items on the Certificate of Live Birth and the Report of Fetal Death. It is critical that all vital registration areas follow these standards to promote uniformity in data collection across registration areas.

The hospital is responsible for completing the Record of Live Birth in the jurisdiction's Electronic Birth Registration System (EBRS). Facility Worksheet data transmitted electronically into the EBRS from the EMR 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.

345 In the following use case, the BFDR-LDS-VR is used as a pre-population document for a forms-based data capture approach using Retrieve Form for Data Capture (RFD). The birth information specialist (BIS) will review and complete the Facilities Worksheet using information that has been prepopulated using the BFDR-LDS-VR. 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
350 data submission for specific jurisdictional implementations. These use cases describe how the content derived by the forms pre-population from the BFDR-LDS-VR are further conveyed to the EBRS through the grouping the RFD Form Receiver or Form Processor with other BFDR family profiles. While these other profiles are not in scope for this BFDR-LDS-VR document, the use cases below describe the complete flow for conveying the report content from the
355 provider system to the jurisdiction.

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 with the BFDR-LDS-VR. The Form Receiver or
360 Form system transforms the information into a BFDR Birth or Fetal Death Reporting v2.6 message from the QRPH-37 profile options, and transmit the information to Public Health EBRS.

X.4.2.1.1 Use Case Description

When the delivery has been documented in the system, a Labor and Delivery Summary
365 document (BFDR-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) Form 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 EMR system.

X.4.2.1.2.2 Main Flow

This flow captures the EBRS information using forms provided by public health and transmits
375 the data that is captured to public health using HL7 Messaging (BFDRFeed [QRPH-37]).

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 use case is defined by ITI RFD. 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-LDS-VR is described below.

The provider EMR presents the Facilities Worksheet providing a BFDR-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 birth information specialist may also interview the mother for completion of the mother’s information to complete the reporting for the birth or fetal death. The Form Receiver Message Exporter transforms the information from the form into an HL7 BFDRFeed [QRPH-37] message and transmits that message to the EBRs system using the BFDRFeed [QRPH-37] transaction using the provider to jurisdiction reporting options for Report Jurisdiction Fetal Death

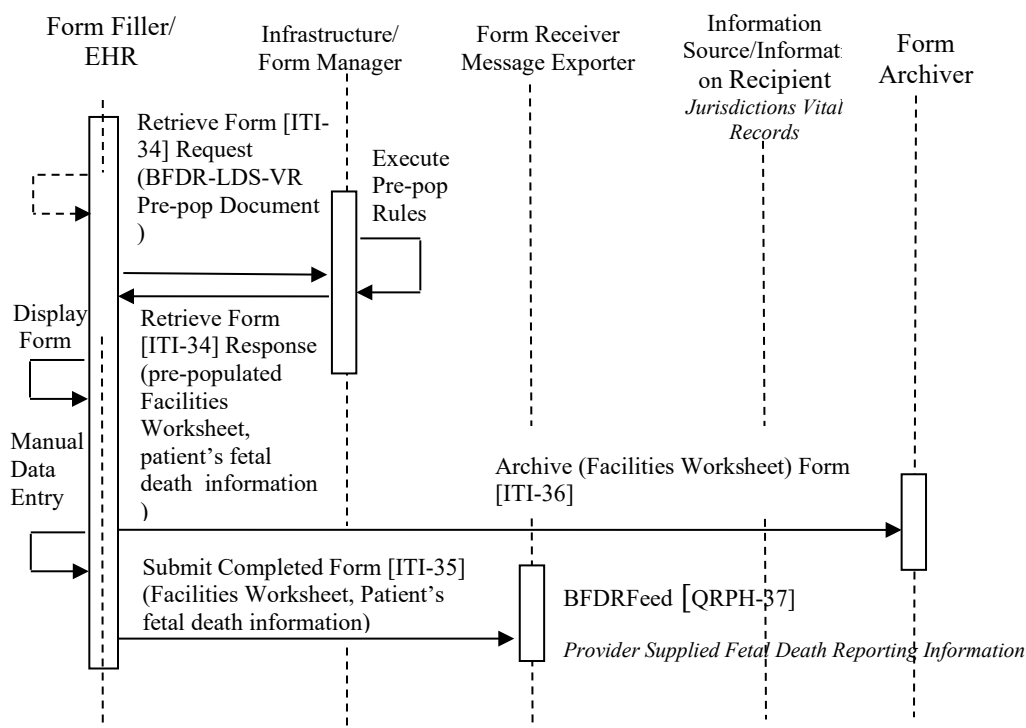


Figure X.4.2.1.3-1: Use Case 1 - Forms Data Capture with Messaging

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 with the BFDR-LDS-VR

document, and the Form Receiver (or Form Processor) system transforms the information into a BFDR Birth FHIR Document or a BFDR Fetal Death FHIR Document. Transforms to BFDR FHIR documents are defined in QRPH-BFDR-E. The Form Receiver or Form Processor
400 transmits 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 (BFDR-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
405 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 or Fetal Death Reporting FHIR document using the transforms defined in QRPH-BFDR-E.

X.4.2.2.2 Processing Steps

X.4.2.2.2.1 Pre-conditions

410 A delivery has been documented in the EMR system.

X.4.2.2.2.2 Main Flow

This flow captures the EBRS information using forms prepopulated by the BFDR-LDS-VR document defined in this profile, and transmits the data that is captured to public health using the BFDR FHIR document.

X.4.2.2.2.3 Post-conditions

415 The EBRS has received the data.

X.4.2.2.3 Process Flow

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

The provider EMR presents the Facilities Worksheet providing a BFDR-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
425 the content to the EBRS by way of a transform to the corresponding BFDR Provider Live Birth Report FHIR Document or the BFDR Provider Fetal Death Report FHIR Document.

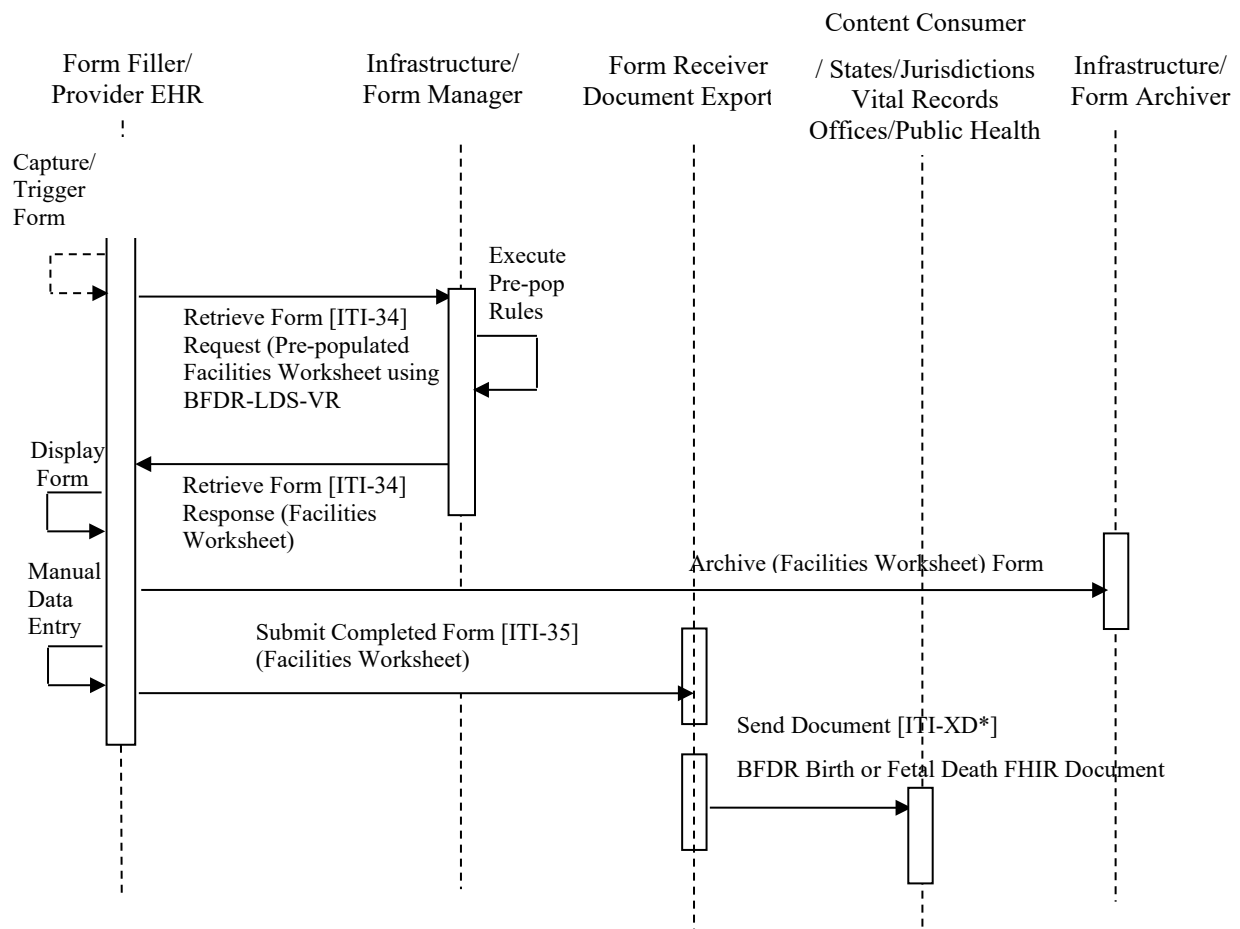


Figure X.4.2.2.3-1: Use Case 2- Forms Data Capture with Document Submission

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

The birth information specialist logs into the EMR and accesses the record of a newborn patient to begin the process of completing information required for birth and fetal death reporting. The EMR presents a form to the BIS that contains some data that has been pre-populated using the information from the BFDR-LDS-VR. 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, additional EBRs processing completed, and the record is filed electronically by the EBRs with the state vital statistics office.

X.4.2.3.1 Use Case Description

When the delivery has been documented in the system, a BFDR-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 Processor. The RFD Form Processor information is consumed directly by the EBRS.

X.4.2.3.2 Processing Steps

X.4.2.3.2.1 Pre-conditions

445 A delivery has been documented in the EMR 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.

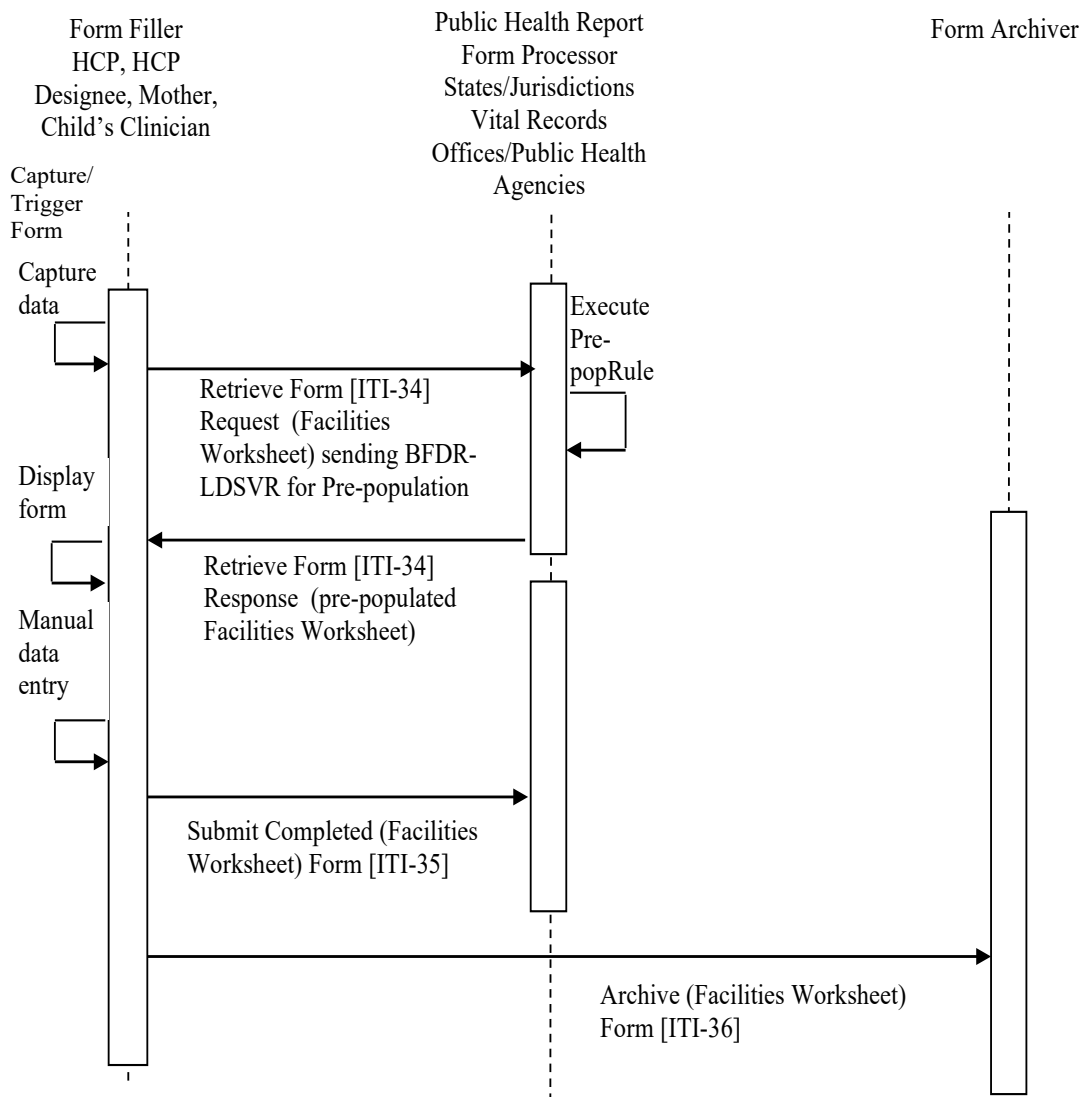
X.4.2.3.2.3 Post-conditions

450 The EBRS has received the data.

X.4.2.3.3 Process Flow

The provider EMR presents the Facilities Worksheet providing a BFDR-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 Processor information is consumed directly by the EBRS.

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

X.5 Security Considerations

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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 Audit Trail and Node Authentication (ATNA) 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 Document Digital Signature (DSG) Profile 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, the Cross-Enterprise User Assertion (XUA) Profile MAY be utilized to support this implementation.

X.6 Cross Profile Considerations

The following informative narrative is offered as implementation guidance.

X.6.1 RFD –Retrieve Form for Data Capture

The BFDR-LDS-VR document may be used with Retrieve form for Data Capture for pre-population. To accomplish this, the Content Creator should be grouped with the Form Filler of RFD, and the Content Consumer should be grouped with the Form Manager or Form Processor of RFD.

X.6.2 XD*– 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-LDS-VR 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-LDS-VR 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).
- 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-LDS-VR Content Creator. A Portable Media Importer in XDM might be grouped with the BFDR-LDS-VR Content Consumer.

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- 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-LDS-VR Content Creator. A Document Recipient in XDR might be grouped with the BFDR-LDS-VR Content Consumer.

X.6.3 Sharing Value Sets (SVS)

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

510

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

515

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

Add to Section 5.1.2 IHE ActCode Vocabulary

No new ActCode vocabulary

520

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

525 6.3.1.D1 Labor and Delivery Summary for Vital Records (LDS-VR) Document

6.3.1.D1.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:qrph:LDS-VR:2014**

6.3.1.D1.2 Parent Template(s)

530 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.D1.3 Referenced Standards

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

Table 6.3.1.D1.3-1: Referenced Standards

Abbreviation	Title	URL
CDAR2	HL7 CDA Release 2.0	http://www.hl7.org/Library/General/HL7_CD_A_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

535 6.3.1.D1.4 Data Element Mapping to CDA

Refer to Section 6.6.1 Form Data Element Mappings from Pre-Pop Document for mapping from BFDR Form data elements to the pre-pop LDS-VR CDA Document

6.3.1.D1.5 Content Module Specifications

540 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.D1.5.1 Document Constraints

545 The following table describes the header, sections, subsections, and entries that compose the LDS-VR document. Subsections are indicated by '+' and '++' for sub-sub-sections.

Table 6.3.1.D1.5.1-1: 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			
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]		componentOf/EncounteringEncounter	NA	PCC TF-2: 6.3.1.1.3	Section 6.3.1.D3.5.2.1
R[0..1]		Subject Participation	1.3.6.1.4.1.19376.1.5.3.1.4.15.2	PCC TF-2: 6.3.4.94	Section 6.3.1.D3.5.2.2
Sections					
R[1..1]		Hospital Admission Diagnosis	1.3.6.1.4.1.19376.1.5.3.1.3.3	PCC TF-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-2: 6.3.3.3.2	Section 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-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-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-2: 6.3.3.6.2	None

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R[1..1]		Pain Assessment Panel	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	PCC TF-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-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-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-2: 6.3.3.2.37	Section 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-2: 6.3.3.2.18	Section 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-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-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-2: 6.3.3.2.3	Section 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-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-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-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-2: 6.3.3.4.30	Section 6.3.1.D3.5.3.5
R2[0..1]		+Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	PCC TF-2: 6.3.3.4.5	Section 6.3.1.D3.5.3.6
R[1..1]		Estimated Delivery Dates	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	PCC TF-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-2: 6.3.3.3.3	Section 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-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-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-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-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-2: 6.3.3.2.44	None

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R[1..1]		Labor and Delivery Events	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	PCC TF-2: 6.3.3.2.39	Section 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-2: 6.3.3.8.3	Section 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-2: 6.3.3.2.49	Section 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-2: 6.3.3.2.40	Section 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-2: 6.3.3.4.2	Section 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-2: 6.3.3.4.5	Section 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-2: 6.3.3.4.6	Section 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-2: 6.3.3.4.26	Section 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-2: 6.3.3.4.20	Section 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-2: 6.3.3.4.25	Section 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-2: 6.3.3.4.22	Section 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-2: 6.3.3.4.27	Section 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-2: 6.3.3.2.3	Section 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-2: 6.3.3.8.3	Section 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-2: 6.3.3.3.3	Section 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-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-2: 6.3.3.2.49	Section 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-2: 6.3.3.5.2	Section 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-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-2: 6.3.3.7.1	Section 6.3.1.D3.5.3.20

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

6.3.1.D1.5.2.1 documentationOf/encompassingEncounter

550 **Admission Source** SHALL indicate whether the mother was transferred from another organization using the following value set unless further extended by national extension:

Transfer In (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177](#)

In:

ClinicalDocument/componentOf/encompassingEncounter/sdtc:admissionSourceCode

555

Facility name of the source of admission SHALL indicate the name of the organization the mother was transferred IF KNOWN

In:

The name of the organization that was the source of the transfer SHALL be recorded in:

560 /encompassingEncounter/encounterParticipant[@typeCode='REF']/assignedEntity/representedOrganization

Facility name where the Birth Occurred SHALL be included in:

ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/location/addr

565 **Facility ID (Jurisdiction Provider ID e.g., US NPI)** SHALL be included in:

ClinicalDocument/componentOf/encompassingEncounter
/location/healthCareFacility/serviceProviderOrganization/id

Facility Town/City SHALL be included in:

570 ClinicalDocument/componentOf/encompassingEncounter
/location/healthCareFacility/serviceProviderOrganization/addr/city

Facility County/Region SHALL be included in:

575 ClinicalDocument/componentOf/encompassingEncounter
/location/healthCareFacility/serviceProviderOrganization/addr/county

using the following value set unless further extended by national extension:

County [2.16.840.1.114222.4.11.829](#)

Or as specified by national extension

580 **6.3.1.D1.5.3 Body - Further Vocabulary or Conditional Constraints**

6.3.1.D1.5.3.1 Admission Medication History

Medication Coded Product

This is implementer guidance regarding appropriate coding to use for specific concepts.

The value set shall not be limited or constrained in this implementation guide.

585 IF the case has any of the following THEN they SHALL be included.

Where these medications have been administered and resulted in this pregnancy, the information about the use of these medications SHALL be recorded using the following value set unless further extended by national extension:

Fertility Enhancing Drugs Medications (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144](#)

590 SHALL be included in:

ClinicalDocument//structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.20']]

/entry/substanceAdministration/ consumable/manufacturedProduct/labeledDrug/code

Medication Administration Date and Time

595 The substance administration date SHALL be included to represent the date or range of dates when these medications were administered:

ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.20']]

/entry/substanceAdministration/effectiveDate

600 **6.3.1.D1.5.3.2 Coded History of Infection**

This is implementer guidance regarding appropriate coding to use for specific concepts.

The value set shall not be limited or constrained in this implementation guide.

Where the antepartum history is available only through scanned documents or through verbal intake, these attributes should be documented in the patient record and included in the LDS-VR.

605 These attributes may be available in the Antepartum Summary. Mapping of these attributes from the Antepartum Summary to the LDS-VR is provided in Table 6.6.4-1: Discrete Data Import Elements Data Mapped to LDS-VR Content Document Modules for Birth in support of the Antepartum Import Option. IF the case has any of the following THEN they SHALL be included.

610 Where these conditions exist,

Infection History Problem SHALL be specified using codes from the following value sets unless further extended by national extension:

- 615 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](#)
620 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](#)
- In:
625 ClinicalDocument/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/value
Where the following location SHALL be populated with the code for 'finding', '404684003'
In:
630 ClinicalDocument/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

6.3.1.D1.5.3.3 Pregnancy History

This document is only concerned with information for the current pregnancy. The pregnancy History section SHALL contain only information about the status of the pregnancy history as of the current pregnancy resulting in this LDS.

- 635 Where the antepartum history is available only through scanned documents or through verbal intake, these attributes should be documented in the patient record and included in the LDS-VR. These attributes may be available in the Antepartum Summary. Mapping of these attributes from the Antepartum Summary to the LDS-VR is provided in Table 6.6.4-1: Discrete Data Import Elements Data Mapped to LDS-VR Content Document Modules for Birth in support of the
640 Antepartum Import Option.

Significant Dates: The concept domain bound to the PregnancyObservation/code/@code SHALL be bound to the value set defined to combine the following value sets unless further extended by national extension.

645

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](#)

650

(e.g., spontaneous or induced losses or ectopic pregnancy)

First Prenatal Care Visit (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133](#)

In:

ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]

655

/entry/observation/code

Documenting the associated Date-Timestamp

In:

ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]

660

/entry/observation/effectiveTime

For the First Prenatal Care Visit, the following guidance should be noted:

1. First Prenatal Care Visit effectiveTime SHALL be NULL if any of the following are true:

665

- a. the patient received prenatal care but the information is not in the record
- b. it is unknown whether or not the patient received prenatal care
- c. there was no prenatal care

Significant metrics: PregnancyObservation/code/@code SHALL be bound to the value set defined to combine the following value sets unless further extended by national extension.

670

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](#)

675 Number of Previous Cesareans (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148](#)

Number Prenatal Care Visits (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135](#)

Previous Other Pregnancy Outcomes (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121](#)

In:

680 ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]

/entry/observation/code

Documenting the associated count as an INT

In:

685 ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]

/entry/observation/value

For the Number of Prenatal Care Visits, the following guidance should be noted:

- 690
1. The value SHALL be NULL if this is unknown or not available in the record.
 2. The value SHALL be the count of the total number of prenatal visits
 - a. Count only visits recorded in the most current record available. Do not estimate additional prenatal visits when the prenatal record is not up to date
 - b. The value SHALL be '0' only if it is known that there were no prenatal care visits.

695

Pregnancy History Findings:

Risk Factors During Pregnancy

700 Where there are Risk Factors During Pregnancy, this SHALL be represented in PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy AND SHALL be bound to the coded values in the following value set unless further extended by national extension where these conditions were present during this pregnancy or impacting the care of this pregnancy.

Previous Cesarean (NCHS) [2.16.840.1.114222.4.11.7165](#)

705 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](#)
710 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](#)

In

ClinicalDocument/structuredBody

715 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]
/entry/observation/ value/@code

No Prenatal Care

720 Where there was No Prenatal Care during the pregnancy, this SHALL be represented in
PregnancyObservation/code/@code='73776-7' CodeSystemName= 'LOINC', DisplayName='
No-prenatal care indicator' AND
documenting the associated indicator as an BL in /value@value= Boolean

6.3.1.D1.5.3.4 Active Problems

725 **Problems**, SHALL include the following problems where these conditions existed during the
pregnancy if known:

Induction of Labor Finding (NCHS) 2.16.840.1.114222.4.11.7531
Method of Delivery Vaginal-Spon Finding (NCHS) 2.16.840.1.114222.4.11.7526
[Method of Delivery Vaginal Forceps Finding \(NCHS\)](#) 2.16.840.1.114222.4.11.7528
Method of Delivery Vaginal Vacuum Finding (NCHS) 2.16.840.1.114222.4.11.7529
730 [Method of Delivery Cesarean Finding \(NCHS\)](#) 2.16.840.1.114222.4.11.7527
[Trial of Labor](#) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115](#)
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](#)

735	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
740	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
745	Pregnancy Resulting From Fertility Enhancing Drugs (NCHS) 2.16.840.1.114222.4.11.7423
	Previous Cesarean (NCHS) 2.16.840.1.114222.4.11.7165
	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
750	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
	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
755	Assistive Reproductive Technology (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146
	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
760	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

765

SHALL include the following problems where these conditions existed during the delivery if known:

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](#)

770

In:

ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]

/entry/act/entryRelationship/observation/value Where the following location SHALL be populated with the code for 'finding', '404684003'

775

ClinicalDocument/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]

/entry/act/entryRelationship/observation/code

6.3.1.D1.5.3.5 Coded Detailed Physical Examination

780

The Coded Detailed Physical Examination Section SHALL be Required if Known and SHALL include the Coded Vital Signs Section.

6.3.1.D1.5.3.6 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

Mother's Height SHALL be included, using the value set:

Height (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190](#)

785

In:

ClinicalDocument/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/organizer/component /observation/code

790

The height measurement SHALL be provided using

ClinicalDocument/ 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']]

795 /entry/organizer/component /observation/value

And the height SHALL be expressed using UCUM for units with the preference to express in feet and inches.

Mother's Weight SHALL be included, using the value set:

800 Body Weight (NCHS) [2.16.840.1.114222.4.11.7421](#)

The weight measurement SHALL be provided using

ClinicalDocument/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]]

805 /entry/organizer/component /observation/value

And the weight SHALL be expressed using UCUM for units with the preference to express in pounds.

with methodCode detailed using the following value set unless further extended by national extension:

810 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](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1']]

815 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2']]

/entry/organizer/component /observation/methodCode

6.3.1.D1.5.3.7 Medications Administered

Medication Coded Product SHALL include the coded product name using the following value sets unless further extended by national extension where these products were given to the patient:

820 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/Spinal Anesthesia - Medication (NCHS) [2.16.840.1.114222.4.11.7475](#)

In:

ClinicalDocument /component/structuredBody

825 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]

/entry/substanceAdministration/consumable/manufacturedProduct/labeledDrug/code

830 **Route** SHALL specifically indicate the route where IV or IM administration route is used to administer the medications using the following value sets unless further extended by national extension:

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](#)

In:

ClinicalDocument/component/structuredBody

835 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]

/entry/substanceAdministration/routeCode

SHALL include the administration dates/times

In:

840 ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]

/entry/substanceAdministration/effectiveTime:

6.3.1.D1.5.3.8 Labor and Delivery Events

No further constraints.

845 **6.3.1.D1.5.3.9 Labor and Delivery Events.Procedures and Interventions**

Procedure SHALL include the coded procedure using the following value sets unless further extended by national extension where these procedures were performed on the patient:

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](#)

850 Spinal Anesthesia - Procedure (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29](#)

Induction of Labor (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34](#)

Steroids For Fetal Lung Maturation (NCHS) [2.16.840.1.114222.4.11.7423](#)

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](#)

855 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](#)

860 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](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3']]

865 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

/entry/procedure/code

Procedure Date and Time SHALL be included for all procedures performed if known in:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3']]

870 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

/entry/procedure/effectiveTime

For External Cephalic Version, the procedure should be documented whether it is performed during prenatal care record or during labor and delivery.

For Failed External Cephalic Version, document External Cephalic Version (NCHS)

875 [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127](#) as INT, with Negation=TRUE

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

Delivery (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14](#)

In:

880 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='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

/entry/procedure/code

885 the Procedures and Interventions SHALL also indicate the **NPI** in:

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='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

/entry/procedure/performer/assignedEntity/id

890 ***Provider Type*** in:

using value sets:

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](#)

895 Midwife (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18](#)

In:

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='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

900 /entry/procedure/performer/assignedEntity/code

Provider Name in:

ClinicalDocument/ component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3']]

905 /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

Route and Method of Delivery SHALL be documented using the following value sets unless further extended by national extension:

910 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](#)

915 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](#)

In:

ClinicalDocument/ component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3']]

920 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11']]

/entry/procedure/methodCode

6.3.1.D1.5.3.10 Labor and Delivery Events.Coded Event Outcomes

Coded Event Outcome

925 ***Birth Counts:*** The birth counts SHALL be provided if known using the following value sets unless further extended by national extension:

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](#)

In:

930 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 observation/code

935 Documenting the associated the count as INT in:

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/ observation/value

940

Delivery Findings:

Delivery findings SHALL be bound to the coded values in the following value sets unless further extended by national extension where these conditions were present resulting from the delivery.

Fetal Intolerance of Labor (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30](#)

945 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](#)
- 950 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](#)
- Route Method of Delivery - Trial of Labor (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115](#)
- 955 Antibiotics Received During Labor Finding (NCHS) 2.16.840.1.114222.4.11.7535
- Method of Delivery Vaginal-Spon Finding (NCHS) 2.16.840.1.114222.4.11.7526
- Method of Delivery Cesarean Finding (NCHS) 2.16.840.1.114222.4.11.7527
- Method of Delivery Vaginal Forceps Finding (NCHS) 2.16.840.1.114222.4.11.7528
- Method of Delivery Vaginal Vacuum Finding (NCHS) 2.16.840.1.114222.4.11.7529
- 960 Scheduled Cesarean Finding (NCHS) 2.16.840.1.114222.4.11.7530
- Induction of Labor Finding (NCHS) 2.16.840.1.114222.4.11.7531
- Augmentation of Labor Finding (NCHS) 2.16.840.1.114222.4.11.7532

Where the following location SHALL be populated with the code for ‘finding’, ‘404684003’

In:

- 965 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[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.5.2']]
- / observation[code[@code="404684003"]]/value

970

Patient Transferred SHALL be documented using the following value set unless further extended by national extension:

ICU Care (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188](#)

In:

- 975 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']]
/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']]
/entry/act[@code='107724000']/entryRelationship/observation/value

980

6.3.1.D1.5.3.11 Newborn Delivery Information

6.3.1.D1.5.3.11.1 Subject Participation

Multiple Birth

985 IF KNOWN, sdtc:multipleBirthInd SHALL be present to indicate whether the infant or fetus is part of a multiple birth in

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/relatedSubject/subject/sdtc:multipleBirthInd

990 ***Multiple Birth Order***

IF KNOWN, sdtc:birthOrder SHALL be present to indicate the order of the infant or fetus in a multiple birth in:

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

Infant's birthTime SHALL be present to indicate date and time of the birth in:

ClinicalDocument/structuredBody/component
/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]
1000 /subject/relatedSubject[code[@code='NCHILD' AND id=idOfTheChild]]
/subject/birthTime

IF THE INFANT HAS DIED, ***Fetus/Infant deceasedIndicator*** SHALL be present to indicate that the infant was not living at the time of the report in:

1005 ClinicalDocument/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/sdtc:deceasedInd

- 1010 Infant's Medical Record Number SHALL be present to indicate the number assigned by the organization for the child in:

ClinicalDocument/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]]/sdtc:id

1015

Administrative Gender SHALL be present to indicate the sex of the baby in:

ClinicalDocument/component/structuredBody/component

/section[templateId[@root='2.16.840.1.113883.10.20.1.21']]

/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]

- 1020 /subject/relatedSubject/administrativeGenderCode

6.3.1.D1.5.3.12 Newborn Delivery Information.Coded Physical Detailed Examination

Neurologic Systems: 1.3.6.1.4.1.19376.1.5.3.1.1.9.35

- 1025 **Neurologic Conditions** SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable):

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](#)

- 1030 Cleft Palate Alone (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189](#)

In:

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]

- 1035 /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/observation/value

Where the following location SHALL be populated with the code for ‘finding’, ‘404684003’

In:

1040 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']]

1045 /entry/ observation/code

Heart 1.3.6.1.4.1.19376.1.5.3.1.1.9.29

Heart Conditions SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable):

1050 Cyanotic Congenital Heart Disease (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54](#)

In:

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]
1055 /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/observation/value

Where the following location SHALL be populated with the code for ‘finding’, ‘404684003’

In:

1060 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']]

1065 /entry/ observation/code

Digestive System 1.3.6.1.4.1.19376.1.5.3.1.1.9.31

Digestive Conditions SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable)

1070

Gastroschisis of the Newborn (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]

1075

/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/ observation/value

Where the following location SHALL be populated with the code for 'finding', '404684003'

1080

In:

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']]

1085

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.31']]

/entry/ observation/code

Musculoskeletal System 1.3.6.1.4.1.19376.1.5.3.1.1.9.34

Musculoskeletal Conditions SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable)

1090

Limb Reduction Defect (NCHS) [6.1.4.1.19376.1.7.3.1.1.13.8.64](#)

In:

ClinicalDocument/component/structuredBody

1095

/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/ observation/value

1100 Where the following location SHALL be populated with the code for ‘finding’, ‘404684003’

In:

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]

1105 /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 /observation/code

Abdomen 1.3.6.1.4.1.19376.1.5.3.1.1.9.31

1110 **Abdominal Conditions** SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable)

Omphalocele of the Newborn (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66](#)

In:

1115 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']]

1120 /entry/ observation/value

Where the following location SHALL be populated with the code for ‘finding’, ‘404684003’

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]

1125 /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/ observation/code

Genitalia 1.3.6.1.4.1.19376.1.5.3.1.1.9.36

- 1130 **Genitalia Conditions** SHALL be populated with coded findings from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable)

Hypospadias (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63](#)

In:

- 1135 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']]

- 1140 /entry/ observation/value

Where the following location SHALL be populated with the code for 'finding', '404684003'

In:

- ClinicalDocument/component/structuredBody
/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]
1145 /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/ observation/code

- 1150 **6.3.1.D1.5.3.13 Newborn Delivery Information.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

Body Weight SHALL be included, using the following value set unless further extended by national extension:

Body Weight (NCHS) [2.16.840.1.114222.4.11.7421](#)

- 1155 In:

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']]

1160 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2']]
/entry/organizer/component /observation/code

The weight measurement SHALL be provided using
ClinicalDocument/component/structuredBody

1165 /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/organizer/component /observation/value

1170 And the weight SHALL be expressed using UCUM for units with the preference to express in grams.

with methodCode detailed using the following value set unless further extended by national extension:

Birth Weight (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20](#)

1175 In:
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']
1180]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2']]
/entry/organizer/component /observation/methodCode

6.3.1.D1.5.3.14 Newborn Delivery Information.Coded Detailed Physical Examination.General Appearance

1185 **General Appearance Findings** SHALL be populated with coded findings (from the following value sets unless further extended by national extension where the condition exists in the newborn (units are not applicable):

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](#)

1190 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](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='

1195 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']]

1200 /entry /observation/code

Apgar Score SHALL be provided for the **5-Minute Apgar Score**, using the value set:

5 Min Apgar Score (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12](#)

1205 IF the 5-Minute Apgar Score is <= 5, then the **10-Minute Apgar Score** SHALL be provided, Identified using the value set:

10 Min Apgar Score (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13](#)

In:

ClinicalDocument/component/structuredBody

1210 /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/observation/code

1215

The Apgar Scores (value) SHALL be provided using

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]

1220 / 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/observation/value

where the value is INT<=10

1225 **6.3.1.D1.5.3.15 Newborn Delivery Information.Active Problems**

Problem Code SHALL be included for the using the following value sets unless further extended by national extension where these conditions are present:

- 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](#)
- 1230 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](#)
- Cyanotic Congenital Heart Disease (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54](#)
- 1235 Gastroschisis of the Newborn (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62](#)
- Limb Reduction Defect (NCHS) [6.1.4.1.19376.1.7.3.1.1.13.8.64](#)
- Omphalocele of the Newborn (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66](#)
- Hypospadias (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63](#)
- Significant Birth Injury (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9](#)
- 1240 Neonatal Death (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149](#)
- 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](#)
- 1245 Assisted Ventilation for >6 hours Finding (NCHS) [2.16.840.1.114222.4.11.7534](#)
- Assisted Ventilation Finding (NCHS) [2.16.840.1.114222.4.11.7533](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]

1250 /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

Problem Date and Time SHALL be included for all problems if known in:

ClinicalDocument/component/structuredBody

1255 /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

6.3.1.D1.5.3.16 Newborn Delivery Information.Procedures and Interventions

1260 **Procedure** SHALL include the coded procedure using the following value sets unless further extended by national extension where these procedures were performed on the patient:

Antibiotic Administration Procedure (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178](#)

Assisted Ventilation (NCHS) [2.16.840.1.114222.4.11.7156](#)

Karyotype Determination (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154](#)

1265 Autopsy Performed (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1](#)

Autopsy Planned (NCHS) [2.16.840.1.114222.4.11.7140](#)

Surfactant Replacement Therapy (NCHS) [2.16.840.1.114222.4.11.7431](#)

In:

ClinicalDocument/component/structuredBody

1270 /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

Procedure Date and Time SHALL be included for all procedures performed if known in:

1275 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

1280 **6.3.1.D1.5.3.17 Newborn Delivery Information.Medications Administered**

Medication Coded Product

SHALL include the coded product name using the following value sets unless further extended by national extension where these products were given to the patient:

1285 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](#)

In:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]

1290 /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/ consumable/manufacturedProduct/labeledDrug/code

1295 ***Route*** SHALL specifically indicate the route where IV or IM administration route is used where Antibiotics are administered for Neonatal Sepsis using the following value sets unless further extended by national extension:

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](#)

In:

1300 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']]

/entry/substanceAdministration/routeCode

1305

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

Neonatal Sepsis (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6](#)

In:

1310 ClinicalDocument/component/structuredBody

1315 /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']]
/entry/substanceAdministration/entryRelationship[@typeCode='RSON']
/observation[cda:templateId/@root='2.16.840.1.113883.10.20.1.28']/code

6.3.1.D1.5.3.18 Newborn Delivery Information.Coded Event Outcomes

Significant findings: SHALL be documented using the following value sets unless further extended by national extension if known.

1320 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](#)
Assisted Ventilation Finding (NCHS) 2.16.840.1.114222.4.11.7533
Assisted Ventilation for >6 hours Finding (NCHS) 2.16.840.1.114222.4.11.7534

In:

ClinicalDocument/component/structuredBody
1325 /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/ observation/value
Where the following location SHALL be populated with the code for 'finding', '404684003'

1330 In:

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']]
1335 /entry/ observation/code

Setting Where the Child was Born, SHALL include the observation code indicating the setting location:

1340 Birthplace Setting (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184](#)
In:

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']]

1345 /entry/ observation/code

Reflecting the setting where the child was born using the value sets:

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](#)

1350 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](#)

In:

ClinicalDocument/component/structuredBody

1355 /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/ observation/value

1360 ***Patient Transferred to NICU*** SHALL be documented using the following value set unless further extended by national extension:

NICU Care (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198](#)

In:

ClinicalDocument/component/structuredBody

1365 /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']]

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']]

/entry /observation/code

- 1370 AND in support of some jurisdictional needs, the date and time that the patient was transferred in to NICU MAY be documented using:

```
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]
1375 /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 /observation/effectiveTime[low]
```

- 1380 AND in support of some jurisdictional needs, the date and time that the patient was transferred out of MAY be documented NICU using:

```
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']]
1385 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']]
/entry /observation/effectiveTime[high]
```

Patient Transferred to Another Facility SHALL be documented using the following value set unless further extended by national extension:

- 1390 Transfer to (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190](#)

In:

```
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]
1395 /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/ participant[typeCode='DST']/participantRole[@typecode='SDLOC']/code
```

Documenting the Institution that the patient was referred to in:

```
ClinicalDocument/component/structuredBody
1400 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3']]
```

1405 /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/
 participant[typeCode='DST']/participantRole[@typecode='SDLOC']/playingEntityChoice/playingEntity/name

For Fetal Deaths, indication of whether a ***Histological Placental Examination was Performed*** shall be documented using

ClinicalDocument/component/structuredBody
1410 /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/ observation/code

Using the value set:

1415 Histological Placental Examination Performed (NCHS) [2.16.840.1.114222.4.11.7430](#)

And indicating whether or not the Histological Placental Examination was performed using

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]
1420 /component/section[templateId[@root='1.3.6.1.4.1.19376.1.7.3.1.1.13.7']]
 /entry /observation/value

Using the value set:

 Histological Placental Examination (NCHS) [2.16.840.1.114222.4.11.7138](#)

For Fetal Deaths, **Time of Fetal Death** SHALL be documented using

1425 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 /observation/code

1430 Using the value set:

 Estimated Time Of Fetal Death (NCHS) [2.16.840.1.114222.4.11.7426](#)

And indicating the Time point of the fetal death using

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]

1435 /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 /observation/value

Using the value set:

Fetal Death Time Point (NCHS) [2.16.840.1.114222.4.11.7112](#)

1440 **6.3.1.D1.5.3.19 Newborn Delivery Information.Coded Results**

Coded results,

Karyotype Results SHALL use the simple observation template to represent the following value set unless further extended by national extension for the 'code' element.

Karyotype Result (NCHS) [1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59](#)

1445 In:

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[templateID[@root='1.3.6.1.4.1.19376.1.5.3.1.4.13']]

1450 /observation/code

The 'value' element not constrained

6.3.1.D1.5.3.20 Payers

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

1455 SHOULD include payer information in:

ClinicalDocument/component/structuredBody

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7']]

/entry/act[code@code='48768-6']

1460 /entryRelationship/act[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.18']]/code

The <code> element SHOULD be present and represents the type of coverage provided by the payer. Potential vocabularies to use include:

Table 6.3.1.D1.5.3.20-1: Payer Type Vocabularies

Vocabulary	Description	OID
HL7 ActCoverageType	The HL7 ActCoverageType vocabulary describes payers and programs. Note that HL7 does not have a specific code to identify an individual payer, e.g., in the role of a guarantor or patient.	2.16.840.1.113883.5.4
X12 Data Element 1336	The X12N 271 implementation guide includes various types of payers. This code set does include a code to identify individual payers.	2.16.840.1.113883.6.255.1336

1465

6.3.1.D1.6 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.

1470

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

1475

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.

1480

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

1485

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

1490 This heading is not currently used in a CDA document.

6.5 Value Sets

1495 The following table describes each of the value sets used to support the BFDR-LDS-VR 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-LDS-VR Profile. Similarly, associated date related metadata attributes will change as a result of value set maintenance activities and can be obtained at the PHIN-VADS URL provided. BFDR-LDS-VR Vocabulary

1500 has dynamic binding of value sets. In dynamic binding the most current version of the value set in the terminology server is used.

6.5.1 Value Sets used by this profile

Table 6.5.1-1: Value Sets used in the BFDR-LDS-VR Profile

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
10 Min Apgar Score (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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
5 Min Apgar Score (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.53	To reflect Anencephaly of the Newborn as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.178	To reflect Antibiotic Administration Procedure during labor and delivery	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Antibiotics (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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
Antibiotics Received During Labor Finding (NCHS)	2.16.840.1.11 4222.4.11.75 35	To identify findings that the mother has received antibiotics during labor.	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7535	IHE BFDR
Artificial or Intrauterine Insemination (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.145	To reflect the Artificial or Intrauterine Insemination as a Risk Factor in Pregnancy	SNOME D-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)	2.16.840.1.11 4222.4.11.71 56	To reflect that the newborn was provided assisted ventilation reflecting an abnormal condition of the newborn	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7156	IHE BFDR
Assisted Ventilation Finding (NCHS)	2.16.840.1.11 4222.4.11.75 33	To identify findings that the newborn received assisted ventilation immediately following delivery.	PHIN VS (CDC Local Coding System)	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7533	IHE BFDR
Assisted Ventilation for >6 hours Finding (NCHS)	2.16.840.1.11 4222.4.11.75 34	To identify findings that the newborn received assisted ventilation for >6 hours following delivery.	PHIN VS (CDC Local Coding System)	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7533	IHE BFDR
Assistive Reproductive Technology (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.146	To reflect the Assistive Reproductive Technology as a Risk Factor in Pregnancy	SNOME D-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 Finding (NCHS)	2.16.840.1.11 4222.4.11.75 32	To identify findings that labor was augmented	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7532	IHE BFDR

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Augmentation of Labor - Medication (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.23	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.22	To reflect a procedure of Augmentation of Labor	SNOME D-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
Autopsy Planned (NCHS)	2.16.840.1.11 4222.4.11.7140	To reflect that an autopsy was planned	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7140	IHE BFDR
Birth Plurality of Delivery (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.132	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.20	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.197	To reflect the birth occurred in the at clinic or office	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197	IHE BFDR
Birth Place Freestanding Birthing Center (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.196	To reflect the birth occurred at a freestanding birthing center	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196	IHE BFDR
Birth Place Home Intended (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.193	To reflect the birth occurred in the at home as intended	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193	IHE BFDR

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Birth Place Home Unintended (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.194	To reflect the birth occurred in the at home as unintended	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194	IHE BFDR
Birth Place Home Unknown Intention (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.195	To reflect the birth occurred in the at home with intention unknown	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195	IHE BFDR
Birthplace Hospital (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.192	To reflect the birth occurred in the hospital	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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
Body Weight (NCHS)	2.16.840.1.11 4222.4.11.74 21	To Reflect the question as to the body weight of the patient	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7421	IHE BFDR
Breastfed Infant (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.41	To reflect Breastfed Infant at discharge	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.17	To reflect the Title of the Attendant responsible for the delivery Procedure as a Certified Midwife	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.125	To reflect Obstetric Procedures as Cervical Cerclage	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.93	To reflect Chlamydia as Infections present and treated during this pregnancy	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.24	To reflect a Chorioamnionitis During Labor	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Cleft Lip with or without Cleft Palate (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.58	To reflect Cleft Lip with/without Cleft Palate as an anomaly of the newborn	SNOME D-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 Palate Alone (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.189	To reflect Cleft Palate alone as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.180	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.55	To reflect Congenital Diaphragmatic Hernia as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.54	To reflect Cyanotic Congenital Heart Disease as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.167	To reflect infection with Cytomegalovirus	SNOME D-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
Date of Last Live Birth (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.67	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.69	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.70	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.14	To reflect the Delivery Procedure	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Doctor of Osteopathic Medicine (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.16	To reflect the Title of the Attendant responsible for the delivery Procedure as a Doctor of Osteopathic Medicine	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.61	To reflect Downs Syndrome as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.140	To reflect Risk Factors of Eclampsia	SNOME D-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/Spinal Anesthesia - Medication (NCHS)	2.16.840.1.11 4222.4.11.74 75	To Reflect an Epidural and Spinal Anesthesia Medication	RxNorm	http://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7475	IHE BFDR
Epidural Anesthesia - Procedure (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.27	To reflect an Epidural Anesthesia Procedure	SNOME D-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
Estimated Time Of Fetal Death (NCHS)	2.16.840.1.11 4222.4.11.74 26	To reflect the question as to the estimated time of fetal death	LOINC	http://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7426	IHE BFDR
External Cephalic Version (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.127	To reflect Obstetric Procedures as External Cephalic Version	SNOME D-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
Facility Location ICU (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Facility Location OR (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.104	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.43	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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.144	To reflect that Fertility Enhancing Drugs were administered as a risk factor for pregnancy	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144	IHE BFDR
Autopsy Performed (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.1	To reflect Autopsy was performed	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.23.8.1	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.	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7112	IHE BFDR
Fetal Presentation at Birth-Breech (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.108	To reflect the Fetal Presentation at Birth-Breech method of delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.109	To reflect the Fetal Presentation at Birth-Cephalic method of delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.110	To reflect the Fetal Presentation at Birth-Other	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Fever Greater Than 100.4 (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.25	To reflect a Fever Greater Than 100.4 During Labor	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.101	To reflect Fourth Degree Perineal Laceration as a maternal morbidity	SNOME D-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
Gastroschisis of the Newborn (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.62	To reflect Gastroschisis of the Newborn as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.137	To reflect Risk Factors of Gestational Diabetes	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.139	To reflect Risk Factors of Gestational Hypertension	SNOME D-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
Gonorrhea (NCHS)	2.16.840.1.11 4222.4.11.60 71	To reflect Gonorrhea as Infections present and treated during this pregnancy	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.6071	IHE BFDR
Group B Streptococcus (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.166	To reflect Infection with Group B Streptococcus	SNOME D-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)	2.16.840.1.11 4222.4.11.71 55	To reflect the mother's height	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7155	IHE BFDR
Hepatitis B (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.96	To reflect Hepatitis B as Infections present and treated during this pregnancy	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.97	To reflect Hepatitis C as Infections present and treated during this pregnancy	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
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	SNOME D-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
Hysterotomy Hysterectomy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150	To reflect hysterotomy/hysterec- tomy as the method of delivery in fetal death	SNOME D-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	SNOME D-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 Administ- ration	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	SNOME D-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
Induction of Labor Finding (NCHS)	2.16.840.1.114222.4.11.7531	To identify findings that labor was induced	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7531	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	SNOME D-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
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 Administ- ration	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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Karyotype Confirmed (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.56	To reflect Karyotype Confirmed as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.154	To reflect Karyotype determination as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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
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	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.42	To reflect the Male Gender	HL7 Administrative Gender	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42	IHE BFDR
Meningomyelocele/S pina Bifida - Newborn (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.65	To reflect Meningomyelocele/S pina Bifida of the Newborn as an anomaly of the newborn	SNOME D-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
Method of Delivery Cesarean Finding (NCHS)	2.16.840.1.11 4222.4.11.75 27	To identify findings of delivery of the entire fetus through the vaginal wall (cesarean)	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7527	IHE BFDR
Method of Delivery Vaginal Forceps Finding (NCHS)	2.16.840.1.11 4222.4.11.75 28	To identify findings of delivery of the fetus using vaginal forceps	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7528	IHE BFDR
Method of Delivery Vaginal-Spon Finding (NCHS)	2.16.840.1.11 4222.4.11.75 26	To identify findings of delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7526	IHE BFDR

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Method of Delivery Vaginal Vacuum Finding (NCHS)	2.16.840.1.114222.4.11.7529	To identify findings of delivery of the fetus using vaginal vacuum	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7529	IHE BFDR
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	SNOME D-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	SNOME D-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	SNOME D-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
Pregnancy Resulting From Fertility Enhancing Drugs (NCHS)	2.16.840.1.114222.4.11.7423	The value set contains a list of items to indicate whether a pregnancy resulted from fertility enhancing drugs	SNOME D-CT	http://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7423	IHE BFDR
Surfactant Replacement Therapy (NCHS)	2.16.840.1.114222.4.11.7431	Surfactant Replacement Therapy (NCHS)	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7431	IHE BFDR

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
NICU Care (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.198	To reflect the that the baby was transferred to NICU following the birth	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148	IHE BFDR
Number of Previous Live Births Now Dead (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.122	To reflect the Number of Previous Live Births Now Dead	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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.123	To reflect the Number of Live Births Now Living	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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.66	To reflect Omphalocele of the Newborn as an anomaly of the newborn	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Parvovirus (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.168	To reflect infection with Parvovirus	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.15	To reflect the Title of the Attendant responsible for the delivery Procedure as a Physician	SNOME D-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
Precipitous Labor (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.130	To reflect Onset of labor with Precipitous Labor	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.129	To reflect Onset of labor with Premature Rupture	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.136	To reflect Risk Factors of Prepregnancy Diabetes	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.138	To reflect Risk Factors of Prepregnancy Hypertension	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.141	To reflect Risk Factors of Preterm Birth (history)	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.147	To reflect Risk Factors of Pregnancy Previous Cesarean	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7165	IHE BFDR
Previous Other Pregnancy Outcomes (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.119	To reflect the Problem Status Active	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Prolonged Labor (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.131	To reflect Onset of labor with Prolonged Labor	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.114	To reflect the Route and Method of Delivery as Cesarean Delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.112	To reflect the Route and Method of Delivery as Forceps Delivery	SNOME D-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
Route and Method of Delivery - Scheduled C (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.116	To reflect the Route and Method of Delivery as Scheduled Cesarean	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.111	To reflect the Route and Method of Delivery as Spontaneous Delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.115	To reflect the Route and Method of Delivery if Cesarean was as Trial of Labor Attempted	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.113	To reflect the Route and Method of Delivery as Vacuum Delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.102	To reflect Ruptured Uterus as a maternal morbidity	SNOME D-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
Scheduled Cesarean Finding (NCHS)	2.16.840.1.11 4222.4.11.75 30	To identify findings that a Cesarean Section was scheduled	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7530	IHE BFDR
Seizure or Serious Neurologic Dysfunction (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.10	To reflect that the newborn suffered a Seizure or Serious Neurologic Dysfunction reflecting an abnormal condition of the newborn	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Significant Birth Injury (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.9	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	SNOME D-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 - Procedure (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.29	To reflect a Spinal Anesthesia Procedure	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.35	To reflect that there was a Spontaneous Onset of Labor	SNOME D-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
Steroids For Fetal Lung Maturation (NCHS)	2.16.840.1.114222.4.11.7425	The value set contains a list of items to indicate whether steroids (glucocorticoids) for fetal lung maturation was received by the mother before delivery	SNOME D-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7423	IHE BFDR
Suspected Chromosomal Disorder (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.57	To reflect Suspected Chromosomal Disorder as an anomaly of the newborn	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.98	To reflect Syphilis as Infections present and treated during this pregnancy	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.100	To reflect Third Degree Perineal Laceration as a maternal morbidity	SNOME D-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
Tocolysis (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1.13.8.128	To reflect Obstetric Procedures as Tocolysis	SNOME D-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

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Toxoplasmosis (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.169	To reflect infection with Toxoplasmosis	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.177	To reflect if the mother was transferred to this facility	Admit source (HL7)	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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.190	To reflect if the infant was transferred within 24 hours of delivery to another facility	SNOME D-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
Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.176	To reflect Transferred for Maternal Medical or Fetal Indications for Delivery	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.99	To reflect Transfusion Whole Blood or Packed Red Blood as a maternal morbidity	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.103	To reflect Ruptured Uterus as a maternal morbidity	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 13.8.105	To reflect Ruptured Uterus as a maternal morbidity	SNOME D-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)	1.3.6.1.4.1.19 376.1.7.3.1.1. 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

1505 None

Appendices to Volume 3

Appendix A – LDS-VR Document Quick Reference

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

1510 This table provides a reference showing the section structure of the LDS-VR document, the templateId's which each section 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.

Section Reference #	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
	<i>Problem Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.2		Entry
	<i>Problem Observation</i>	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
	<i>Medications</i>			Entry
3	Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	10154-3	Section
	<i>No entries defined</i>			Entry
4	Transport Mode	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	11459-5	Section
	<i>Transport (act)</i>	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
	<i>No Entries Defined</i>			Entry

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Section Reference #	LDS-VR	TemplateId	LOINC	Type
6	Pain Assessment Panel	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	38212-7	Section
	<i>No entries defined</i>			Entry
7	Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	30954-2	Section
	<i>Procedure Entry</i>	1.3.6.1.4.1.19376.1.5.3.1.4.19		Entry
	<i>References Entry</i>	1.3.6.1.4.1.19376.1.5.3.1.4.4		Entry
	<i>Simple Observation</i>	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
	<i>Antenatal Testing and Surveillance Battery</i>	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
	<i>Problem Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.2		Entry
	<i>Problem Observation</i>	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
	<i>Pregnancy History Organizer</i>	1.3.6.1.4.1.19376.1.5.3.1.4.13.5.1		Entry
	<i>Pregnancy Observation</i>	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
	<i>No Entries Defined</i>			Entry
12	History of Past Illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	11348-0	Section
	<i>Problem Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.2		Entry
	<i>Problem Observation</i>	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
	<i>Problem Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.2		Entry

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Section Reference #	LDS-VR	TemplateId	LOINC	Type
	<i>Problem Observation</i>	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
	<i>No entries defined</i>			Entry
15	Birth Plan	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	57079-6	Section
	<i>No entries defined</i>			Entry
16	Allergies and Other Adverse Reactions	1.3.6.1.4.1.19376.1.5.3.1.3.13	48765-2	Section
	<i>Allergy Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.3		Entry
	<i>Allergy Intolerances Observation</i>	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
	<i>No Entries Defined</i>			Entry
17.1	Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	8716-3	Section
	<i>Vital Signs Organizer</i>	1.3.6.1.4.1.19376.1.5.3.1.4.13.1		Entry
	<i>Vital Signs Observation</i>	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
	<i>Estimated Delivery Date Observation (a simple observation)</i>	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
	<i>Medications</i>	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
	<i>Intravenous Fluids (substanceAdministration)</i>	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
	<i>No entries defined</i>			Entry

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Section Reference #	LDS-VR	TemplateId	LOINC	Type
22	Estimated Blood Loss	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	8717-1	Section
	<i>Simple Observation</i>	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
	<i>No Entries Defined</i>			Entry
24	History of Surgical Procedures	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	10167-5	Section
	<i>No Entries Defined</i>			Entry
25	Labor and Delivery Events	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	57074-7	Section
	<i>No Entries Defined</i>			Entry
25.1	Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	10167-5	Section
	<i>Procedures</i>	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
	<i>Patient Transfer (act)</i>	1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1		Entry
	<i>Simple Observation</i>	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
	<i>No Entries Defined</i>			Entry
26.1	Detailed Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	29545-1	Section
	<i>No Entries Defined</i>			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
	<i>Vital Signs Organizer</i>	1.3.6.1.4.1.19376.1.5.3.1.4.13.1		Entry
	<i>Vital Signs Observation</i>	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
	<i>Problem Observation</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5		Entry

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Section Reference #	LDS-VR	TemplateId	LOINC	Type
26.2	Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	11450-4	Section
	<i>Problem Concern</i>	1.3.6.1.4.1.19376.1.5.3.1.4.5.2		Entry
	<i>Problem Observation</i>	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
	<i>Procedure</i>	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
	<i>Medications</i>	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
	<i>No entries defined.</i>			Entry
26.6	Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	42545-4	Section
	<i>Patient Transfer</i>	1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1		Entry
	<i>Simple Observation</i>	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
	<i>Procedure Entry</i>	1.3.6.1.4.1.19376.1.5.3.1.4.19		Entry
	<i>References Entry</i>	1.3.6.1.4.1.19376.1.5.3.1.4.4		Entry
	<i>Simple Observation</i>	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
	<i>No entries defined</i>			Entry
27	Payers	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	48768-6	Section

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

Section Reference #	LDS-VR	TemplateId	LOINC	Type
	Coverage Entity	1.3.6.1.4.1.19376.1.5.3.1.4.17		Entry

1515 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
2.16.840.1.113883.6.63	FDDC	First DataBank Drug Codes

IHE Quality, Research and Public Health Technical Framework Supplement – Birth and Fetal Death Reporting-Labor and Delivery Summary for Vital Records (BFDR-LDS-VR)

codeSystem	codeSystemName	Description
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)

1520

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

Add to section 5.1.2 IHE ActCode Vocabulary

1525 No new ActCode Vocabulary

Add to section 5.1.3 IHE RoleCode Vocabulary

No new RoleCode Vocabulary

Volume 4 – National Extensions

<i>Add appropriate Country section</i>
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1530 **4 National Extensions**

4.I National Extensions for IHE USA

None