Integrating the Healthcare Enterprise

IHE Quality, Research and Public Health Technical Framework Supplement

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

HL7® FHIR® STU 3

Using Resources at FMM Level 2-5

Revision 3.0 – Draft for Public Comment

Date: May 29, 2018

Author: QRPH Technical Committee

Email: qrph@ihe.net

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

Foreword

This is a supplement to the IHE Quality, Research and Public Health (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 May 29, 2018 for public comment. Comments are invited and may be submitted at http://www.ihe.net/QRPH_Public_Comments. In order to be considered in development of the trial implementation version of the supplement, comments must be received by June 28, 2018.

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

Amend Section X.X by the following:

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

General information about IHE can be found at 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.

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

CONTENTS

Introduction to this Supplement

Whenever possible, IHE profiles are based on established and stable underlying standards. However, if an IHE committee determines that an emerging standard offers significant benefits for the use cases it is attempting to address and has a high likelihood of industry adoption, it may develop IHE profiles and related specifications based on such a standard.

The IHE committee will take care to update and republish the IHE profile in question as the underlying standard evolves. Updates to the profile or its underlying standards may necessitate changes to product implementations and site deployments in order for them to remain interoperable and conformant with the profile in question.

This BFDR-E Profile uses the emerging HL7®[1] FHIR®[2] specification. The FHIR release profiled in this supplement is STU 3. HL7 describes the STU (Standard for Trial Use) standardization state at https://www.hl7.org/fhir/versions.html.

In addition, HL7 provides a rating of the maturity of FHIR content based on the FHIR Maturity Model (FMM): level 0 (draft) through 5 (normative ballot ready). The FHIR Maturity Model is described at http://hl7.org/fhir/versions.html#maturity.

Key FHIR STU 3 content, such as Resources or ValueSets, used in this profile, and their FMM levels are:

FHIR Resource Name	FMM Level
Composition	2
MedicationAdministration	2
Procedure	3
Observation	5
Condition	3
Encounter	2
Patient	5
Coverage	2

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

[1] HL7 is the registered trademark of Health Level Seven International.

[2] FHIR is the registered trademark of Health Level Seven International.

This supplement also references the following documents[3]. The reader should review these documents as needed:

1. PCC Technical Framework, Volume 1
2. PCC Technical Framework, Volume 2
3. PCC Technical Framework Supplement: CDA®[4] Content Modules
4. IT Infrastructure Technical Framework Volume 1
5. IT Infrastructure Technical Framework Volume 2
6. IT Infrastructure Technical Framework Volume 3
7. HL7 and other standards documents referenced in Volume 1 and Volume 2
8. Birth Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Live Birth (4/2004; 3/2005; Updated 7/2012)
9. Natality 2003 Revision – File In-Processing Documentation (14 Dec 2010)
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
    - 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:

[3] 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.

[4] CDA is the registered trademark of Health Level Seven International.

Item Count	Issue Description	Status
1	HL7 Issue – OBX is optional in HL7 – we want it required. a. This will be brought through the formalization process in HL7 b. Once HL7 formalizes the OBX R then statements leading in to the section requirements in Volume 2 should be updated to indicate NO FURTHER constraints	Review during Volume 2 development A STU Comment needs to be added against the VRBFDR STU 2013OCT 1. Fix type-o in ADT^A04 and ADT^A08 OBX to [{OBX}] 2. Fix cardinality to [1..*] 3. All observation types in Table 53 SHALL be recorded Check with Mead on how to make this further constraint. These constraints will be added to the Volume 2 message for QRPH BFDR Message.
2	Failed External cephalic Version – mapping to CDA output is listed as 'Pending' due to underlying HL7 Specification – missing. Profiling deferred pending HL7 resolution of the modelling.	Further discussion with HL7 pending.
3	A01, A03 – appear to be missing - not in HL7	Further discussion pending with HL7.
4	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.
5	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.
6	Glucocorticosteroids received by the mother prior to delivery may need to be checked in antepartum	Referenced in definitions only.
7	Addition of FHIR®[6] resources is deferred at this time	Will revisit pending additional work in this area.
8	Consider a Data Consumer Option or binding for Content Creator when adding FHIR to this profile.	
9	The concept of Packs of Cigarettes/day may be eliminated	
10	The HL7 CDA IG for Birth and Fetal Death Reporting will be updated to align with in-progress updates to the v2.6 messaging implementation guide. Mapping of new attributes included in the messaging guide have not yet been mapped to the CDA mapping in volume 3.	This mapping will be updated once the underlying HL7 CDA IG is updated with this content.

[6] FHIR is the registered trademark of Health Level Seven International.

Item Count	Issue Description	Status
11	Several new attributes are contemplated and modelling for these still have assigned temporary code assignments. These are expected to be conveyed as observations (OBX): • 64794-1 LOINC Number of Cigarettes Smoked in 3 months prior to Pregnancy • 64795-8 LOINC Number of Cigarettes Smoked in third or last trimester • LOINC 01 LOINC Acknowledgment of paternity signed • LOINC 02 LOINC Mother's body height • LOINC 03 LOINC Date of birth registration • LOINC 04 LOINC Father's education • LOINC 05 LOINC Father's reported age in years • LOINC 06 LOINC Mother Married at conception, birth, or between • LOINC 07 LOINC Mother Receive WIC food • LOINC 08 LOINC Mother's education • LOINC 09 LOINC Mother's reported age in years • LOINC 10 LOINC Number of Cigarettes Smoked in 1st 3 months • LOINC 11 LOINC Number of Cigarettes Smoked in 2nd 3 months • LOINC 12 LOINC Baby name not yet chosen • LOINC 13 LOINC Birth attendant details • LOINC 14 LOINC Birth certifier details • LOINC 15 LOINC Date birth certified • LOINC 16 LOINC Date of fetal death registration • LOINC 17 LOINC Date of fetal delivery • LOINC 18 LOINC Father date of birth • LOINC 19 LOINC Father's legal name • LOINC 20 LOINC Father's ethnicity • LOINC 21 LOINC Father's race • LOINC 22 LOINC Name of fetus • LOINC 23 LOINC Person providing information for mother's live birth information • LOINC 24 LOINC Relationship of person providing information for mother's live birth information • LOINC 25 LOINC Request Social Security Number for Newborn • LOINC 26 LOINC SSN request date • LOINC 27 LOINC SSN request signature	Inclusion of specification and definitions for new concepts will completed once the final codes are assigned and NCHS provides the definitions.

Item Count	Issue Description	Status
12	NCHS will be updating the references and links for newly released Edit Specifications and forms for Birth and Fetal Death Reporting.	Awaiting link update content from NCHS
13	NCHS will be reviewing the recently deleted items.	Updates to content may be applied for deleted items.
14	HL7 is reviewing how best to reflect optionality included for backward compatibility.	The PID segment may need additional clarification for these attributes once HL7 finalizes its position.
15	The HL7 specification observations and attributes breakdown regarding what is supported for each message type needs further review.	This profile specifies inclusion requirements consistent with the attribute list in the Appendix B – BFDR-E Profile - Data Element Definitions listed in Volume 1
16	Referencing the Child's record in FHIR mapping should be reviewed in public comment.	Pending public comment review and feedback
17	Observations for the Fetus in FHIR may need to be expressed as observations for the mother as there may be no record for the fetus created.	Pending public comment review and feedback. If observations are needed for the mother's record, then we will need to request LOINC Codes
18	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.
19	There are still some temporary LOINC codes assigned which were not resolved by the published HL7v2.6 specification.	Review with HL7 the status of these codes and/or modelling.

Closed Issues

Closed Issue List:

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

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

[7] CCD is the registered trademark of Health Level Seven International.

Item	Issue Description	Status
10	TEMPLATE OPEN ISSUE: The template does not really support the need to specify the mappings for the form receiver message exporter, form receiver CDA exporter, and the Pre-population requirements for the Form Manager. These have been reflected together as sub-sections to 6.3.1.D.4 Data Element Requirement Mappings.	Resolved: Referred to documentation.
11	Template Issue: Where should the list of data elements be specified in this new template? In the past, they were included in X.6 Content Module in some profiles. We have tentatively included a new Section X.7 Data Requirements until this issue has been resolved.	Added a reference to the Appendix in X.7 as follows: This profile defines specific data element content. These data elements are used to create the HL7 CDA Birth and Fetal Death Reporting Document, generate the HL7 BFDR-E Message, or populate a form defined to gather the required structured data, such as the US BFDR-E Form. That set of data elements in the form are identified and defined in Appendix B.
12	Should there be only one option, the LDS-VR Option' – this had been considered but we want to be able to offer a lower participation threshold where possible – the pre-pop Option may need to be renamed, but it supports the LDS or the LDS-VR document.	Resolved.
13	Do we need a new transaction for each new type of outbound message? Is there are more generalized way to do this (like PCD-01)?	Resolved. Will continue to reference separate transactions using common actors.
14	The use of Null flavors for unknown is under review by HL7. This is slated for discussion in May HL7. This also impacts the output mapping to CDA documents as we are 'silent' on how to handle the 'N' status of each observation.	This has been resolved in the HL7 IG and does not need to be further constrained. Clarified the mapping in handling UNKNOWN.
15	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.
16	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.
17	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.

Item	Issue Description	Status
18	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.
19	PNC – needs to be added from Spec to data dictionary and mapping tables 73776-7 No-prenatal care	Added 73776-7 No-prenatal care
20	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)
21	Review of Birth vs FDeath Forms to assess any impact on logic in using numbers as a reference. Some information is needed in one form vs the other, and there may be differences in the information captured on the form for similar concepts. There are differences in the form numbers between the 2 documents, so any reference to the form numbers needs to be handled separately between birth and fetal death.	Added 2 tables to volume 4 to clarify the mapping to the two US forms.
22	HL7 CDA document is missing specification of UCUM units for some metrics. No profiling added pending HL7 resolution of this issue.	HL7 spec already references the data type PQ, so no change needed.
23	PPO: DEPRECATED. Sample forms do not reflect that this is removed at this time	Removed forms from Vol 1 Appendix A.1 and A.2 for the BC and FD to replace with NCHS web links to these forms. Also, need guidance from DVS to include language that indicates removed items from form
24	International considerations for form options currently identified as US Form Option on form manager	No change needed. BFDR-E Form Manager has already been generalized to Form Pre-pop Option
25	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.
26	Handling of these 'Pending' flag indicators from the Edit Specifications needs to be reviewed in the context of the workflow. These status flags may not be pertinent in the proposed profile use cases.	Not an issue for the profile. This is managed by the birth information specialist submission and VR system responses for incomplete data.
27	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/hystereotomy unplanned.

Item	Issue Description	Status
28	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 included additional codes based on feedback from the VRVC (Vital Records Vocabulary Committee)
29	Need to post sample CDA documents for BFDR-Birth and BFDR-FD	No change to profile. Update FTP site with samples from CDA IG.
30	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.
31	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.
32	Fever Greater Than 100.4 (NCHS) value set - This is not likely to be present on a problem list and instead will be represented in discrete data if the temperature was taken	Decided to limit prepopulation for this item when fever greater than 100.4 is on the problem list and chorioamnionitis.
33	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.
34	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.
35	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.
36	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.
37	The finalized and published HL7 CDA STU documents are expected to be available to HL7 members early June 2014, and to non-members by early September 2014.	All of the HL7 VR related standards have been published as STUs and are posted on the HL7 STU comments website.

Item	Issue Description	Status
38	The number of fetal deaths in the delivery (FDTH) is not currently mapped to the HL7 CDA Fetal Death Document. There is currently no attribute in the CDA given that there is no request for this information on the forms used as a basis for this work.	Included the mapping for FDTH for consistency with the HL7 CDA IG
39	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.
40	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.
41	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.
42	ROL segment is defined for the facility.	The updated HL7 document will use the PID segment for the facility address, and the OBX for the National ID and for the Birth facility Name
43	This profile is aligned with the latest information available from the HL7 specification which uses the Mother as the patient when reporting a fetal death and NK1 to indicate demographics of the fetus.	HL7 has agreed to modify the structure of the message to represent the fetus in PID and the mother in NK1.
44	There is no birth order for NK1. If the fetus is in the PID then there is no need for a separate observation. If the OBX is used to determine the fetus birth order, it may be better to use this for the live birth set order as well.	HL7 has agreed to modify the structure of the message to represent the fetus in PID and the mother in NK1. Birth order is in PID-25
45	NK1-16 may be used for fetal date of delivery but it may be considered better to use an observation for this with LOINC17.	HL7 has agreed to modify the structure of the message to represent the fetus in PID and the mother in NK1. Birth or Fetal date of delivery is in PID-7.
46	Facility Address and Facility Name and Attendant NPI were in ROL in v2.5 messaging guide, but in v2.6 ROL is not indicated.	The updated HL7 document will use the PID segment for the facility address, and the OBX for the National ID and for the Birth facility Name

General Introduction

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

Appendix A – Actor Summary Definitions

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

Actor	Definition
Information Source	The Information Source is responsible for creating and transmitting an HL7 V2.6message to an Information Recipient.
Information Recipient	The Information Recipient is responsible for receiving the HL7 V2.6 message from an Information Source or from a Form Receiver Message Exporter.
Form Receiver CDA Exporter	This Form Receiver CDA Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer.
Form Processor CDA Exporter	This Form Processor CDA Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer.
Form Receiver Message Exporter	This Form Receiver Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to an HL7 message, and sends that message to an Information Recipient.
Form Processor Message Exporter	This Form Processor Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to an HL7 message, and sends that message to an Information Recipient.

Appendix B – Transaction Summary Definitions

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

Transaction	Definition
BFDRFeed [QRPH-37]	This transaction transmits the HL7 V2.6 formatted message containing the Birth and Fetal Death Reporting information

Glossary

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

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

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

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

Glossary Term	Definition
Spina bifida	Spina bifida is a herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure.
Spinal anesthesia	Spinal anesthesia or sub-arachnoidal block is a form of regional anesthesia involving the injection of local anesthetic into the cerebrospinal fluid.
Fetal death	Fetal death is a death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles. Heartbeats are to be distinguished from fleeting respiratory efforts or gasps.
Metabolism disorder	Metabolism disorders are disorders that affect chemical processes that take place in living organisms, resulting in growth, generation of energy, elimination of wastes, and other body functions as they relate to the distribution of nutrients in the blood after digestion.
Ultrasound	Ultrasound study is a radiologic study using sound waves used in the assessment of gestational age, size, growth, anatomy, and blood flow of a fetus or in the assessment of maternal anatomy and blood flow.
Vaginal birth/spontaneous	Vaginal birth/spontaneous birth is the delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.
Vaginal birth with forceps	Vaginal birth with forceps is the delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head.
Vaginal birth with vacuum	Vaginal birth with vacuum is the delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head.
Vertex Presentation	Vertex presentation is the presentation of the upper or back part of the infant's head

Volume 1 – Profiles

Copyright Licenses

Not applicable

Domain-specific additions

Not applicable

Add Section X

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

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

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

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

BFDR-E also defines a mechanism to transform form submission data and transmit it as a standard HL7 v2 message. The BFDRFeed [QRPH-37] transaction adapts the HL7 V2.6 BFDR Message for this purpose. BFDR-E 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-E Profile defines three ways to exchange data required for birth and fetal death reporting in an electronic form. First, creation of a BFDR Birth CDA Document Content and a BFDR Fetal Death CDA Document is supported. Second, communication of the BFDR content in an HL7 message is supported. Third, a form-based data collection method is supported using RFD transactions and pre-population 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 CDA Document, the BFDR Fetal Death CDA Document, or the BFDR message format.

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

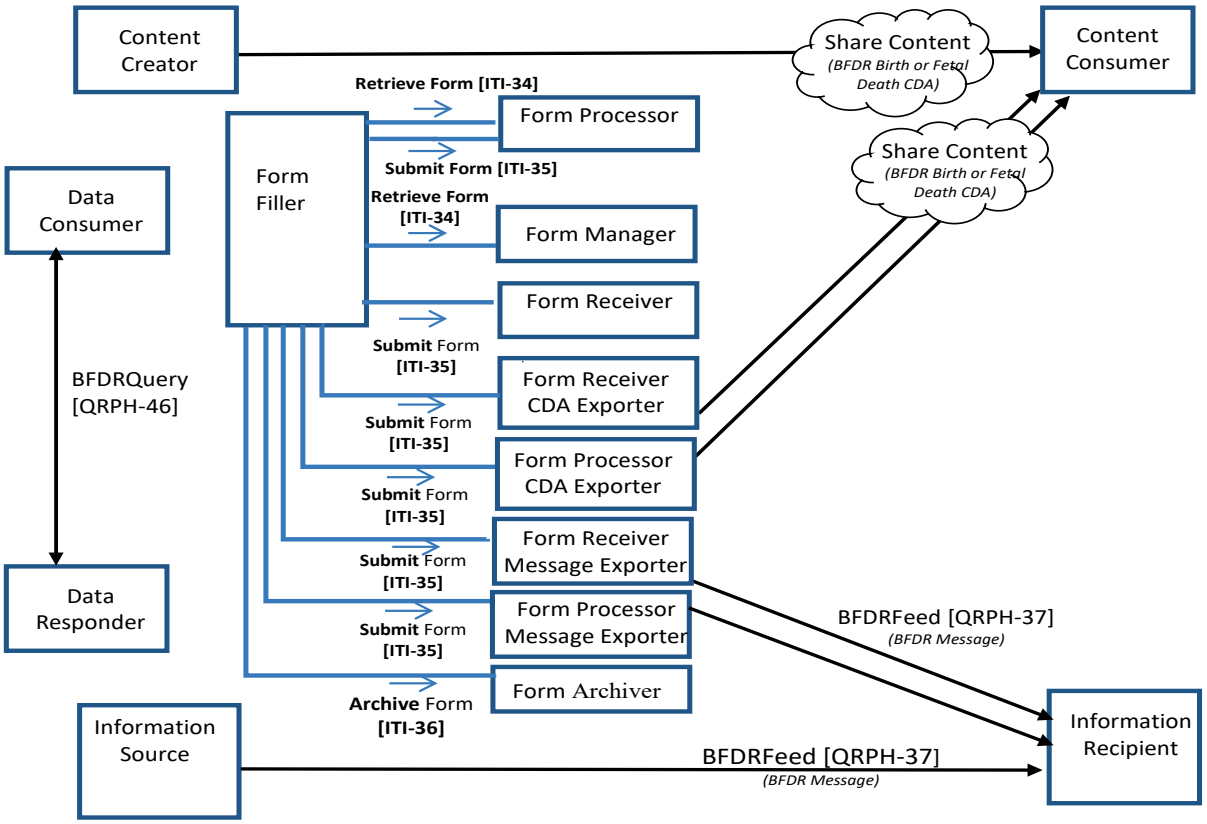


Figure X.1-1: BFDR-E Actor Diagram

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

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

Actors (see Note 1 and Note 2)	Transactions	Optionality	TF Reference
Form Receiver	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Receiver CDA Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Processor CDA Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Receiver Message Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.37
Form Processor Message Exporter	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.37
Form Archiver	Archive Form [ITI-36]	R	ITI TF-2b: 3.36
Information Source	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.37
Information Recipient	BFDRFeed [QRPH-37]	R	QRPH TF 2: 3.37
Data Consumer	BFDRQuery [QRPH-46]	R	QRPH TF 2: 3.46
Data Responder	BFDRQuery [QRPH-46]	R	QRPH TF 2: 3.46
Content Creator	NA	NA	NA
Content Consumer	NA	NA	NA

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

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

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

Actors	Content Modules	Optionality	Reference
Content Creator	BFDR Fetal Birth Document (for live births) (1.3.6.1.4.1.19376.1.7.3.1.1.19.2)	R	QRPH TF-3: 6.3.1.D1.5
	BFDR Fetal Death Document (for fetal death) (1.3.6.1.4.1.19376.1.7.3.1.1.19.3)	R	QRPH TF-3: 6.3.1.D2.5
Form Receiver CDA Exporter	BFDR Fetal Birth Document (for live births) (1.3.6.1.4.1.19376.1.7.3.1.1.19.2)	R	QRPH TF-3: 6.3.1.D1.5
	BFDR Fetal Death Document (for fetal death) (1.3.6.1.4.1.19376.1.7.3.1.1.19.3)	R	QRPH TF-3: 6.3.1.D2.5
Form Processor CDA Exporter	BFDR Fetal Birth Document (for live births) (1.3.6.1.4.1.19376.1.7.3.1.1.19.2)	R	QRPH TF-3: 6.3.1.D1.5

Actors	Content Modules	Optionality	Reference
	BFDR Fetal Death Document (for fetal death) (1.3.6.1.4.1.19376.1.7.3.1.1.19.3)	R	QRPH TF-3: 6.3.1.D2.5
Content Consumer	BFDR Fetal Birth Document (for live births) (1.3.6.1.4.1.19376.1.7.3.1.1.19.2)	R	QRPH TF-3: 6.3.1.D1.5
	BFDR Fetal Death Document (for fetal death) (1.3.6.1.4.1.19376.1.7.3.1.1.19.3)	R	QRPH TF-3: 6.3.1.D2.5
Form Filler with Pre-Pop Option	LDS Document (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2)	R	PCC Labor and Delivery Profiles Trial Implementation Supplement, Vol 3, Sec 6.3.1.B
Form Filler with LDS-VR Pre-Pop Option	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
Form Manager	LDS Document (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2)	R	PCC Labor and Delivery Profiles Trial Implementation Supplement, Vol 3, Sec 6.3.1.B
	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
Form Processor	LDS Document (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2)	R	PCC Labor and Delivery Profiles Trial Implementation Supplement, Vol 3, Sec 6.3.1.B
	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

X.1.1.1 Content Creator

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

- A Content Creator that supports the Antepartum Import Option SHALL support discrete data import of critical vital record attributes from the Antepartum Summary according to the transforms specified in QRPH TF-3: 6.6.4 Discrete Data Import Element Mappings From APS to LDS-VR Content Document

X.1.1.2 Content Consumer

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

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

X.1.1.3 Form Filler

The Form Filler SHALL support requirements defined for the Form Filler in ITI RFD [ITI TF-1:17] with the following qualifications:

The Form Filler SHALL support XHTML of the Retrieve Form [ITI-34] transaction.

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

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

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

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

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

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

X.1.1.4 Form Manager

The Form Manager SHALL support all the requirements defined for the Form Manager in ITI RFD [ITI TF-1:17] with the following qualifications:

The Form Manager SHALL support XHTML of the Retrieve Form [ITI-34] transaction.

A Form Manager in the BFDR-E Profile SHALL accept pre-pop data in the form of content defined by the IHE PCC LDS document template (Template id 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2) or the IHE QRPH LDS-VR document template (Template id

1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1) and return a form that has been appropriately pre-populated based on the pre-population rules specified in QRPH TF-3: 6.3.1.D3.4 Data Element Requirement Mappings for Form Pre-Population.

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

X.1.1.5 Form Receiver

The Form Receiver is defined in ITI RFD [ITI TF-1:17].

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

X.1.1.6 Form Processor

The Form Processor is defined in ITI RFD [ITI TF-1:17].

The Form Processor SHALL support XHTML of the Retrieve Form [ITI-34] transaction.

A Form Processor in the BFDR-E Profile SHALL accept pre-pop data in the form of content defined by the IHE PCC LDS Profile (1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2 or the IHE QRPH (LDS-VR) (1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1) and return a form that has been appropriately pre-populated based on the mapping rules specified in QRPH TF-3: 6.3.1.D2.4 Data Element Requirement Mappings for Form Pre-Population.

If the same request is submitted for the same patient then the Form Processor shall supply the previously populated and saved form.

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

X.1.1.7 Form Receiver CDA Exporter

The Form Receiver CDA Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer. For BFDR, this transforms that data to create the BFDR Birth CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.2) defined in QRPH TF-3: 6.3.1.D1 or the BFDR Fetal Death CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.3) defined in QRPH TF-3: 6.3.1.D2, and shares that newly created BFDR document with a Content Consumer. Specification of the transformation rules from the US BFDR Form to the CDA content is defined in QRPH TF-3: 6.6.2 Form Data Element Mappings to Output Content Document.

X.1.1.8 Form Processor CDA Exporter

The Form Processor CDA Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to create a CDA document, and shares that newly created CDA document with a Content Consumer. For BFDR, this transforms that data to create the BFDR Birth CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.2) defined in QRPH TF-3: 6.3.1.D1 or the BFDR Fetal Death CDA Document Content (1.3.6.1.4.1.19376.1.7.3.1.1.19.3) defined in QRPH TF-3: 6.3.1.D2, and shares that newly created BFDR document with a Content Consumer. Specification of the transformation rules from the US BFDR Form to the CDA content is defined in QRPH TF-3: 6.6.2 Form Data Element Mappings to Output Content Document.

X.1.1.9 Form Receiver Message Exporter

The Form Receiver Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to an HL7 message, and sends that message to an Information Recipient. For BFDR, this transforms that data to be in compliance with the requirements of the BFDRFeed [QRPH-37] transaction and sends that data to an Information Recipient. Detailed rules for the BFDRFeed [QRPH-37] transaction are fully defined in QRPH TF-2: 3.37. Transformation rules from the form to the message content are fully specified in QRPH TF-3: 6.6.3 Form Data Element Mappings to Output HL7 Message.

X.1.1.10 Form Processor Message Exporter

The Form Processor Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to an HL7 message, and sends that message to an Information Recipient. For BFDR, this transforms that data to be in compliance with the requirements of the BFDRFeed [QRPH-37] transaction and sends that data to an Information Recipient. Detailed rules for the BFDRFeed [QRPH-37] transaction are fully defined in QRPH TF-2: 3.37. Transformation rules from the form to the message content are fully specified in QRPH TF-3: 6.6.3 Form Data Element Mappings to Output HL7 Message.

X.1.1.11 Form Archiver

The actions of the Form Archiver are defined in ITI RFD [ITI TF-1:17].

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

X.1.1.12 Information Source

The Information Source is responsible for creating the BFDRFeed [QRPH-37] message containing the Birth and Fetal Death Reporting attributes and transmitting this message to an Information Recipient. The Information Source SHALL transmit content as specified by in QRPH TF-2: 3.37.

X.1.1.13 Information Recipient

The Information Recipient is responsible for receiving the BFDRFeed [QRPH-37] message containing the Birth and Fetal Death Reporting attributes from the Information Source.

X.1.1.12 Data Consumer

The Data Consumer Actor is responsible for initiating a query using the BFDRQuery [QRPH-46] message to the Data Responder to retrieve the Birth and Fetal Death Reporting data.

X.1.1.13 Data Responder

The Data Responder Actor is responsible for responding to a BFDRQuery [QRPH-46] message to the Data Consumer to provide the Birth and Fetal Death Reporting data.

X.2 Actor Options

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-E - Actors and Options

Actor	Option Name	TF Reference
Content Creator	Antepartum Import	QRPH TF-1: X.2.4
Content Consumer	View	PCC TF-2: 3.1.1
	Document Import	PCC TF-2: 3.1.2
	Discrete Data Import	PCC TF-2: 3.1.4
Form Filler	Pre-Pop Note 1	QRPH TF-1: X.2.1
	VR Pre-Pop Note 1	QRPH TF-1: X.2.2
	Archive Form	QRPH TF-1: X.2.3
Form Manager	None	--
Form Processor	None	--
Form Receiver	None	--
Form Receiver CDA Exporter	None	--
Form Processor CDA Exporter	None	--
Form Receiver Message Exporter Form Processor Message Exporter	Provider Supplied Live Birth Reporting Option Note 2	QRPH TF-1: X.2.5
	Provider Supplied Mother's Live Birth Information Option Note 2	QRPH TF-1: X.2.6
	Provider Supplied Facility's Live Birth Information Option Note 2	QRPH TF-1: X.2.7
	Provider Supplied Fetal Death Reporting Option	QRPH TF-1: X.2.8
	Fetal Death Facility's Information Option	QRPH TF-1: X.2.9

Actor	Option Name	TF Reference
	Fetal Death Mother's Information Option	QRPH TF-1: X.2.10
	Jurisdiction Live Birth Reporting Option	QRPH TF-1: X.2.11
	Jurisdiction Fetal Death Reporting Option	QRPH TF-1: X.2.12
Form Archiver	None	--
Information Source	Provider Supplied Live Birth Information Option	QRPH TF-1: X.2.5
	Provider Supplied Mother's Live Birth Information Option	QRPH TF-1: X.2.6
	Provider Supplied Facility Live Birth Information Option	QRPH TF-1: X.2.7
	Provider Supplied Fetal Death Information Option	QRPH TF-1: X.2.8
	Fetal Death Facility's Information Option	QRPH TF-1: X.2.9
	Fetal Death Mother's Information Option	QRPH TF-1: X.2.10
	Jurisdiction Supplied Live Birth Reporting Option	QRPH TF-1: X.2.11
	Jurisdiction Fetal Death Reporting Option	QRPH TF-1: X.2.12
	Void Certificate Reporting Option	QRPH TF-1: X.2.13
	Coded Cause of Death Reporting Option	QRPH TF-1: X.2.14
	Coded Race/Ethnicity Reporting Option	QRPH TF-1: X.2.15
Information Recipient	Provider Supplied Live Birth Reporting Option	QRPH TF-1: X.2.5
	Provider Supplied Mother's Live Birth Information Option	QRPH TF-1: X.2.6
	Provider Supplied Facility's Live Birth Information Option	QRPH TF-1: X.2.7
	Provider Supplied Fetal Death Reporting Option	QRPH TF-1: X.2.8
	Fetal Death Facility's Information Option	QRPH TF-1: X.2.9
	Fetal Death Mother's Information Option	QRPH TF-1: X.2.10
	Jurisdiction Live Birth Reporting Option	QRPH TF-1: X.2.11
	Jurisdiction Fetal Death Reporting Option	QRPH TF-1: X.2.12

Actor	Option Name	TF Reference
	Void Certificate Reporting Option	QRPH TF-1: X.2.13
	Coded Cause of Death Reporting Option	QRPH TF-1: X.2.14
	Coded Race/Ethnicity Reporting Option	QRPH TF-1: X.2.15
Data Consumer	None	
Data Responder	None	

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

Note 2: At least one of these birth reporting options SHALL be supported

X.2.1 Pre-Pop Option

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

If the Form Filler supports the Pre-Pop Option, the value of the pre-pop Data parameter in the Retrieve Form Request (see ITI TF-2b: 3.34.4.1.2) shall be a well-formed xml document as defined in the PCC Labor and Delivery Summary (LDS) Content Profile (see Labor and Delivery Profiles Trial Implementation Supplement, 6.3.1.B Labor and Delivery Summary 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2).

X.2.2 VR Pre-Pop Option

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

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

X.2.3 Archive Form Option

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

X.2.4 Antepartum Import Option

This option defines the discrete data import requirements placed on Content Creators for incorporating information from the antepartum setting in the LDS or LDS-VR.

A Content Creator that supports the Antepartum Import Option SHALL support the Content Consumer of the IHE PCC Antepartum Summary (APS) Profile with the Discrete Data Import Option for those attributes specified by this option. Detailed discrete data import rules for the information that will support the pre-pop attributes are fully defined in QRPH TF-3: 6.6.4 Discrete Data Import Element Mappings to LDS-VR Content Document.

X.2.5 Provider Supplied Live Birth Reporting Option

This option is intended to support communications from the system collecting the worksheet information from the facility (e.g., Electronic Health Record) to a jurisdictional vital records office for a live birth. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Provider Supplied Live Birth Reporting Option (PSLBI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.38.4.1

X.2.6 Provider Supplied Mother's Live Birth Information Option

This option is intended to support communications from the system collecting the worksheet information from the mother (e.g., Personal Health Record, Patient Portal) to a jurisdictional vital records office for a live birth. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Provider Supplied Mother's Live Birth Information Option (PSMLBI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1

X.2.7 Provider Supplied Facility's Live Birth Information Option

This option is intended to support communications from the provider to the jurisdictional vital records office for both the facility's work sheet and the mother's live birth information. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Provider Supplied Facility's Live Birth Information Option (PSFLBI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1

X.2.8 Provider Supplied Fetal Death Reporting Option

This option is intended to support communications from the provider to the jurisdictional vital records office for both the facility's work sheet and the mother's information for a fetal death. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Provider Supplied Fetal Death Reporting Option (PSFDI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1

X.2.9 Fetal Death Facility's Information Option

This option is intended to support communications from the system collecting the worksheet information from the facility (e.g., Electronic Health Record) to a jurisdictional vital records office for a fetal death. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Fetal Death Facility's Information Option (PSFFDI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1

X.2.10 Fetal Death Mother's Information Option

This option is intended to support communications from the system collecting the worksheet information from the mother (e.g., Personal Health Record, Patient Portal) to a jurisdictional vital records office for a fetal death. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Fetal Death Mother's Information Option (PSMFDI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1

X.2.11 Jurisdiction Live Birth Reporting Option

This option is intended to support communications from the jurisdictional vital records office to a national statistics agency for a live birth. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Jurisdiction Live Birth Reporting Option (JLBI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1.

X.2.12 Jurisdiction Fetal Death Reporting Option

This option is intended to support communications from the jurisdictional vital records office to a national statistics agency for a fetal death. The Form Receiver Message Exporter, the Information Source, and the Information Recipients implementing this option shall support the content defined for the Jurisdiction Fetal Death Reporting Option (JFDI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1.

X.2.13 Void Certificate Reporting Option

This option is intended to support instructions from the jurisdictional vital records office to a national statistics agency to void a previously recorded live birth certificate or fetal death report. The Information Source, and the Information Recipients implementing this option shall support the content defined for the Void Certificate Reporting Option (JVFDI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1.

X.2.14 Coded Cause of Death Reporting Option

This option is intended to support communications from a national statistics agency to the jurisdictional vital records office. The Information Source and the Information Recipients shall

support the content defined for the Coded Cause of Death Reporting Option (CCOFD) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.37.4.1.

Actors that support this option are able to send or receive coded cause of death information.

X.2.15 Coded Race/Ethnicity Reporting Option

This option is intended to support communications from the national statistics agency to a jurisdictional vital records office. The Information Source and the Information Recipients shall support the content defined for the Coded Race/Ethnicity Reporting Option (CREI) in the BFDRFeed [QRPH-37] transaction, see QRPH TF-2: 3.38.4.1.

Actors that support this option are able to send or receive race and ethnicity information.

In some jurisdictions, it is prohibited to send race and/or ethnicity. Use of this option may be constrained by national extension.

X.3 BFDR-E 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).

If this is a content profile, and actors from this profile are grouped with actors from a workflow or transport profile, the Content Bindings reference column references any specifications for mapping data from the content module into data elements from the workflow or transport transactions.

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-E - Required Actor Groupings

BFDR-e 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	None	--	--
Form Filler	None	--	--
Form Manager	None	--	--
Form Processor	None	--	--
Form Receiver	None	--	--
Form Receiver CDA Exporter	None	--	--
Form Processor CDA Exporter	None		

BFDR-e Actor	Actor to be grouped with	Reference	Content Bindings Reference
Form Receiver Message Exporter	None	--	--
Form Processor Message Exporter	None		
Form Archiver	None	--	--
Information Source	None	--	--
Information Recipient	None	--	--
Data Consumer	None	--	--
Data Responder	None	--	--

Note 1: A Content Creator supporting the Antepartum Import Option SHALL be grouped with the APS Content Consumer with the Discrete Data Import Option for those attributes specified by the Antepartum Import Option; see QRPH TF-1: X.2.4.

X.4 BFDR-E 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.

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.

Additionally, standard worksheets are used to enhance the collection of quality, reliable data. Forms for the "mother's live birth information for Child's Birth Certificate", have been established by some jurisdictions to identify information to be collected directly from the mother. The "Facility Worksheet for the Live Birth Certificate" identifies information for which the best sources are the mother's and infant's medical records. The use of separate worksheets promotes standardized collection. The "Patient's Worksheet for the Report of Fetal Death" and the

"Facility Worksheet for the Report of Fetal Death" have also been established for the purpose of reporting fetal death information.

The hospital is responsible for completing the Record of Live Birth in the jurisdiction's Electronic Birth Registration System (EBRS). Information collected from the mother on the mother's live birth information must be data entered into the 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. Select birth data may be transmitted later to public health authorities as allowed by individual state statute and other vital records stakeholders.

Example Forms:

- Facility Worksheet (https://www.cdc.gov/nchs/data/dvs/facility-worksheet-2016.pdf)
- U.S. Standard Certificate of Live Birth (http://www.cdc.gov/nchs/data/dvs/birth11-03final-ACC.pdf)
- https:/www.cdc.gov/nchs/data/dvs/FDEATH11-03finalACC.pdf
- Mother's Worksheet for Child's Birth Certificate
- Patient's worksheet for the report of fetal death

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

X.4.2 Use Cases

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

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

X.4.2.1.1 Use Case Description

When the delivery has been documented in the system, a Labor and Delivery Summary document (LDS, LDS-VR) is created with Vital Record Birth and Fetal Death Reporting Content requirements. This summary document is provided as pre-population data to a public health IHE ITI Retrieve Form for Data Capture (RFD) 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 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-E is described below.

The provider EMR presents the Facilities Worksheet providing an LDS or LDS-VR document for Pre-population by the Form Manager. The birth information specialist completes the form, verifies the accuracy of all information, and submits the form. The 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 a 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. The coded cause of fetal death is returned to the jurisdiction EDRS. Race and/or Ethnicity are also returned from the National Statistics Agency to the originating jurisdictional vital records office using the Coded Race / Ethnicity Option for the fetal death. Due to paper jam damage of the printed official certificate that bears the death report number, a Void Certificate Reporting message is sent by the jurisdictional vital records office to the national statistics agency to void the submission. The fetal death registration will subsequently be transmitted with a new fetal death report number using the same transaction series between the originating jurisdictional vital records office and the National Statistics Agency.

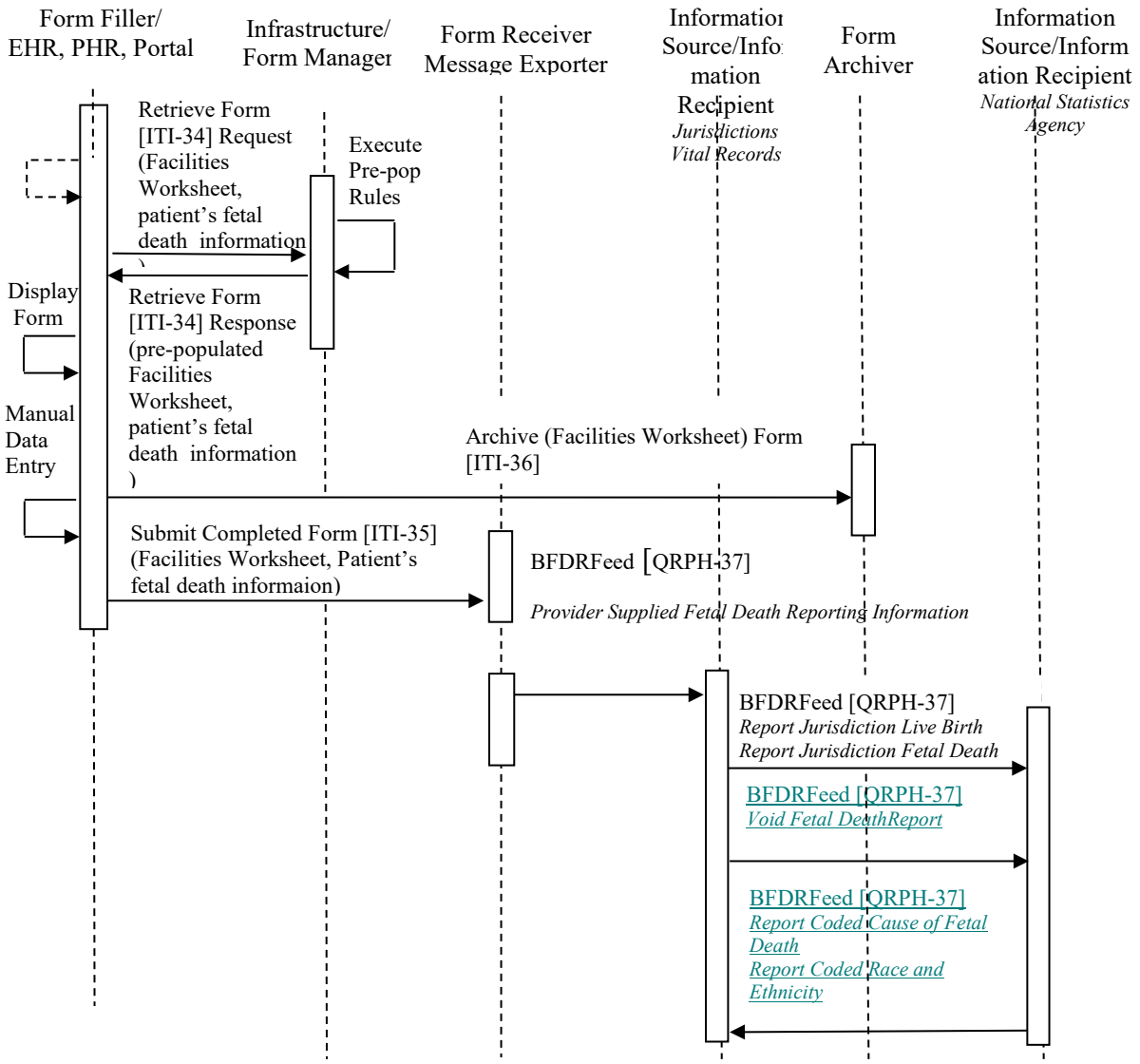


Figure X.4.2.1.3-1: Use Case 1 - Forms Data Capture with Messaging

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

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

X.4.2.2.1 Use Case Description

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

X.4.2.2.2 Processing Steps

X.4.2.2.2.1 Pre-conditions

A delivery has been documented in the EMR system.

X.4.2.2.2.2 Main Flow

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

X.4.2.2.2.3 Post-conditions

The EBRS has received the data.

X.4.2.2.3 Process Flow

The process flow of this 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-E is described below.

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

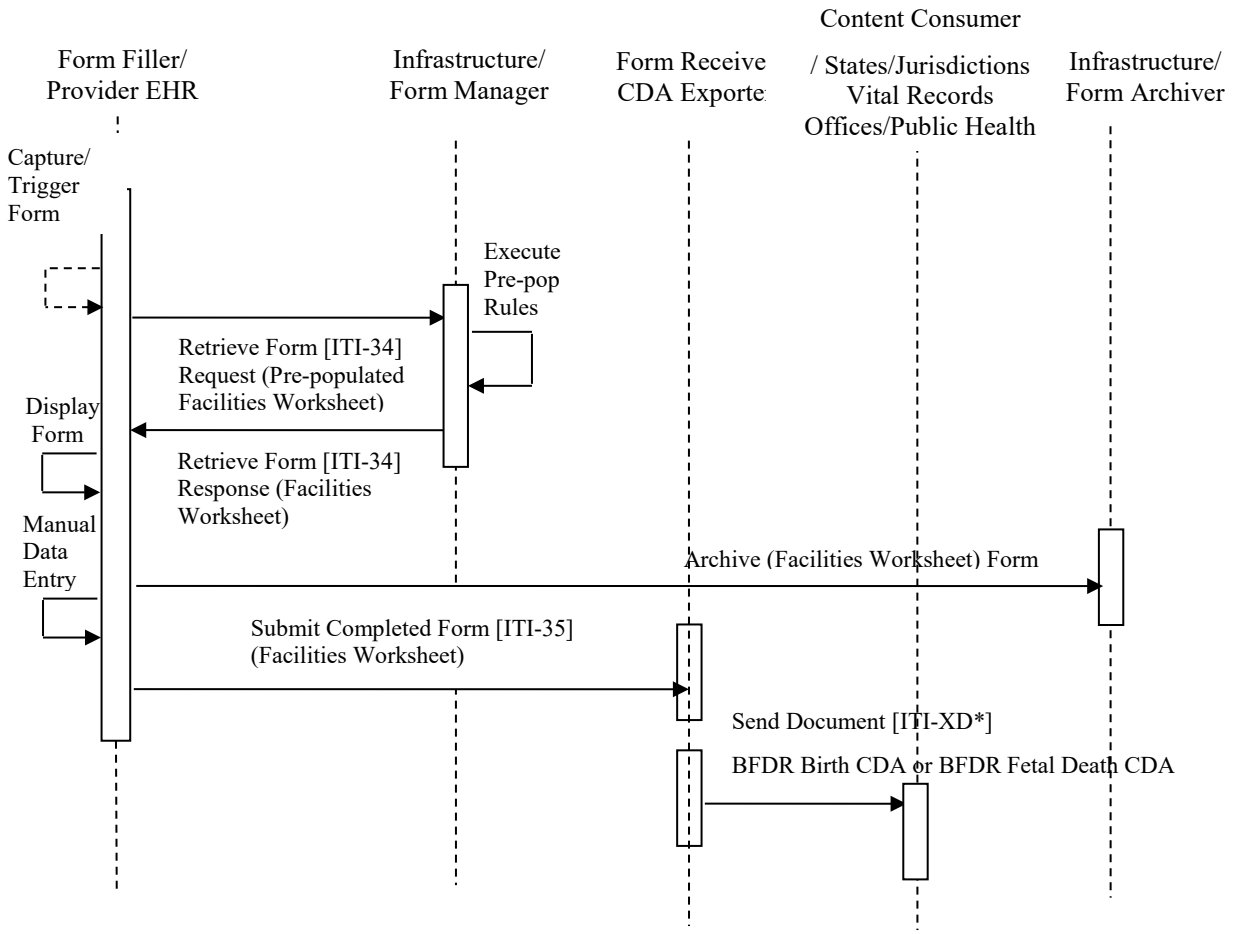


Figure X.4.2.2.3-1: Use Case 2- Forms Data Capture with Document Submission

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

The birth information specialist logs into the 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. 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 Labor and Delivery Summary document (LDS, LDS-VR) is created with Vital Record Birth and Fetal Death Reporting Content requirements. This document is provided as pre-population data to a public health IHE ITI Retrieve Form for Data Capture Forms 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

A delivery has been documented in the EMR system.

X.4.2.3.2.2 Main Flow

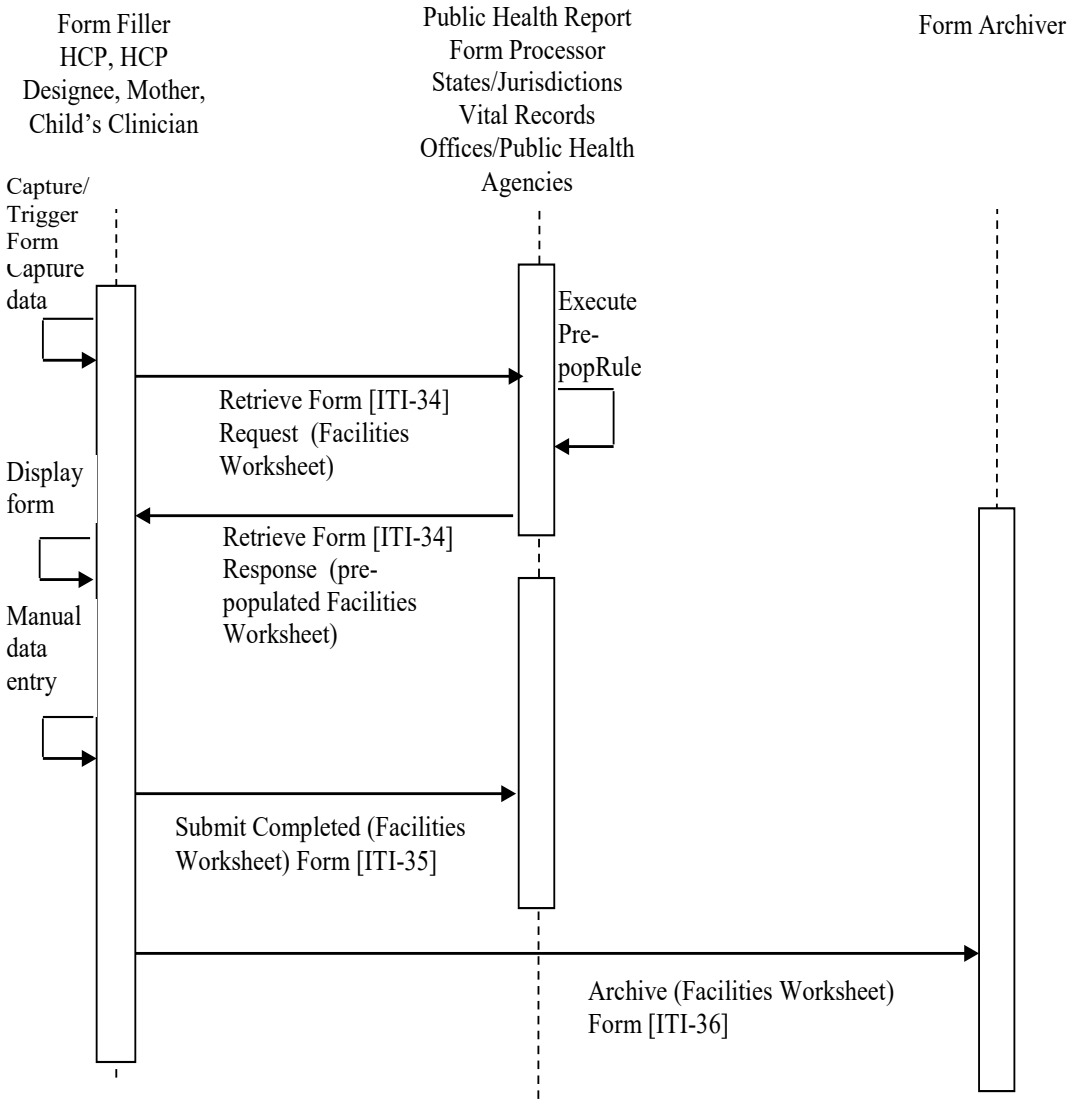
This flow captures the EBRS information using forms provided by public health and incorporates the data that is captured using product-defined methods.

X.4.2.3.2.3 Post-conditions

The EBRS has received the data.

X.4.2.3.3 Process Flow

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



1575

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

X.4.2.4 Use Case #4: EMR BFDR Messaging

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

1580 #### X.4.2.4.1 Use Case Description

When the delivery has been documented in the system, the EMR system creates an HL7 BFDRFeed [QRPH-37] message and sends the message to the EBRS directly.

X.4.2.4.2 Processing Steps

X.4.2.4.2.1 Pre-conditions

A delivery has been documented in the EMR system.

X.4.2.4.2.2 Main Flow

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

X.4.2.4.2.3 Post-conditions

The EBRS has received the data.

X.4.2.4.3 Process Flow

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

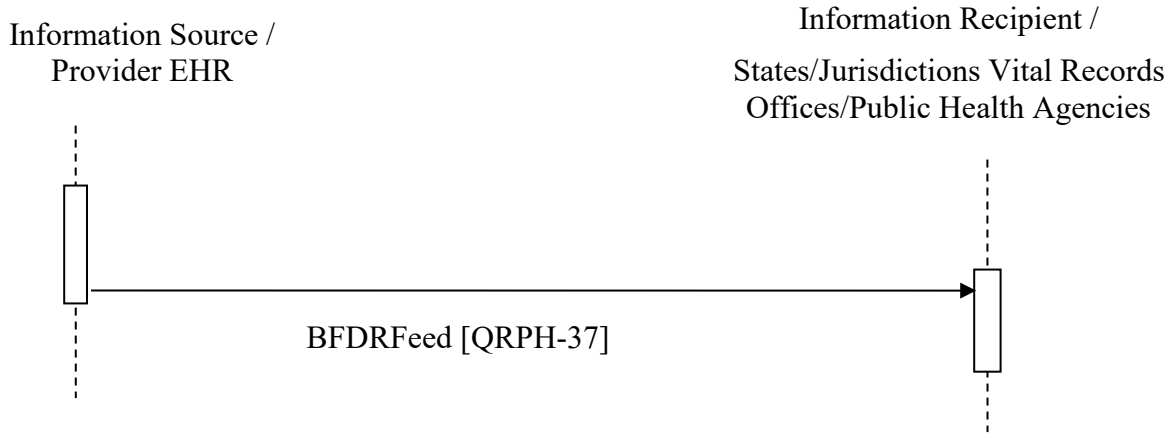


Figure X.4.2.4.3-1: Use Case 4-EMR BFDR Messaging

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

The EMR BFDR Document Submission use case creates the QRPH BFDR document directly and transmits the document to the EBRS.

X.4.2.5.1 Use Case Description

When the delivery has been documented in the system, the EMR system creates the QRPH BFDR document and sends it to the EBRS.

X.4.2.5.2 Processing Steps

X.4.2.5.2.1 Pre-conditions

A delivery has been documented in the EMR system.

X.4.2.5.2.2 Main Flow

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

X.4.2.5.2.3 Post-conditions

The EBRS has received the data.

X.4.2.5.3 Process Flow

The provider EMR sends the QRPH BFDR document to the EBRS.

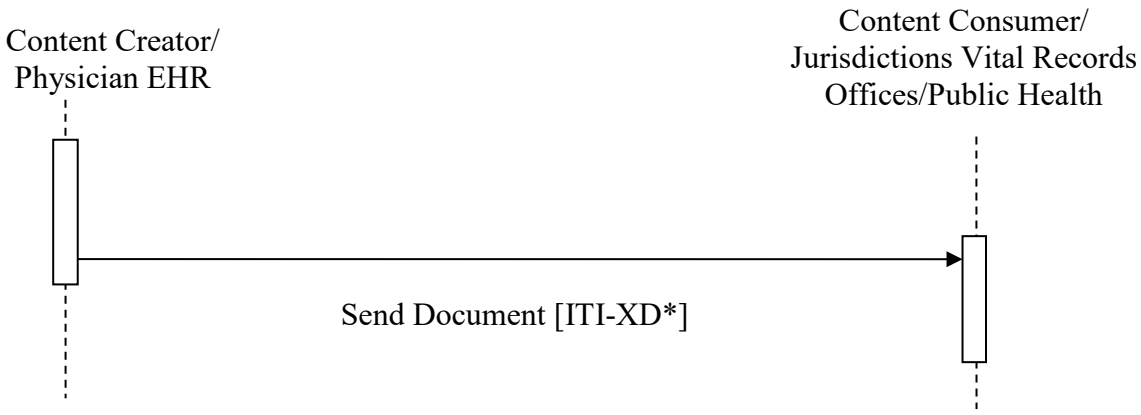


Figure X.4.2.5.3-1: Use Case 5- EMR BFDR Document Submission

X.4.2.6 Use Case #6: Mother's Information Data Collection

In the Mother's Information Data Collection use case, a SMART-on-FHIR app is available to the mother that uses PHR related information that to retrieve the mother information, and allows the mother to complete the relevant portions of the Mother's information. The completed reporting information is sent to the EBRS where the jurisdiction completes the processing of the information with the national statistics agency.

X.4.2.6.1 Mother's Information Data Collection Use Case Description

When the mother is ready to provide information that will be used to generate the vital records report associated with the delivery, the mother's delivery vital record SMART-on-FHIR app queries the EHR using BFDRQuery (QRPH-46) to retrieve information about the parents. The mother is able to complete the form with information not already available through the PHR.

Once the reporting information is documented using the app, the system, creates an HL7 BFDR message or a BFDR CDA document and sends the message to the EBRS directly. The EBRS communicates jurisdiction information to the national statistic agency where the standard coded cause of death is determined and returned to the jurisdiction.

X.4.2.6.2 Mother's Information Data Collection Process Flow

The SMART-on-FHIR app Data Consumer sends the BFDRQuery [QRPH-46] message to the PHR Data Responder to assist the mother in completing delivery reporting details. The mother's delivery reporting information is sent to the jurisdiction vital records office EBRS.

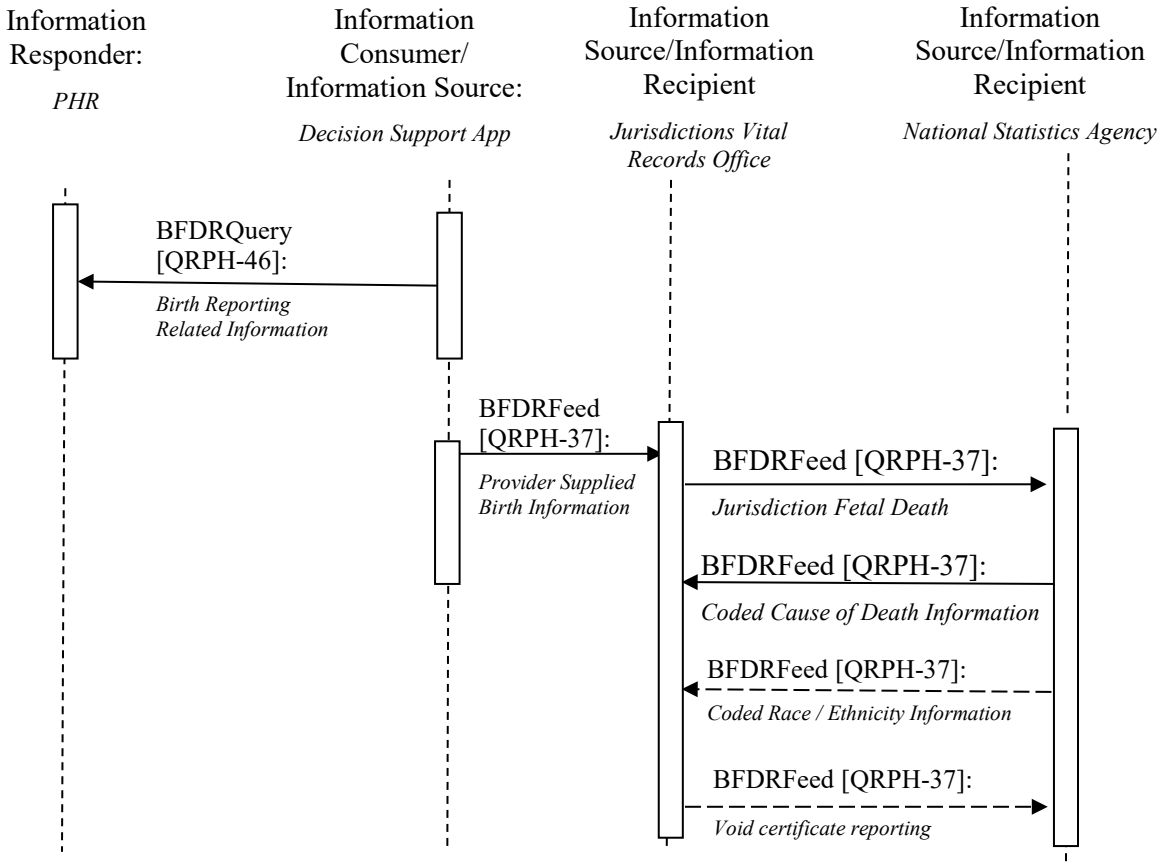


Figure X.4.2.6.2-1: Use Case 6- Mother's Information Data Collection

X.5 Security Considerations

BFDR includes clinical content related to the information subject. As such, it is anticipated that the transfers of Personal Health Information (PHI) will be protected. The IHE ITI 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. See QRPH TF-2: 3.37.5, 3.Y.5.2, 3.Y.5.3, 3.Y.5.4.

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 mRFD – Mobile Retrieve Form for Data Capture

The BFDRQuery[46] transaction may be used with Mobile Retrieve form for Data Capture as an alternative for form pre-population. To accomplish this, the Data Consumer should be grouped with the Form Manager of mRFD, and the Data Responder should be grouped with the Form Filler of mRFD.

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-E 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-E 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-E Content Creator. A Portable Media Importer in XDM might be grouped with the BFDR-E Content Consumer.
- A reliable messaging-based infrastructure is defined by the IHE Cross Enterprise Document Reliable Interchange (XDR) Profile. A Document Source in XDR might be grouped with the BFDR-E Content Creator. A Document Recipient in XDR might be grouped with the BFDR-E Content Consumer.

X.6.3 Sharing Value Sets (SVS)

Actors in the BFDR-E 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.

X.7 BFDR Data Elements

This profile defines specific data element content. These data elements are used to create the BFDR Birth CDA Document or the BFDR Fetal Death CDA Document, generate the HL7 BFDRFeed [QRPH-37] message, or populate a form defined to gather the required structured data, such as the US BFDR Form. That set of data elements in the form are identified and defined in Appendix B.

Appendices

Appendix A – BFDR-E Profile - Sample Forms

A.1 Sample Birth Reporting Facilities Worksheet

The sample Birth Reporting Facilities Worksheet form included in this content profile reflects the U.S. Standard Certificate of Live Birth reporting requirements from the birthing facility. However, the BFDR Content Profile may be modified by national extension to include and accommodate international birth reporting requirements. The sample form is posted at https://www.cdc.gov/nchs/data/dvs/facility-worksheet-2016.pdf.

Note: The following form elements are no longer included as part of the U.S. national birth file and will be removed from the facilities worksheet form in the next formal release of that document:

- Date of last prenatal care visit
- Premature rupture of the membranes >=12 hours (Onset of labor)
- Precipitous labor <3 hours (Onset of labor)
- Prolonged labor => 20 hours(Onset of labor)
- Tocolysis (Obstetric procedure)
- Cervical cerclage (Obstetric procedure)
- Unplanned operating room procedures (Maternal morbidity)
- Significant birth injury (Abnormal condition of the Newborn)
- Other previous poor pregnancy outcomes (Risk Factors in this Pregnancy)
- Moderate/heavy meconium staining of the amniotic fluid (Characteristics of Labor and Delivery)
- Fetal intolerance of labor (Characteristics of Labor and Delivery)

* Item previously announced as dropped from the national birth file.

**All checkboxes on the national standard worksheet under this category have been dropped.

A.2 Sample US Fetal Death Facilities Worksheet

The sample Fetal Death Reporting Facilities Worksheet form included in this content profile reflects the U.S. Standard Report of Fetal Death reporting requirements from the birthing facility. However, the BFDR Content Profile may be modified to include and accommodate international fetal death reporting requirements. The sample form is posted at http://www.cdc.gov/nchs/data/dvs/FacilityFetal04.pdf.

Note: The following form elements are no longer included as part of the U.S. national fetal death file and will be removed from the facilities worksheet form in the next formal release of that document:

- Total number of prenatal visits for this pregnancy
  - Edit flag - Total number of prenatal visits for this pregnancy
- Date of last prenatal care visit*
- Mother's weight at delivery
  - Edit flag – Mother's weight at delivery
- Number of other pregnancy outcomes
- Date of last other pregnancy outcome
- Mother/patient transferred for maternal medical or fetal indications for delivery?
- Previous preterm birth (Risk factors for this pregnancy)
- Other previous poor pregnancy outcomes (Risk factors for this pregnancy)*
- Gonorrhea (Infections present and/or treated during this pregnancy**)
- Syphilis (Infections present and/or treated during this pregnancy**)
- Chlamydia (Infections present and/or treated during this pregnancy**)

- Listeria (Infections present and/or treated during this pregnancy**)
- Group B strep (Infections present and/or treated during this pregnancy**)
- Cytomegalovirus (Infections present and/or treated during this pregnancy**)
- Parvovirus (Infections present and/or treated during this pregnancy**)
- Toxoplasmosis (Infections present and/or treated during this pregnancy**)
- Other (Specify) (Infections present and/or treated during this pregnancy**)
- Hysterotomy/hysterectomy (Method of delivery)
- Maternal transfusion (Maternal morbidity)
- Third or fourth degree perineal laceration (Maternal morbidity)
- Unplanned hysterectomy (Maternal morbidity)
- Unplanned operating room procedure (Maternal morbidity)
- Anencephaly (Congenital anomalies of the fetus**)
- Meningomyelocele/Spina bifida (Congenital anomalies of the fetus**)
- Cyanotic congenital heart disease (Congenital anomalies of the fetus**)
- Congenital diaphragmatic hernia (Congenital anomalies of the fetus**)
- Omphalocele (Congenital anomalies of the fetus**)
- Gastroschisis (Congenital anomalies of the fetus**)
- Limb reduction defect (Congenital anomalies of the fetus**)
- Cleft Lip with or without Cleft Palate (Congenital anomalies of the fetus**)
- Cleft palate alone (Congenital anomalies of the fetus**)
- Down syndrome- karyotype confirmed/pending (Congenital anomalies of the fetus**)

- Suspected Chromosomal disorder - karyotype confirmed/pending (Congenital anomalies of the fetus**)
- Hypospadias (Congenital anomalies of the fetus**)

* Item previously announced as dropped from the national birth file.

**All checkboxes on the national standard worksheet under this category have been dropped.

A.3 Sample US mother's live birth information for Child's Birth Certificate

The sample mother's live birth information for Child's Birth Certificate form included in this content profile reflects the reporting requirements from the mother. However, the BFDR Content Profile may be modified to include and accommodate international reporting requirements that may be captured from the mother. The sample form is posted at https://www.cdc.gov/nchs/data/dvs/moms-worksheet-2016.pdf.

Note: The following form elements are no longer included as part of the U.S. Mother's Worksheet for Child's Birth Certificate file and will be removed from the worksheet form in the next formal release of that document:

- Has the mother ever been married?
- Mother Married (At birth, conception, or any time between)

A.4 Sample Patient's Worksheet for the Report of Fetal Death

The sample Patient's Worksheet for the Report of Fetal Death form included in this content profile reflects the reporting requirements from the mother. However, the BFDR Content Profile may be modified to include and accommodate international reporting requirements that may be captured from the mother. The sample form is posted at https://www.cdc.gov/nchs/data/dvs/patientwkstfetaldth.pdf.

Note: The following form elements are no longer included as part of the U.S. Patient's Worksheet for the Report of Fetal Death file and will be removed from the worksheet form in the next formal release of that document:

- Has the mother ever been married?
- Mother Married (At birth, conception, or any time between)

Appendix B – BFDR-E Profile - Data Element Definitions

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

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ANTI	Y	N	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Any antibacterial drug given systemically (intravenous or intramuscular.) For example, penicillin, ampicillin, gentamicin, cefotoxine, etc.)
AVEN1	Y	N	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes free flow (blow-by) oxygen only, laryngoscopy for aspiration of meconium, nasal cannula, and bulb suction.
AVEN6	Y	N	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP). Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula.
BINJ	Y	N	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	Significant birth injury: (skeletal fracture(s), peripheral nerve injury and/or soft tissue/solid organ hemorrhage which requires intervention). Defined as present immediately following delivery or manifesting following delivery. Includes any bony fracture or weakness or loss of sensation but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and /or extremity ecchymossi accompanied by evidence of anemia and/or hypovolemia and or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma. All require confirmation by diagnostic imaging or exploratory laparotomy.
NICU	Y	N	Abnormal conditions of the newborn: Admission to NICU	Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn. Include NICU admission at any time during the infant's hospital stay following delivery. Do not include units that do not provide continuous mechanical ventilation. Do not include well-baby nurseries or special care nurseries (i.e., Level II nursery). Do not include if the newborn was taken to the NICU for observation but is not admitted to the NICU.

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

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ATTENDS	Y	Y	Attendant: Other specified	The specific title of the person (attendant) responsible for delivering the child if not included in the list of provided titles. Examples include nurse, father, police officer, and EMS technician. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.
NPI	Y	Y	Attendant's NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.
BWG	Y	N	Birth weight (Infant's)	Infant's birthweight in grams.
BWO	Y	N	Birth weight (Infant's)	Infant's birthweight in ounces.
BWP	Y	N	Birth weight (Infant's)	Infant's birthweight in pounds.
ANTB	Y	N	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	Antibiotics received by the mother during labor. Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxine, and Ceftriaxone. Information about the course of labor and delivery. Mother should have undergone labor, regardless of method of delivery. Check the timing of the administration of the antibacterial medications. Check this item only if medications were received systemically by the mother during labor. If information on onset of labor cannot be determined from the records, check with the birth attendant.
AUGL	Y	N	Characteristics of labor and delivery: Augmentation of labor	Augmentation of labor: Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun). Check this item if medication was given or procedures to augment labor were performed AFTER labor began. If it is not clear whether medication or procedures were performed before or after labor had begun, review records to determine when labor began and when medication were given or procedures performed. If this information is unclear or not available check with the birth attendant. Do not include if induction of labor was performed.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CHOR	Y	N	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Any recorded maternal temperature at or above 38oC (100.4oF) or clinical diagnosis of chorioamnionitis during labor made by the delivery attendant (usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, or fetal tachycardia). Information about the course of labor and delivery.
ESAN	Y	N	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body. Mother should have undergone labor, regardless of method of delivery.
INDL	Y	N	Characteristics of labor and delivery: Induction of labor	Induction of labor: Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun). Examples of methods include, but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostaglandin, luminaria, or other cervical ripening agents. Check this item if medication was given or procedures to induce labor were performed BEFORE labor began. If it is not clear whether medication or procedures were performed before or after labor had begun, review records to determine when labor began and when medications were given or procedures performed. If this information is unclear or not available check with the birth attendant. Induction of labor should be checked even if the attempt to initiate labor is not successful or the induction follows a spontaneous rupture of the membrane without contractions. Does not include augmentation of labor, which applies only after labor/contractions have begun.
STER	Y	N	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Steroids received by the mother prior to delivery to accelerate fetal lung maturation. Typically administered in anticipation of preterm (less than 37 completed weeks of gestation) delivery Steroids. Includes: Betamethasone dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Does not include: Steroid medication given to the mother as an anti- inflammatory treatment before or after delivery. Three conditions must be met for this item. Check this item when 1) steroid medication was given to the mother 2) prior to delivery 3) for fetal lung maturation. Steroids may be administered to the mother prior to admittance to the hospital for delivery. Review the mother's prenatal care and other hospital records for mention of steroid administration for this purpose.
NOA04	Y	N	Characteristics of labor and delivery: None of the above	None of the listed characteristics of labor and delivery that provide information about the course of labor and delivery.
IDOB_YR	Y	N	Child: Date of Birth: Year	The infant's date (year) of birth.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
IDOB_MO	Y	N	Child: Date of Birth: Month	The infant's date (month) of birth.
IDOB_DY	Y	N	Child: Date of Birth: Day	The infant's date (day) of birth.
KIDFNAME	Y	Y	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	The legal name (first) of the child as provided by the parents.
KIDMNAME	Y	Y	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	The legal name (middle) of the child as provided by the parents.
KIDLNAME	Y	Y	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	The legal name (last) of the child as provided by the parents.
KIDSUFFX	Y	Y	Child's Last Name Suffix:	The legal name (suffix) of the child as provided by the parents.
BFED	Y	N	Child: Infant being breastfed?	Information on whether the infant was receiving breastmilk/colostrum during the period between birth and discharge from the hospital. Breastfeeding refers to the establishment of breastmilk through the action of breastfeeding or pumping (expressing). Include any attempt to establish breastmilk production during the period between birth and discharge from the hospital. Include if the infant received formula in addition to being breastfed. Does not include the intent to breastfeed.
ILIV	Y	N	Child: Infant living at time of report?	Information on the infant's survival. Check "Yes" if the infant is living. Check "Yes" if the infant has already been discharged to home care. Check "No" if it is known that the infant has died. If the infant was transferred but the status is known, indicate the known status.
IRECNUM	Y	N	Child: Newborn Medical Record Number	The medical record number assigned to the newborn.
ISEX	Y	N	Child: (infant) Sex -	The sex of the infant.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ITRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	Transfer status of the infant within 24 hours after delivery.
FTRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility	
TB	Y	N	Child: Time of Birth	The infant's time of birth.
ANEN	Y	Y	Congenital anomalies of the Newborn: Anencephaly	Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).
CCHD	Y	Y	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Congenital heart defects that cause cyanosis.
CDH	Y	Y	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.
CDIC	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Suspected chromosomal disorder karyotype confirmed
CDIS	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.
CDIP	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Suspected chromosomal disorder karyotype pending.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CL	Y	Y	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.
CP	Y	Y	Congenital anomalies of the Newborn: Cleft Palate alone	Cleft palate refers to incomplete fusion of the palatal shelves. This may be limited to the soft palate or may also extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without cleft Palate" category, rather than here.
DOWC	Y	Y	Congenital anomalies of the Newborn: Down Karyotype Confirmed	Down Karyotype confirmed
DOWN	Y	Y	Congenital anomalies of the Newborn: Down Syndrome	Down Syndrome: Trisomy 21 - A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21. Check if a diagnosis of Down syndrome, Trisomy 21 is confirmed or pending.
DOWP	Y	Y	Congenital anomalies of the Newborn: Down Karyotype Pending	Down Karyotype pending
GAST	Y	Y	Congenital anomalies of the Newborn: Gastroschisis	An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.
HYPO	Y	Y	Congenital anomalies of the Newborn: Hypospadias	Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree – on the glans ventral to the tip, second degree – in the coronal sulcus, and third degree – on the penile shaft.
LIMB	Y	Y	Congenital anomalies of the Newborn: Limb reduction defect	Limb reduction defect: (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.
MNSB	Y	Y	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
OMPH	Y	Y	Congenital anomalies of the Newborn: Omphalocele	A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.
NOA55	Y	Y	Congenital anomalies of the Newborn: None of the anomalies listed above	None of the listed congenital anomalies of the newborn or fetus.
YLLB	Y	Y	Date of last live birth:	The year of birth of the last live-born infant.
MLLB	Y	Y	Date of last live birth:	The month of birth of the last live-born infant.
DLMP_DY	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.
DLMP_MO	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.
DLMP_YR	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.
YOPO	Y	Y	Date of Last Other Pregnancy Outcome: Year	The date (year) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy. If applicable, enter the month and year. If date information is incomplete, Enter all parts of the date that are known. Enter "unknown" for any parts of the date that are missing. Do not estimate or guess a date.
MOPO	Y	Y	Date of Last Other Pregnancy Outcome: Month	The date (month) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy. If applicable, enter the month and year. If date information is incomplete, Enter all parts of the date that are known. Enter "unknown" for any parts of the date that are missing. Do not estimate or guess a date.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
ADDRESS_D	Y	Y	Facility Address	
FNAME	Y	Y	Facility Name (if Not institution, give street and number)	The name of the facility where the delivery took place.
FNPI	Y	Y	Facility National Provider Identifier	National Provider Identifier.
CHAM	Y	Y	Infections present and treated during this pregnancy: Chlamydia	Chlamydia: A positive test for Chlamydia trachomatis. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
GON	Y	Y	Infections present and treated during this pregnancy: Gonorrhea	Gonorrhea: A positive test/culture for Neisseria gonorrhea. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
HEPB	Y	N	Infections present and treated during this pregnancy: Hepatitis B	Hepatitis B (HBV, serum hepatitis): A positive test for the hepatitis B virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
HEPC	Y	N	Infections present and treated during this pregnancy: Hepatitis C	Hepatitis C (non-A, non-B hepatitis (HCV)): A positive test for the hepatitis C virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
SYPH	Y	Y	Infections present and treated during this pregnancy: Syphilis	Syphilis (also called lues) A positive test for Treponema pallidum. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
NOA02	Y	Y	Infections present and treated during this pregnancy: None of the above	None of the listed infections were present and treated during this pregnancy.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
AINT	Y	Y	Maternal Morbidity: - Admission to Intensive care [unit]	Admission to intensive care unit: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care. Serious complications experienced by the mother associated with labor and delivery.
MTR	Y	Y	Maternal Morbidity: Maternal Transfusion	Maternal transfusion: Includes infusion of whole blood or packed red blood cells within the period specified. Serious complications experienced by the mother associated with labor and delivery.
PLAC	Y	Y	Maternal Morbidity: [Third or fourth degree] perineal laceration	Third or fourth degree perineal laceration: 3rd degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4th degree laceration is all of the above with extension through the rectal mucosa. Serious complications experienced by the mother associated with labor and delivery.
RUT	Y	Y	Maternal Morbidity: Ruptured Uterus	Ruptured Uterus: Tearing of the uterine wall. Tearing of the uterine wall. Uterine rupture is a full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum (uterine serosa). Does not include uterine dehiscence in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.
UHYS	Y	Y	Maternal Morbidity: Unplanned hysterectomy	Unplanned hysterectomy: Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure. Serious complications experienced by the mother associated with labor and delivery.
UOPR	Y	Y	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Unplanned operating room procedure following delivery: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations. Serious complications experienced by the mother associated with labor and delivery.
NOA05	Y	Y	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	None of the listed serious complications experienced by the mother associated with labor and delivery.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
PRES	Y	Y	Method of Delivery: Fetal presentation [at birth]: Cephalic	The physical process by which the complete delivery of the fetus was affected. Fetal presentation at birth - Cephalic: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP); Breech: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech; Other: Any other presentation not listed above.
ROUT	Y	Y	Method of Delivery: [Final]Route and method of delivery	The physical process by which the complete delivery of the fetus was affected. Includes: Vaginal/spontaneous: delivery of the entire fetus through the vagina by the nature force of labor with or without manual assistance from the delivery attendant; Vaginal/forceps: Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head; Vaginal/vacuum: Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head; or Cesarean: Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.
TLAB	Y	Y	Method of Delivery: Trial of labor attempted	If cesarean, indicate if a trial of labor was attempted (labor was allowed, augmented, or induced with plans for a vaginal delivery).
MFNAME	Y	Y	Mother's Current Legal Name: First Name	The current legal first name of the mother.
MMNAME	Y	Y	Mother's Current Legal Name: Middle Name	The current legal middle name of the mother.
MLNAME	Y	Y	Mother's Current Legal Name: Last Name	The current legal last name of the mother.
MSUFF	Y	Y	Mother's Current Legal Name: suffix	The current legal name suffix of the mother.
HFT	Y	Y	Mother's Height: Feet	Mother’s height feet
HIN	Y	Y	Mother's Height: Inches	Mother’s height inches
MRECNUM	Y	Y	Mother's medical record number	The mother’s medical record number for this facility admission

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
PWGT	Y	Y	Mother's pre-pregnancy weight	The mother's prepregnancy weight
NFACL	Y	Y	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Indicates the name of the facility the mother was transferred from if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.
TRAN	Y	Y	Mother transferred for maternal medical or fetal indications for delivery?	Indicates if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.
DWGT	Y	Y	Mother's weight at delivery	The mother's weight at the time of delivery.
POPO	Y	Y	Number of other pregnancy outcomes	Total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.
PLBD	Y	Y	Number of previous live births now dead (do not include this child)	The total number of previous live-born infants now dead.
PLBL	Y	Y	Number of previous live births now living (do not include this child)	The total number of previous live-born infants now living.
PNC	Y	Y	Prenatal Care	The mother did not receive prenatal care at any time during the pregnancy.
OWGEST	Y	Y	Obstetric Estimate of Gestation	The best obstetric estimate of the infant's gestational age (OE) in completed weeks is based on the clinician's final estimate of gestation. The final number of weeks should be available in the OB admission H&P as the first source. The final number of weeks may also be obtained from the PNC records as a secondary source if the information is not available in the OB admissions H&P.

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

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

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
NPREV	Y	Y	Prenatal care visits: Total number of prenatal visits for this pregnancy	The total number of visits recorded in the record. A prenatal visit is one in which the physician or other health care professional examines or counsels the pregnant woman for her pregnancy Do not include visits for laboratory and other testing in which a physician or health care professional did not examine or counsel the pregnant woman Access the most recent prenatal records available. If up-to-date records are not available, contact the prenatal care provider for the most current information. Count the prenatal visits recorded in the record. Exclude visits for laboratory and other tests or classes in which the mother was not seen by a physician or other health care professional for pregnancy-related care. If it is not clear whether the mother was seen by a physician or other health care professional, include the visit(s) in the total number.
PAY	Y	N	Principal source of payment for this delivery	The principal source of payment at the time of delivery: Includes: Private insurance (Blue Cross/Blue Shield, Aetna, etc.); Medicaid (or a comparable State program); Self-pay (no third party identified); Other (Indian Health Service, CHAMPUS/ TRICARE, other government [Federal, State, local]); Unknown
PDIAB	Y	Y	Risk factors in this pregnancy: Prepregnancy Diabetes	Prepregnancy Diabetes (diagnosis of glucose intolerance requiring treatment before this pregnancy).
GDIAB	Y	Y	Risk factors in this pregnancy: Gestational Diabetes	Gestational Diabetes (diagnosis of glucose intolerance requiring treatment during this pregnancy).
PHYPE	Y	Y	Risk factors in this pregnancy: Prepregnancy Hypertension	Prepregnancy (Chronic) Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis prior to the onset of this pregnancy. Does not include gestational (pregnancy induced) hypertension (PIH)).
GHYPE	Y	Y	Risk factors in this pregnancy: Gestational Hypertension	Gestational Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis in this pregnancy (pregnancy-induced hypertension or preeclampsia.))
EHYPE	Y	Y	Risk factors in this pregnancy: Eclampsia	Eclampsia Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with proteinuria with generalized seizures or coma.) May include pathologic edema.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
PPB	Y	Y	Risk factors in this pregnancy: Previous preterm births	History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.
INFT	Y	Y	Risk factors in this pregnancy: Infertility treatment	Any assisted reproductive treatment used to initiate the pregnancy. Includes: Any assisted reproductive treatment used to initiate the pregnancy. Includes: - Drugs (such as Clomid, Pergonal) - Artificial insemination - Technical procedures (such as in-vitro fertilization) Drugs (such as Clomid, Pergonal); Artificial insemination; Technical procedures (such as in-vitro fertilization).
INFT_DRG	Y	Y	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Fertility-enhancing drugs, artificial insemination or intrauterine insemination Any fertility enhancing drugs (e.g., Clomid, Pergonal), artificial insemination or intrauterine insemination used to initiate the pregnancy.
INFT_ART	Y	Y	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer GIFT)) Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy.
PCES	Y	Y	Risk factors in this pregnancy: Previous cesarean	Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.
NPCES	Y	Y	Risk factors in this pregnancy: Number of previous cesareans	Number of previous deliveries extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.
NOA01	Y	Y	Risk factors in this pregnancy: None of the above	The patient had none of the listed risk factors in this pregnancy.
SORD	Y	Y	Set Order	Order this infant was delivered in the set.
FSEX	N	Y	Child: (fetus) Sex -	The sex of the fetus.
FDOD_YR	N	Y		Date of Delivery (Fetus) Year
FDOD_MO	N	Y		Date of Delivery (Fetus) Month

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
FDOD_DY	N	Y		Date of Delivery (Fetus) Day
ETIME	N	Y	Estimated Time of Fetal Death	Item to indicate when the fetus died with respect to labor and assessment.
LIVEB	Y	N	Not single birth - specify number of infants in this delivery born alive.	Specify the number of infants in this delivery born alive
FDTH	N	Y	Number of fetal deaths	Specify the number of fetal deaths in this delivery
HYST	N	Y	Method of Delivery: Hysterotomy/Hysterectomy?	Hysterotomy/Hysterectomy was the physical process by which the complete delivery of the fetus was affected. Hysterotomy: Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy: Surgical removal of the uterus. May be performed abdominally or vaginally.
TD	N	Y	Time of delivery	Hour and minute fetus was delivered.
AUTOP	N	Y	Was an autopsy performed?	Information on whether or not an autopsy was performed
FWO	N	Y	Weight of Fetus (in ounces)	Fetus' weight in ounces.
FWG	N	Y	Weight of Fetus (grams preferred, specify unit)	Fetus' weight in grams.
FWP	N	Y	Weight of Fetus (in pounds)	Fetus' weight in pounds.
LM	N	Y	Infections present and treated during this pregnancy: Listeria	Listeria: A diagnosis of or positive test for Listeria monocytogenes. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
GBS	N	Y	Infections present and treated during this pregnancy: Group B Streptococcus	Group B Streptococcus: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CMV	N	Y	Infections present and treated during this pregnancy: Cytomeglovirus	Cytomegalovirus (CMV): A diagnosis of or positive test for Cytomegalovirus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.
B19	N	Y	Infections present and treated during this pregnancy: Parvovirus	Parvovirus: A diagnosis of or positive test for Parvovirus B19. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record
HISTOP	N	Y	Was a Histological Placental Examination performed?	Information on whether or not a histological placental examination was performed
TOXO	N	Y	Infections present and treated during this pregnancy: Toxoplasmosis	Toxoplasmosis: A diagnosis of or positive test for Toxoplasma gondii.
COD18a1	N	Y	Initiating Cause/Condition - Rupture of membranes prior to onset of labor	NA
COD18a2	N	Y	Initiating Cause/Condition - Abruptio placenta	NA
COD18a3	N	Y	Initiating Cause/Condition - Placental insufficiency	NA
COD18a4	N	Y	Initiating Cause/Condition - Prolapsed cord	NA
COD18a5	N	Y	Initiating Cause/Condition - Chorioamnionitis	NA
COD18a6	N	Y	Initiating Cause/Condition - Other complications of placenta, cord, or membranes	NA
COD18a7	N	Y	Initiating Cause/Condition - Unknown	NA

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
COD18a8	N	Y	Initiating Cause/Condition - Maternal conditions/diseases literal	NA
COD18a9	N	Y	Initiating Cause/Condition - Other complications of placenta, cord, or membranes literal	NA
COD18a10	N	Y	Initiating Cause/Condition - Other obstetrical or pregnancy complications literal	NA
COD18a11	N	Y	Initiating Cause/Condition - Fetal anomaly literal	NA
COD18a12	N	Y	Initiating Cause/Condition - Fetal injury literal	NA
COD18a13	N	Y	Initiating Cause/Condition - Fetal infection literal	NA
COD18a14	N	Y	Initiating Cause/Condition - Other fetal conditions/disorders literal	NA
COD18b1	N	Y	Other Significant Cause/Condition - Rupture of membranes prior to onset of labor	NA
COD18b2	N	Y	Other Significant Cause/Condition - Abruptio placenta	NA
COD18b3	N	Y	Other Significant Cause/Condition - Placental insufficiency	NA
COD18b4	N	Y	Other Significant Cause/Condition - Prolapsed cord	NA
COD18b5	N	Y	Other Significant Cause/Condition - Chorioamnionitis	NA

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
COD18b6	N	Y	Other Significant Cause/Condition - Other complications of placenta, cord, or membranes	NA
COD18b7	N	Y	Other Significant Cause/Condition - Unknown	NA
COD18b8	N	Y	Other Significant Cause/Condition - Maternal conditions/diseases literal	NA
COD18b9	N	Y	Other Significant Cause/Condition - Other complications of placenta, cord, or membranes literal	NA
COD18b10	N	Y	Other Significant Cause/Condition - Other obstetrical or pregnancy complications literal	NA
COD18b11	N	Y	Other Significant Cause/Condition - Fetal anomaly literal	NA
COD18b12	N	Y	Other Significant Cause/Condition - Fetal injury literal	NA
COD18b13	N	Y	Other Significant Cause/Condition - Fetal infection literal	NA
COD18b14	N	Y	Other Significant Cause/Condition - Other fetal conditions/disorders literal	NA
KIDFNAME	Y	Y	Child's First Name/ Name of Fetus(optional at the discretion of the parents)*	The legal name (first) of the child as provided by the parents.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
KIDMNAME	Y	Y	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)*	The legal name (middle) of the child as provided by the parents.
KIDLNAME	Y	Y	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	The legal name (last) of the child as provided by the parents.
KIDSUFFX	Y	Y	Child's Last Name Suffix:	The legal name (suffix) of the child as provided by the parents.
UNUM	Y	Y	Mother's Residence: Apartment or Unit Number	Mother's Residence: Apartment or Unit Number
CITY	Y	Y	Mother's Residence: City, Town or Location	Mother's Residence: City or Town name
CITYC	Y	Y	Mother's Residence: Code for City, Town or Location	Mother's Residence: City or Town code
COUNTY	Y	Y	Mother's Residence: County*	Mother's Residence: County
LIMITS	Y	Y	Mother's Residence: Inside City Limits	Indicates if the mother's residence is within city limits
STATE	Y	Y	Mother's Residence: State	Mother's Residence: State/Province
STNAME	Y	Y	Mother's Residence: Street Name	Mother's Residence: Street Name
STNUM	Y	Y	Mother's Residence: Street Number	Mother's Residence: Street Number
ZIP	Y	Y	Mother's Residence: Zip Code	Mother's Residence: Zip Code
LIMITS	Y	Y	Mother's Residence: Inside City Limits*	Indicates if the mother's residence is within city limits
MSTNAME	Y	Y	Mother's Mailing Address*: Name	The mother's mailing address (complete number and street name)
MAPT	Y	Y	Mother's Mailing Address: Apartment	The mother's mailing address (Apartment number)
MCITY	Y	Y	Mother's Mailing Address: City	The mother's mailing address (city or town name)
MSTATE	Y	Y	Mother's Mailing Address: State	The mother's mailing address (state, territory or province)
MZIP	Y	Y	Mother's Mailing Address: Zip	The mother's mailing address (zip code)

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
MCOUNTRY	Y	Y	Mother's Mailing Address: Country	The mother's mailing address (country)
MDOB_YR	Y	Y	Mother's Date of Birth* Year	The mother's date (year) of birth
MDOB_MO	Y	Y	Mother's Date of Birth* Month	The mother's date (month) of birth
MDOB_DY	Y	Y	Mother's Date of Birth* Day	The mother's date (day) of birth
BPLACEC_CNT*	Y	Y	Birthplace – Code for Mother's country of birth	Code for Mother's country of birth
BPLACE_ST*	Y	Y	Birthplace – Mother's state of birth	Mother's state of birth (literal)
BPLACE_TER*	Y	Y	Birthplace – Mother's territory of birth	Mother's territory of birth (literal)
BPLACEC_ST_TER *	Y	Y	Birthplace – Code for Mother's state or territory of birth	Code for Mother's state or territory of birth
METHNIC1	Y	Y	Mother of Hispanic Origin? Mexican/ Mexican American/ Chicana	Mother's Hispanic Origin is Mexican/Mexican American/Chicana
METHNIC2	Y	Y	Mother of Hispanic Origin? Puerto Rican	Mother's Hispanic Origin is Puero Rican
METHNIC3	Y	Y	Mother of Hispanic Origin? Cuban	Mother's Hispanic Origin is Cuban
METHNIC4	Y	Y	Mother of Hispanic Origin? Other Spanish/Hispanic/Latina	Mother's Hispanic Origin is Other Spanish/Hispanic/Latina
METHNIC5	Y	Y	Mother of Hispanic Origin? Other Literal Entry	Mother's Hispanic Origin is Other (specify)
MRACE1	Y	Y	Mother's Race: White	Mother's Race is White
MRACE2	Y	Y	Mother's Race: Black or African American	Mother's Race: Black or African American
MRACE3	Y	Y	Mother's Race: American Indian or Alaska Native	Mother's Race: American Indian or Alaska Native

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
MRACE4	Y	Y	Mother's Race: Asian Indian	Mother's Race: Asian Indian
MRACE5	Y	Y	Mother's Race: Chinese	Mother's Race: Chinese
MRACE6	Y	Y	Mother's Race: Filipino	Mother's Race: Filipino
MRACE7	Y	Y	Mother's Race: Japanese	Mother's Race: Japanese
MRACE8	Y	Y	Mother's Race: Korean	Mother's Race: Korean
MRACE9	Y	Y	Mother's Race: Vietnamese	Mother's Race: Vietnamese
MRACE10	Y	Y	Mother's Race: Other Asian	Mother's Race: Other Asian (specify)
MRACE11	Y	Y	Mother's Race: Native Hawaiian	Mother's Race: Native Hawaiian
MRACE12	Y	Y	Mother's Race: Guamanian or Chamorro	Mother's Race: Guamanian or Chamorro
MRACE13	Y	Y	Mother's Race: Samoan	Mother's Race: Samoan
MRACE14	Y	Y	Mother's Race: Other Pacific Islander	Mother's Race: Other Pacific Islander (specify)
MRACE15	Y	Y	Mother's Race: Other Race	Mother's Race: Other Race (specify)
MRACE16	Y	Y	Mother's Race: First American Indian or Alaska Native	Mother's Race: First American Indian or Alaska Native (literal)
MRACE17	Y	Y	Mother's Race: Second American Indian or Alaska Native	Mother's Race: Second American Indian or Alaska Native (literal)
MRACE18	Y	Y	Mother's Race: First Other Asian	Mother's Race: First Other Asian (literal)
MRACE19	Y	Y	Mother's Race: Second Other Asian	Mother's Race: Second Other Asian (literal)
MRACE20	Y	Y	Mother's Race: First Other Pacific Islander	Mother's Race: First Other Pacific Islander (literal)
MRACE21	Y	Y	Mother's Race: Second Other Pacific Islander	Mother's Race: Second Other Pacific Islander (literal)
MRACE22	Y	Y	Mother's Race: First Other Race	Mother's Race: First Other Race (literal)
MRACE22	Y	Y	Mother's Race: Second Other Race	Mother's Race: Second Other Race (literal)

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CMHR	Y	Y	Mother: Did the mother get WIC food for herself during this pregnancy	Indicates if there was use of the Women, Infant's and Children (WIC) nutritional program by the mother during the pregnancy
CIGPN	Y	Y	Cigarette Smoking before and during pregnancy: Number of cigarettes smoked prior to pregnancy	Number cigarettes smoked prior to pregnancy
CIGPP	Y	Y	Cigarette Smoking before and during pregnancy :Number of packs of cigarettes smoked prior to pregnancy	Number of packs smoked prior to pregnancy
CIGFN	Y	Y	Cigarette Smoking before and during pregnancy: Number of cigarettes smoked in 1st three months of pregnancy	Number of cigarettes smoked in 1st three months
CIGFP	Y	Y	Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the first three months of pregnancy	Number of packs smoked in 1st three months
CIGSN	Y	Y	Cigarette Smoking before and during pregnancy: Number of cigarettes smoked in the 2nd three months of pregnancy	Number of cigarettes smoked in 2nd three months
CIGSP	Y	Y	Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the 2nd three months of pregnancy	Number of packs smoked in 2nd three months
CIGLN			Cigarette Smoking before and during pregnancy: Number cigarettes smoked in 3rd three months of pregnancy	Number of cigarettes smoked in third trimester

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
CIGLP	Y	Y	Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the 3rd three months of pregnancy	Number of packs smoked in third trimester
FBPLACE_ST_TER_L	Y	Y	Father's Birthplace (State or Territory)	The geographic location (state or territory) of the father's place of birth (literal).
FBPLACE_ST_L	Y	Y	Father's Birthplace (Code for Father's State of Birth)	The geographic location (state) of the father's place of birth (code).
FBPLACE_ST_TER_C	Y	Y	Father's Birthplace (Code for Father's State or Territory of Birth)	The geographic location (state or territory) of the father's place of birth (code).
FBPLACE_CNT_C	Y	Y	Father's Birthplace (Code for Father's Country of Birth)	The geographic location (country) of the father's place of birth (code).
FFNAME	Y	Y	Father's Current Legal Name*: First Name	The current legal first name of the father.
FMNAME	Y	Y	Father's Current Legal Name*: Middle Name	The current legal middle name of the father.
FLNAME	Y	Y	Father's Current Legal Name*: Last Name	The current legal last name of the father.
FSUFF	Y	Y	Father's Current Legal Name*: Suffix	The current legal name suffix of the father.
FNREF	Y	Y	Father's Current Legal Name*: Refused	Indicates if the father's name can be entered and the mother refuses to name the father. This should only occur when the mother was married at birth, conception, or any time in between and refuses the name of her husband.
FDOB_YR	Y	Y	Father's Date of Birth*: Year	The father's date (year) of birth
FDOB_MO	Y	Y	Father's Date of Birth*: Month	The father's date (month) of birth
FDOB_DY	Y	Y	Father's Date of Birth*: Day	The father's date (day) of birth
FEDUC	Y	N	Father's Education*	The highest degree or level of schooling completed by the father at the time of this delivery
FETHNIC1	Y	N	Father of Hispanic Origin? Mexican, Mexican American or Chicano	Father is Mexican, Mexican American or Chicano

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
FETHNIC2	Y	N	Father of Hispanic Origin? Puerto Rican	Father is Puerto Rican
FETHNIC3	Y	N	Father of Hispanic Origin? Cuban	Father is Cuban
FETHNIC4	Y	N	Father of Hispanic Origin? Other	Father is other: Spanish/Hispanic/Latino
FETHNIC5	Y	N	Father of Hispanic Origin? Other literal entry	Other literal entry
FRACE1	Y	N	Father's Race: White	Father’s Race is White
FRACE2	Y	N	Father's Race: Black or African American	Father’s Race is Black or African American
FRACE3	Y	N	Father's Race: American Indian or Alaska Native	Father’s Race is American Indian or Alaska Native (Name of the enrolled or principal tribe)
FRACE4	Y	N	Father's Race: Asian Indian	Father’s Race is Asian Indian
FRACE5	Y	N	Father's Race: Chinese	Father’s Race is Chinese
FRACE6	Y	N	Father's Race: Filipino	Father’s Race is Filipino
FRACE7	Y	N	Father's Race: Japanese	Father’s Race is Japanese
FRACE8	Y	N	Father's Race: Korean	Father’s Race is Korean
FRACE9	Y	N	Father's Race: Vietnamese	Father’s Race is Vietnamese
FRACE10	Y	N	Father's Race: Other Asian	Father’s Race is Other Asian (specify)
FRACE11	Y	N	Father's Race: Native Hawaiian	Father’s Race is Native Hawaiian
FRACE12	Y	N	Father's Race: Guamanian or Chamorro	Father’s Race is Guamanian or Chamorro
FRACE13	Y	N	Father's Race: Samoan	Father’s Race is Samoan
FRACE14	Y	N	Father's Race: Other Pacific Islander	Father’s Race is Other Pacific Islander (specify)
FRACE15	Y	N	Father's Race: Other Race	Father’s Race is Other Race (specify)
FRACE16	Y	N	Father's Race: First American Indian or Alaska Native	Father’s Race is First American Indian or Alaska Native (literal)

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
FRACE17	Y	N	Father's Race: Second American Indian or Alaska Native	Father's Race is Second American Indian or Alaska Native (literal)
FRACE18	Y	N	Father's Race: First Other Asian	Father's Race is: First Other Asian (literal)
FRACE19	Y	N	Father's Race: Second Other Asian	Father's Race is: Second Other Asian (literal)
FRACE20	Y	N	Father's Race: First Other Pacific Islander	Father's Race is First Other Pacific Islander (literal)
FRACE21	Y	N	Father's Race: Second Other Pacific Islander	Father's Race is Second Other Pacific Islander (literal)
FRACE22	Y	N	Father's Race: First Other Race	Father's Race is: First Other Race (literal)
FRACE23	Y	N	Father's Race: Second Other Race	Father's Race is: Second Other Race (literal)
MSSN	Y	N	Mother's Jurisdiction Identifier (e.g., Security Number)	The jurisdiction identifier (e.g., social security number (SSN)) of the mother
FSSN	Y	N	Father's Jurisdiction Identifier (e.g., Security Number)	The jurisdiction identifier (e.g., social security number (SSN)) of the father named on the certificate.
ACKN	Y	N	Acknowledgment of paternity signed	The mother and father signed a form (Insert name of the State acknowledgement of paternity form) in which the father accepted legal responsibility for the child?
MHT	Y	Y	Mother's body height	Open Issue: Mother's Body Height is listed as a separate new LOINC code
BREGDATE	Y	N	Date of birth registration	The date on which the birth was registered.
FAGE	Y	Y	Father's reported age in years	A record of the father's age at the time of birth or delivery.
HDELPLAN	Y	N	Planned to deliver at home	Open Issue: Planned to deliver at home is part of the Birthplace value set, but a separate LOINC code has been assigned for the draft HL7 spec. Boolean indicator (Yes/No/Unknown) that indicates whether the mother intended to have a home birth. Only value this observation if the birth took place at home.
MAGE	Y	Y	Mother's reported age in years	Mother's age is calculated using mother's date of birth (completed dates only) and the child's date of birth. Calculated age must be >8 and < 65
NOINAME	Y	Y	Baby name not yet chosen	Open Issue: Baby name not yet chosen is not in edit specifications. An indicator that the name for a newborn baby has not yet been chosen. Enter "Yes" if no name has been chosen
BATTEND	Y	N	Birth attendant details	Name and identifier information for the person attending the birth.

Attribute Name	Used in Birth	Used in Fetal Death	Birth and Fetal Death Report Data Element	Description
BCERTIFIER	Y	N	Birth certifier details	Name and identifier information for the person certifying the birth.
CERTDATE	Y	N	Date birth certified	The date the birth was certified by the certifying professional.
FDREGDATE	N	Y	Date of fetal death registration	The date the fetal death was registered at the jurisdictional vital statistics office.
FDELDATE	N	Y	Date of fetal delivery	The date of delivery for the fetus.
FETNAME	N	Y	Name of fetus	Name given to the fetus.
INFOSRC	Y	N	Person providing information for mother's live birth information	The name of the person providing information for the mother's worksheet.
RELINFOSRC	Y	N	Relationship of person providing information for mother's live birth information	The relationship between the mother and the person providing information for the mother's worksheet
DISPMET	N	Y	Fetal remains disposition method	To reflect the method by which the fetal remains were disposed
OTHCOD	N	Y	Death cause other significant conditions	Coded value that provides information on a significant condition or conditions that contributed to death but did not result in the underlying cause that is elsewhere described. This data is returned to the jurisdiction as an ICD 10 code.
INITCOD	N	Y	Initiating cause of death or condition	Coded value that indicates one or more diseases, injuries, or complications that were implicated as the initiating cause of fetal death. This data is returned to the jurisdiction as an ICD 10 code.

Volume 2 – Transactions

Add Section 3.37

3.37 BFDRFeed [QRPH-37]

3.37.1 Scope

This transaction is used to communicate clinician-sourced birth and fetal death information from the Information Source to the Information Recipient. This transaction may alternatively be initiated by a Form Receiver Message Exporter and communicated to the Information Recipient. This transaction uses the Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU).

3.37.2 Actor Roles

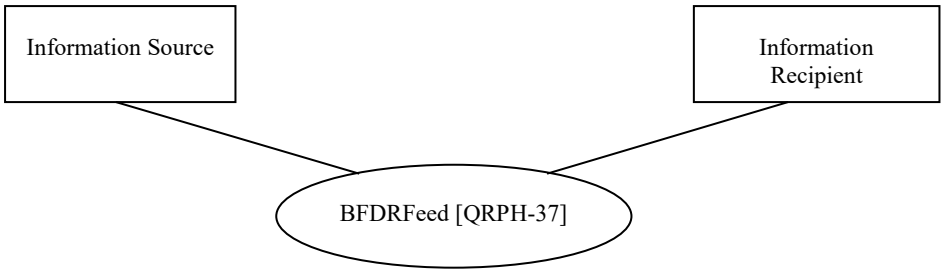


Figure 3.37.2-1: Use Case Diagram between Information Source and Information Recipient

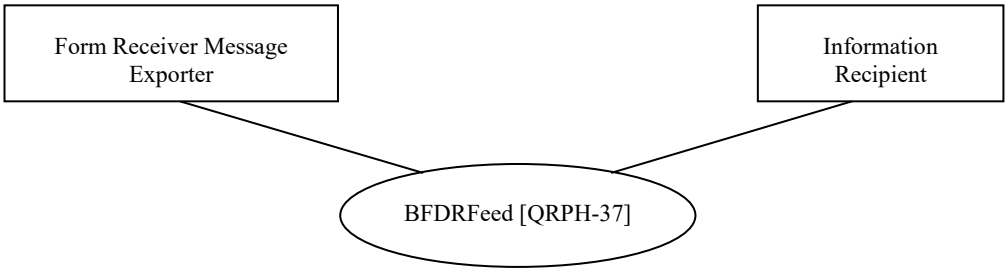


Figure 3.37.2-2: Use Case Diagram between Form Receiver Message Exporter and Information Recipient

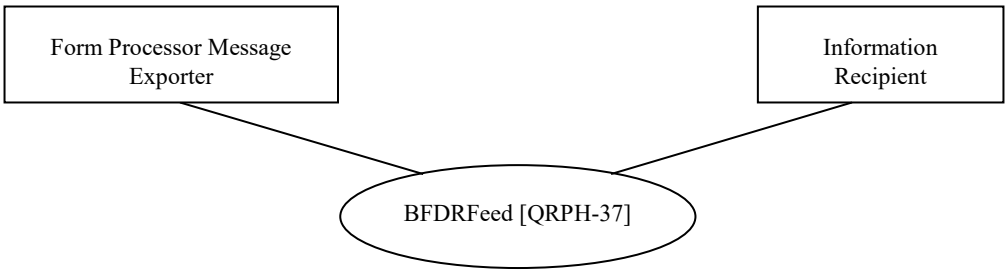


Figure 3.37.2-3: Use Case Diagram between Form Processor Message Exporter and Information Recipient

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

Table 3.37.2-1: Actor Roles

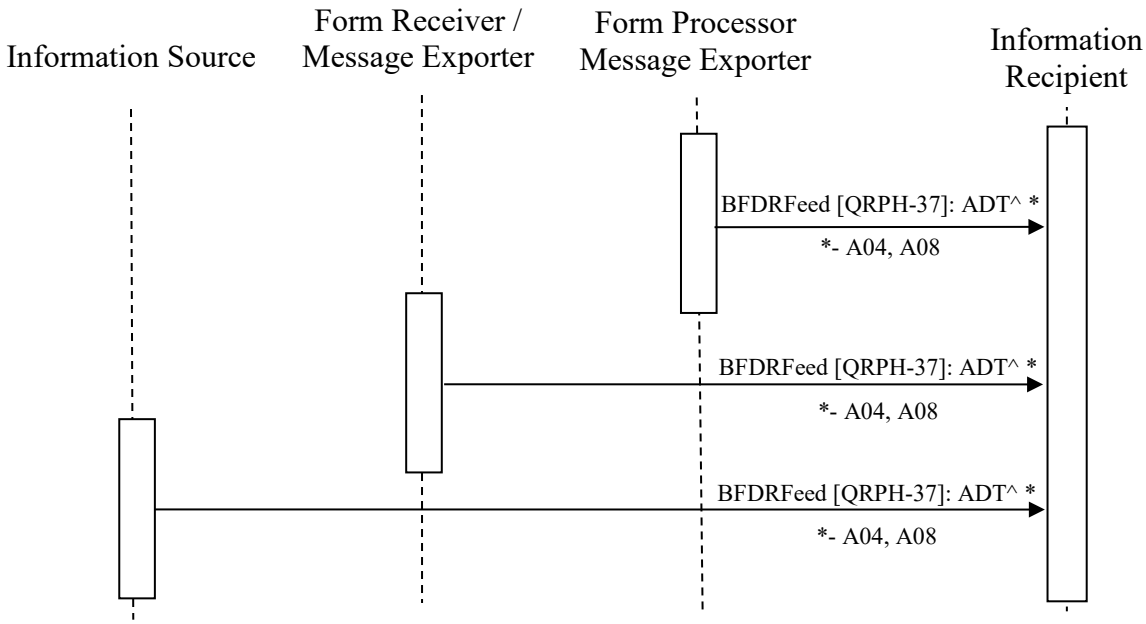
Actor:	Information Source
Role:	The Information Source is responsible for creating and transmitting an HL7 V2.6 message to an Information Recipient.
Actor:	Information Recipient
Role:	The Information Recipient is responsible for receiving the HL7 V2.6 message from an Information Source or from a Form Receiver Message Exporter.
Actor:	Form Receiver Message Exporter
Role:	The Form Receiver Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to be in compliance with the requirements of the BFDRFeed [QRPH-37] transaction and sends that data to an Information Recipient using BFDRFeed [QRPH-37].
Actor:	Form Processor Message Exporter
Role:	The Form Processor Message Exporter receives data submitted through the Submit Form [ITI-35] transaction, transforms that data to be in compliance with the requirements of the BFDRFeed [QRPH-37] transaction and sends that data to an Information Recipient using BFDRFeed [QRPH-37].

3.37.3 Referenced Standards

1. HL7 Version 2.6 Implementation Guide: Vital Records Birth and Fetal Death Reporting, Release 1 STU Release 2EMR

2. Birth Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Live Birth
3. Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Report of Fetal Death
4. International Classification of Diseases, Tenth Revision (ICD-10)
5. International statistical classification of diseases and related health problems 10th Revision, Volume 2 Instruction Manual
    a. Section 4.1.2 The international death certificate
6. Section 7.1 form 7.1.1 International form of medical certificate of cause of death

3.37.4 Interaction Diagram



3.37.4.1 BFDRFeed [QRPH-37]

This transaction transmits the HL7 V2.6 formatted message containing the clinician-sourced birth and fetal death information from Information Source the Form Processor Message Exporter, or the Form Receiver / Message Exporter to the Information Recipient. A given Information Recipient implemented at a public health jurisdiction may receive this transaction from multiple sources.

3.37.4.1.1 Trigger Events

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

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

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

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

3.37.4.1.2 Message Semantics

The BFDRFeed are ADT messages that conform to the HL7 VR_BAFDRPT v2.6 IG message profile use cases. The semantics of the ADT messages sent by the Information Source, the Form Processor Message Exporter, or Form Receiver Message Exporter vary depending on the option(s) supported by those actors; see Table 3.38.4.1.2-1.

Information Source, the Form Processor Message Exporter, and the Form Receiver Message Exporter Actors supporting one or more option shall send ADT messages that conform to the message profile identified in Table 3.38.4.1.2-1 AND as further constrained in Table 3.38.4.1.2-2. In column 2 below, the value in parentheses identifies the abbreviations used in the optionality column in Table 3.38.4.1.2-2.

The ADT^A04 (Register a Patient) message is constrained for the first transmission of information about a birth or fetal death within the context of a particular use case. The ADT^A08 (Update Patient Information) message is constrained for updating previously transmitted information. Since the segment pattern of the message does not change even though it responds to a different trigger event, the message semantics in the table are the same for both message types. The ADT^A11 has no further constraints to the underlying standard.

Table 3.38.4.1.2-1: Actor Options Mapped to HL7 message Profile Use Cases

IHE BFDR-E Profile Actors	IHE BFDR-E Profile Option	HL7 BFDR V2.6 IG Message Profile Use Case
Information Source Form Processor Message Exporter Form Receiver Message Exporter Information Recipient	Provider Supplied Live Birth Reporting Option (PSLBI)	Report Provider Supplied Live Birth Information Revise Provider Supplied Live Birth Information
	Provider Supplied Mother's Live Birth Information Option (PSMLBI)	Report Provider Supplied Mother's Live Birth Information Revise Provider Supplied Mother's Live Birth Information

IHE BFDR-E Profile Actors	IHE BFDR-E Profile Option	HL7 BFDR V2.6 IG Message Profile Use Case
	Provider Supplied Facility's Live Birth Information Option (PSFLBI)	Report Provider Supplied Facility's Live Birth Information Revise Provider Supplied Facility's Live Birth Information Report Provider Supplied
	Provider Supplied Fetal Death Reporting Option (PSFDI)	Report Provider Supplied Fetal Death Information Revise Provider Supplied Fetal Death Information
	Fetal Death Facility's Information Option (PSFFDI)	Report Provider Supplied Facility's Fetal Death Information Revise Provider Supplied Facility's Fetal Death Information
	Fetal Death Mother's Information Option (PSMFDI)	Report Provider Supplied Mother's Fetal Death Information Revise Provider Supplied Mother's Fetal Death Information
Information Source Form Processor Message Export Form Receiver Message Exporter Information Recipient	Jurisdiction Live Birth Reporting Option (JLBI)	Report Jurisdiction Live Birth Information Revise Jurisdiction Live Birth Information
	Jurisdiction Fetal Death Reporting Option (JFDI)	Report Jurisdiction Fetal Death Information Revise Jurisdiction Fetal Death Information
Information Source Information Recipient	Void Certificate Reporting Option (JVFDI)	Report Void Fetal Death Report Information
Information Source Information Recipient	Coded Cause of Death Reporting Option (CCOFD)	Report Coded Cause of Fetal Death Revise Coded Cause of Fetal Death
Information Source Information Recipient	Coded Race/Ethnicity Reporting Option (CREI)	Report Coded Race & Ethnicity Revise Coded Race & Ethnicity

Optionality for segments in the ADT message is defined in Table 3.38.4.1.2-2. Note that this table and the sub-sections for each segment contain some IHE constraints on the underlying HL7 BFDR V2.6 IG.

RE+ and O+ indicate that there is an IHE extension to the HL7 BFDR V2.6 IG Message Profile Use Cases.

Table 3.37.4.1.2-2: BFDRFeed Constraints on the HL7 BFDR V2.6 IG Message Profile Use Cases between the Provider and the Jurisdiction

Seg-ment	Name	Repeat-able (Y/N)	Optionality						See Section
			PSLBI	PSFLBI	PSMLBI	PSFDI	PSFFDI	PSMFDI	
MSH	Message Header	N	R	R	R	R	R	R	3.38.4.1.2.1

Seg-ment	Name	Repeat-able (Y/N)	Optionality						See Section
			PSLBI	PSFLBI	PSMLBI	PSFDI	PSFFDI	PSMFDI	
SFT	Software Segment	Y	O	O	O	O	O	O	3.38.4.1.2.2
UAC	User Authentication Credential	Y	O	O	O	O	O	O	3.38.4.1.2.3
EVN	Event Type	N	R	R	R	R	R	R	3.38.4.1.2.4
PID	Patient Identification	N	R	R	R	R	R	R	3.38.4.1.2.5
NK1	Next of Kin/Associated Parties	Y	RE	RE+	RE	O	O	O	3.38.4.1.2.7
PV1	Patient Visit Information	N	R	R	R	R	R	R	3.38.4.1.2.8
OBX	Observation /Result	Y	R	R	R	R	R	R	3.38.4.1.2.11
DG1	Diagnosis Information	Y	RE+	RE+	RE+	RE+	RE+	RE+	3.38.4.1.2.13
[{	***Procedure Begin***	Y							
PR1	Procedure	N	RE+	RE+	RE+	RE+	RE+	RE+	3.38.4.1.2.15
ROL	Role	Y	O	O	O	O	O	O	3.38.4.1.2.24
}]	***Procedure End***	N/A							

Table 3.37.4.1.2-3: BRDRFeed Constraints on the HL7 BFDR V2.6 IG Message Profile Use Cases between the Jurisdiction and National Statistics Agency

Seg-ment	Name	Repeat-able (Y/N)	Optionality						See Section
			JLBI	JFDI	JVLBI	JVFDI	CCOFD	CREII	
MSH	Message Header	N	R	R	R	R	R	R	3.38.4.1.2.1
SFT	Software Segment	Y	O	O	O	O	O	O	3.38.4.1.2.2
EVN	Event Type	N	R	R	R	R	R	R	3.38.4.1.2.4
PID	Patient Identification	N	R	R	R	R	R	R	3.38.4.1.2.5

Seg-ment	Name	Repeat-able (Y/N)	Optionality						See Section
			JLBI	JFDI	JVLBI	JVFDI	CCOFD	CREII	
NK1	Next of Kin/Associated Parties	Y	RE	O	O	O	O	RE	3.38.4.1.2.7
PV1	Patient Visit Information	N	R	R	R	R	R	R	3.38.4.1.2.8
OBX	Observation/ Result	Y	R	R	O	O	R	R	3.38.4.1.2.11
DG1	Diagnosis Information	Y	RE+	RE+	O	O	O	O	3.38.4.1.2.13
[{	***Procedure Begin***	Y							
PR1	Procedure	N	RE+	RE+	O	O	O	O	3.38.4.1.2.15
ROL	Role	Y	O	O	O	O	O	O	3.38.4.1.2.24
}]	***Procedure End***	N/A							

3.37.4.1.2.1 MSH Segment

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

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

3.37.4.1.2.2 SFT Segment

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

No further constraints are required of the SFT segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU)).

3.37.4.1.2.3 EVN Segment

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

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

3.37.4.1.2.4 PID Segment

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

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

Bolded text in the table below highlights areas in this profile that are different from the underlying HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU)).

There are 3 flavors of PID used in the profiles:

- Live Birth (LB), where the data subject of the message is the newborn covers the following profiles:
  - PSLBI
  - PSFLBI
  - PSMLBI
  - JLBI
- Fetal Death (FD), where the data subject of the message is the mother covers the following profiles:
  - PSFDI
  - PSFFDI
  - PSMFDI
  - JFDI
- Identification (ID), which is used for the void certificate reporting, for reporting coded fetal cause of death, and for coded race and ethnicity reporting, to identify the relevant certificate
  - JVLBI
  - JVFDI
  - CCOFD
  - CREII

Table 3.37.4.1.2.4-1: IHE Profile - PID segment

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
1	4	SI	O	O	O		00104	Set ID - Patient ID	Literal Value: '1'.

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
2	20	CX	O	O	O		00105	Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.
3	250	CX	R	R	R		00106	Patient Identifier List	Field used to convey all types of patient/person identifiers. Use of the Medical Record Number is expected if the birth (for the baby) or fetal death (for the mother) takes place in a hospital, or the baby is admitted to one.
4	20	CX	O	O	O		00107	Alternate Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3.
5	250	XPN	R	R	R		00108	Patient Name	New born name. In the case of fetal death reporting, the name is for the mother.
6	**250**	**XPN**	**RE+**	**O**	**RE+**		**00109**	**Mother's Maiden Name**	**Optional in IG, but Optional in PIX** **Additional constraint included for international support**
7	26	TS	RE	RE	RE		00110	Date/Time of Birth	Newborn's date and time of birth, or (for fetal death reporting) the mother's. Format: YYYY[MM[DD[HH[MM[SS[.S[S[S[S]]]]]]]]][+/-ZZZZ]
8	1	IS	RE	RE	RE	0001	00111	Administrative Sex	Sex of the newborn or of the fetus.
9	250	XPN	O	O	O		00112	Patient Alias	Deprecated as of HL7 Version 2.4. See PID-5 Patient Name.
10	250	CE	O	RE	O	0005	00113	Race	

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
11	250	XAD	RE	RE	O		00114	Patient Address	Address type code = Birth Address. Only use the field, if the birth or fetal delivery does not take place in a healthcare facility. When used, the field captures the place of birth, or the place of fetal delivery. Street address, city, state and zip code are expected. If descriptive information is provided instead of an address, the Other Geographic Designation component of the XAD data type is used. Note, either PID.11 or ROL.11 may be used to record the place of birth or delivery depending on circumstances.
12	4	IS	O	O	O	0289	00115	County Code	Deprecated as of HL7 Version 2.3. See PID-11 - Patient Address, component 9 County/Parish Code.
13	250	XTN	O	O	O		00116	Phone Number – Home	
14	250	XTN	O	O	O		00117	Phone Number - Business	
15	250	CE	O	O	O	0296	00118	Primary Language	
16	250	CE	O	O	O	0002	00119	Marital Status	
17	250	CE	O	O	O	0006	00120	Religion	
18	250	CX	O	O	O		00121	Patient Account Number	
19	16	ST	O	O	O		00122	SSN Number – Patient	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.
20	25	DLN	O	O	O		00123	Driver's License Number - Patient	Deprecated as of HL7 Version 2.5. See PID-3 Patient Identifier List.
21	250	CX	O	O	O		00124	Mother's Identifier	
22	250	CE	O	RE	O	0189	00125	Ethnic Group	
23	250	ST	O	O	O		00126	Birth Place	

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
24	1	ID	RE	O	O	0136	00127	Multiple Birth Indicator	Indicates whether the baby or fetus was part of a multiple birth.
25	2	NM	RE	O	O		00128	Birth Order	Indicate the order delivered in the pregnancy of the baby or fetus, aka "Set Number". Leave the field empty for singleton births or deliveries.
26	250	CE	O	O	O	0171	00129	Citizenship	
27	250	CE	O	O	O	0172	00130	Veterans Military Status	
28	**250**	**CE**	**RE+**	**RE+**	**RE+**	**0212**	**00739**	**Nationality**	**Constrained for international use.**
29	26	TS	O	O	O		00740	Patient Death Date and Time	
30	1	ID	O	O	O	0136	00741	Patient Death Indicator	
31			O	O	O			Identity Unknown Indicator	
32			O	O	O			Identity Reliability Code	
33			O	O	O			Last Update Date/Time	
34			O	O	O			Last Update Facility	
35			O	O	O			Species Code	
36			O	O	O			Breed Code	
37			O	O	O			Strain	
38			O	O	O			Production Class Code	
39			O	O	O			Tribal Citizenship	

Adapted from the HL7 standard, Version 2.6

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

The Information Source shall provide the patient identifier in the ID component (first component) of the PID-3 field (PID-3.1). The Information Source Actor shall use component PID-3.4 to convey the assigning authority (Patient Identification Domain) of the patient

identifier. Either the first subcomponent (namespace ID) or the second and third subcomponents (universal ID and universal ID type) shall be populated. If all three subcomponents are populated, the first subcomponent shall reference the same entity as is referenced by the second and third components.

3.37.4.1.2.5 NK1 Segment

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

No further constraints are required of the NK1 segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU)).

3.37.4.1.2.6 PV1 Segment

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

No further constraints are required of the PV1 segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU)).

3.37.4.1.2.7 ROL Segment

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

No further constraints are required of the ROL segment from the corresponding HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU)).

3.37.4.1.2.8 OBX Segment

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

The Information Source, the Form Receiver Message Exporter, or the Form Processor Message Exporter may populate the following attributes using value sets other than those defined by the HL7 message (Health Level Seven International (HL7) Version 2.6 Implementation Guide (IG): Vital Records Birth & Fetal Death Reporting Release 1 - US Realm Standard for Trial Use (STU):

- Marital Status
- Education

- Race
- Ethnicity

3.37.4.1.2.9 DG1 Segment

The Information Source, the Form Receiver Message Exporter, and the Form Processor Message Exporter SHOULD populate the DG1 segment with any additional diagnoses and problems needed for jurisdiction reporting. Additional problems of interest and timeframes may be further specified by National Extension.

3.37.4.1.2.10 PR1 Segment

The Information Source, the Form Receiver Message Exporter, and the Form Processor Message Exporter SHOULD populate PR1 segment with additional any additional procedures performed needed for jurisdiction reporting. Additional procedures of interest and timeframes may be further specified by National Extension.

3.37.4.1.3 Expected Actions

3.37.4.1.3.1 ACK

Having received the ADT message from the Information Source, the Information Recipient SHALL parse this message and integrate its content, and then an applicative acknowledgement message is sent back to the Information Source. This General Acknowledgement Message ACK SHALL be built according to the HL7 V2.6 standard, following the acknowledgement rules described in IHE ITI TF-2x: C.2.3.

3.37.5 Security Considerations

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

The BFDRFeed [QRPH-37] ADT messages are audited as “PHI Export” events, as defined in ITI TF-2a: Table 3.20.4.1.1.1-1. The following tables show items that are required to be part of the audit record for these specific BFDRFeed transactions.

3.37.5.1.1 Information Source Actor audit message

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

1990 Where:

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

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

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

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

1995

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

3.37.5.1.2 Information Recipient Actor audit message

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

Patient(1)

Where:

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

2000

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

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

2005

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

3.37.5.1.3 Form Receiver Message Exporter Actor audit message

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

Where:

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

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

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

2015

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

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

3.37.5.1.4 Form Processor Message Exporter Actor audit message

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

Where:

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

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

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

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

2025

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

3.37.5.2 Security Audit Considerations – Retrieve Form [ITI-34] audit message

The Retrieve Form Transaction in the BFDR-E Profile is a PHI-Export event, as defined in ITI TF-2a: Table 3.20.4.1.1.1-120.6-1. The actors involved in the transaction SHALL create audit
2030 data in conformance with Retrieve Form [ITI-34] audit messages where such PHI Audit is required by Jurisdictional Law. See QRPH TF-2: 5.Z3.1 (currently in the CRD Trial Implementation Supplement).

3.37.5.3 Security Audit Considerations – Submit Form [ITI-35] audit messages

The Submit Form Transaction is a PHI-Export event, as defined in ITI TF-2a: Table 3.20.
2035 4.1.1.1-1. The actors involved in the transaction SHALL create audit data in conformance with

Submit Form [ITI-35] audit messages where such PHI Audit is required by Jurisdictional Law. See QRPH TF-2: 5.Z3.2 (currently in the CRD Trial Implementation Supplement).

3.37.5.4 Security Audit Considerations –Archive Form [ITI-36] audit messages audit messages

The Archive Form Transaction is a PHI-Export event, as defined in ITI TF-2a: Table 3.20.4.1.1.1-1. The actors involved in the transaction SHALL create audit data in conformance with Archive Form [ITI-36] audit messages where such PHI Audit is required by Jurisdictional Law. See QRPH TF-2: 5.Z3.3 (currently in the CRD Trial Implementation Supplement).

3.46 BFDRQuery [QRPH-46]

The Data Consumer retrieves death reporting related health information from the Data responder.

3.46.1 Scope

This transaction connects a Data Consumer to a Data Responder to allow query/retrieve of birth or fetal death reporting related health information.

3.46.2 Actor Roles

Figure 3.46.2-1: Use Case Diagram between Data Consumer and Data Responder

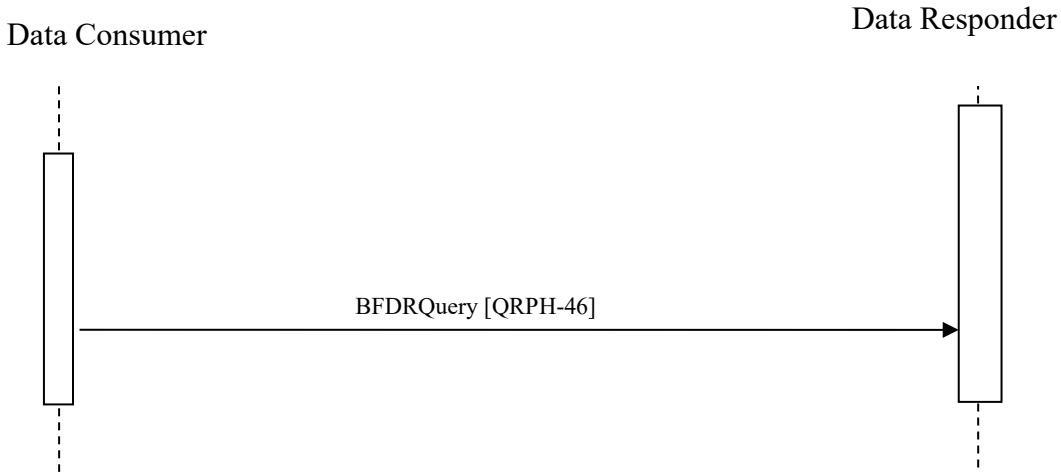
Table 3.46.2-1: Actor Roles

Actor:	Data Consumer
Role:	The Data Consumer is responsible for creating a FHIR-based request for birth or fetal death reporting related health information and retrieving this information from the Data responder.
Actor:	Data Responder
Role:	The Data Responder responds to the request for birth or fetal death reporting related health information or provides the appropriate response if the information does not exist.

3.46.3 Referenced Standards

- HL7 FHIR standard STU3
  http://www.hl7.org/implement/standards/product_brief.cfm?product_id=449

3.46.4 Interaction Diagram



3.46.4.1 BFDRQuery message

Data Consumer retrieves the birth or fetal death reporting related health information from the Data Responder.

3.46.4.1.1 Trigger Events

Data Consumer shall trigger a FHIR-based query (QRPH-46) to the Data Responder when:

- The clinician is preparing to complete the birth or fetal death reporting details for jurisdictional vital records reporting

3.46.4.1.2 Message Semantics

The message is a FHIR HTTP or HTTPS GET of Birth or Fetal Death Reporting Data where the parameter provided is the PatientID. While both HTTP and HTTPS are permitted, the implementation SHOULD consider HTTPS.

As the information is retrieved from multiple resources, the URL resources for this operation are

- [base]/Composition/[id]

- [base]/Patient/[id]
- [base]/Condition/[id]
- [base]/Observation/[id]
- [base]/Procedure/[id]
- [base]/MedicationAdministration/[id]
- [base]/Encounter/[id]
- [base]/Coverage/[id]

3.46.4.1.3 Expected Actions

The Data Consumer initiates the retrieve request for the resources specified in QRPH TF-3: 6.6.5.2 FHIR Resource Data Specifications using HTTP or HTTPS GET, and the Data Responder responds using the resources specified in QRPH TF-3: 6.6.5.2 FHIR Resource Data Specifications according to the FHIR GET specification with the requested birth or fetal death reporting related health information Birth or Fetal Death Reporting information or an error message. See: http://hl7.org/fhir/http.html#read.

3.46.5 Security Considerations

This transaction includes identifiable health information, and depending upon the implementation and application, may constitute a disclosure of health information that require audit, encryption, and authentication of the Data Consumer and Data responder. For further guidance, see ITI TF Supplement: Appendix Z.

Volume 2 Namespace Additions

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

None

Volume 3 – Content Modules

5 Namespaces and Vocabularies

Add to Section 5 Namespaces and Vocabularies

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

Add to Section 5.1.1 IHE Format Codes

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

Add to Section 5.1.2 IHE ActCode Vocabulary

No new ActCode vocabulary

Add to Section 5.1.3 IHE RoleCode Vocabulary

No new RoleCode vocabulary

6 CDA Content Modules

6.3.1 CDA Document Templates

Add to Section 6.3.1.D Document Content Modules

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

6.3.1.D1.1 Format Code

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

6.3.1.D1.2 Parent Template(s)

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

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: Birth Reporting (BFDR-Birth) - Referenced Standards

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

6.3.1.D1.4 Data Element Mapping to CDA

Refer to Section 6.6.2 Form Data Element Mappings to Output Content Document for mapping from BFDR Form data elements to the output the BFDR Birth CDA Document. Table 6.6.2-1 defines the form data element mapping to the output content document modules for Birth.

6.3.1.D1.5 Content Module Specifications

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

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

6.3.1.D1.5.1 Document Constraints

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

Opt and Card	Condition	Header Element or Section Name	Template ID	Specification Document	Vocabulary Constraint
Demographic Header Elements					
R[1..1]		Personal Information: name		HL7 Birth Reporting to VR CDA	
R2[0..1]	**Section 6.3.1.D1.5.2.1**	**Mother's Information: birthtime**		**Section 6.3.1.D1.5.2.1**	
R2[0..1]		Mother's Information: addr		HL7 Birth Reporting to VR CDA	
O[0..1]	**Section 6.3.1.D1.5.2.2**	**Mother's Information: ethnicity**		**Section 6.3.1.D1.5.2.2**	**HL7 0189**
O[0..*]	**Section 6.3.1.D1.5.2.3**	**Mother's Information: race**		**Section 6.3.1.D1.5.2.3**	**HL7 0005**
O[0..1]	**Section 6.3.1.D1.5.2.4**	**Mother's Information: gender**		**Section 6.3.1.D1.5.2.4**	**HL7 0001**
R[1..1]		Mother's Information: id		HL7 Birth Reporting to VR CDA	
R[1..1]	**Section 6.3.1.D1.5.2.5**	**realmCode**		**Section 6.3.1.D1.5.2.5**	
Sections					
No Section Constraints apply					

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

6.3.1.D1.5.2.1 Mother's Information: birthtime

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

6.3.1.D1.5.2.2 Mother's Information: ethnicity

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

6.3.1.D1.5.2.3 Mother's Information: race

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

2.16.840.1.113883.1.11.14914 unless further extended by national extension.

6.3.1.D1.5.2.4 Mother's Information: gender

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

6.3.1.D1.5.2.5 realmCode

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

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

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

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

6.3.1.D1.6 Document Example

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

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

6.3.1.D2.1 Format Code

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

6.3.1.D2.2 Parent Template(s)

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

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

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

6.3.1.D2.4 Data Element Mapping to CDA

Refer to Section 6.6.2 Form Data Element Mappings to Output Content Document for mapping from BFDR Form data elements to the output BFDR Fetal Death CDA Document. Table 6.6.2-2 defines the form data element mapping to the output content document modules for Fetal Death.

6.3.1.D2.5 Content Module Specifications

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

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

through the Medical Documents Specification parent template (1.3.6.1.4.1.19376.1.5.3.1.1.1). Only the constrained sections and clinical statements are listed here, but there are additional requirements in the HL7 CDA Implementation Guide.

6.3.1.D2.5.1 Document Constraints

Template Name		BFDR Fetal Death CDA document			
Template ID		1.3.6.1.4.1.19376.1.7.3.1.1.19.3			
Parent Template		Reporting Fetal Death Information from a clinical setting to vital records 2.16.840.1.113883.10.20.26.2 (HL7) NOTE: Constraints to the Header Section Appl			
General Description		Document specification covers the provision of Birth and Fetal Death reporting data to the applicable jurisdictional vital reporting agencies			
Document Code		SHALL be 69045-3 (CodeSystem: 2.16.840.1.113883.6.1 LOINC), "U.S. standard report of fetal death - 2003 revision "			
Opt and Card	**Condition**	**Header Element or Section Name**	**Template ID**	**Specification Document**	**Vocabulary Constraint**
Header Elements					
R[1..1]		Personal Information: name		HL7 Birth Reporting to VR CDA	
R2[0..1]	Section 6.3.1.D2.5.2.1	Mother's Information: birthtime		Section 6.3.1.D2.5.2.1	
R2[0..1]		Mother's Information: addr		HL7 Birth Reporting to VR CDA	
O[0..1]	Section 6.3.1.D2.5.2.2	Mother's Information: ethnicity		Section 6.3.1.D2.5.2.2	HL7 0189
O[0..*]	Section 6.3.1.D2.5.2.3	Mother's Information: race		Section 6.3.1.D2.5.2.3	HL7 0005
O[0..1]	Section 6.3.1.D2.5.2.4	Mother's Information: gender		Section 6.3.1.D2.5.2.4	HL7 0001
R[1..1]		Mother's Information: id		HL7 Birth Reporting to VR CDA	
R[1..1]	Section 6.3.1.D2.5.2.5	realmCode		Section 6.3.1.D2.5.2.5	
Sections					
No section constraints					

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

6.3.1.D2.5.2.1 Mother's Information: birthtime

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

6.3.1.D2.5.2.2 Mother's Information: ethnicity

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

6.3.1.D2.5.2.3 Mother's Information: race

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

6.3.1.D2.5.2.4 Mother's Information: gender

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

6.3.1.D2.5.2.5 realmCode

The realmCode SHALL be included and SHALL indicate the country for the jurisdiction of the implementation. The value for realmCode SHALL be drawn from CodeSystem: 1.0.3166.1 Country (ISO 3166-1).

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

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

6.3.1.D2.6 Document Example

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

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

6.3.1.D3.1 Format Code

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

6.3.1.D3.2 Parent Template(s)

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

6.3.1.D3.3 Referenced Standards

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

Table 6.3.1.D3.3-1: Referenced Standards

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

6.3.1.D3.4 Data Element Mapping to CDA

Refer to 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.D3.5 Content Module Specifications

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

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

6.3.1.D3.5.1 Document Constraints

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

Template Name		Labor and Delivery Summary – Vital Records			
Template ID		1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1			
Parent Template		Specialization of 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2 Labor and Delivery Summary Document Template, IHE PCC			
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/EncompassingEncounter	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
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
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.D3.5.2 Header – Further Vocabulary or Conditional Constraints

6.3.1.D3.5.2.1 documentationOf/encompassingEncounter

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

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: /encompassingEncouter/encounterParticipant[@typeCode='REF']/assignedEntity/representedOrganization

Facility name where the Birth Occurred SHALL be included in:

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

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

ClinicalDocument/componentOf/encompassingEncouter /location/healthCareFacility/serviceProviderOrganization/id

Facility Town/City SHALL be included in:

ClinicalDocument/componentOf/encompassingEncouter /location/healthCareFacility/serviceProviderOrganization/addr/city

Facility County/Region SHALL be included in:

ClinicalDocument/componentOf/encompassingEncouter /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

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

6.3.1.D3.5.3.1 Admission Medication History

Medication Coded Product

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.

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

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

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

6.3.1.D3.5.3.2 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. 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.

Where these conditions exist,

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

Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071

Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98

Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

In:
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:

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.D3.5.3.3 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.

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 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.

SHALL include the following observations if known:

Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70

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

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']]

/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']]

/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:
    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.

Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122

Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123

Number of Preterm Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187

Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124

Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148

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:

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:

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:

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.

Pregnancy History Findings:

Risk Factors During Pregnancy

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

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

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

/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

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.D3.5.3.4 Active Problems

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

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

Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071

Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98

Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

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

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

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

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

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

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'

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.D3.5.3.5 Coded Detailed Physical Examination

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

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

Coded Vital Signs 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

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

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

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']]

/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:

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]]

/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:

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']]

/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.D3.5.3.7 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:

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

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

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

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

/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:

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.D3.5.3.8 Labor and Delivery Events

No further constraints.

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

Procedure 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

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

Cervical Cerclage (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125

External Cephalic Version (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

Tocolysis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128

Hysterotomy Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150

Transfusion Whole Blood or Packed Red Bld (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99

Unplanned Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103

Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138

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/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']]

/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) 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:

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

the Procedures an 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

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

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']]

/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']]

/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:

Route and Method of Delivery - Spontaneous (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111

Route and Method of Delivery - Forceps (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112

Route and Method of Delivery - Vacuum (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113

Route 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']]

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

Coded Event Outcome

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:

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

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

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

Third Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100

Fourth Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101

Ruptured Uterus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102

Fetal Presentation at Birth- Breech (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108

Fetal Presentation at Birth- Cephalic (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109

Fetal Presentation at Birth- Other (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110

Precipitous Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130

Prolonged Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131

Premature Rupture (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129

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

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

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:

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

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:

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

6.3.1.D3.5.3.11 Newborn Delivery Information

6.3.1.D3.5.3.11.1 Subject Participation

Multiple Birth

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

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']

/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']]

/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:

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

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

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]

/subject/relatedSubject/administrativeGenderCode

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

Neurologic Systems: 1.3.6.1.4.1.19376.1.5.3.1.1.9.35

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

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]

/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:

ClinicalDocument/component/structuredBody

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

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

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

/component/section[templateId[@root=’1.3.6.1.4.1.19376.1.5.3.1.1.9.35’]]

/entry/ 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):

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]

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

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']]
/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'
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']]
/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)

Limb Reduction Defect (NCHS) 6.1.4.1.19376.1.7.3.1.1.13.8.64

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']]

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.34']]

/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']]

/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/code

Abdomen 1.3.6.1.4.1.19376.1.5.3.1.1.9.31

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:

ClinicalDocument/component/structuredBody

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

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

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

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

/entry/ 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']]

/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

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:

ClinicalDocument/component/structuredBody

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

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

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

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.36']]

/entry/ 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']]

/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

6.3.1.D3.5.3.13 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

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']]

/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

/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

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

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']]

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

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

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='

ClinicalDocument/component/structuredBody

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

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

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

/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.16']]

/entry /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

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

/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

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]
/ 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

6.3.1.D3.5.3.15 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
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
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

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

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']]

/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

/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.D3.5.3.16 Newborn Delivery Information.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:

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

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

/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:

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

6.3.1.D3.5.3.17 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:

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']]
/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

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:

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

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:

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/entryRelationship[@typeCode='RSON']

/observation[cda:templateId/@root='2.16.840.1.113883.10.20.1.28']/code

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

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

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

/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'

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']]

/entry/ observation/code

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

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']]

/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

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

/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

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
/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

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]
/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]

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']]
/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:

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]

/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

/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/ 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

/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:

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]

/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

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

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']]

/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

6.3.1.D3.5.3.19 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

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']]

/observation/code

The 'value' element not constrained

6.3.1.D3.5.3.20 Payers

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

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']
/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.D3.5.3.20-1: 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

6.3.1.D3.6 Document Example

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

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

A complete example of the Labor and Delivery Summary – Vital Records (LDS-VR) Document Content Module is available on the IHE ftp server at: ftp://ftp.ihe.net/TF_Implementation_Material/QRPH/packages/. Note that this is an example and is meant to be informative and not normative. This example shows the 1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1 elements for all of the specified templates.

6.3.2 CDA Header Templates

Add to Section 6.3.2 Header Content Module Templates

None

6.3.3 CDA Section Templates

Add to Section 6.3.3.10 Section Content Module Templates

None

6.3.4 CDA Entry Content Module Templates

Add to Section 6.3.4.E Entry Content Modules

None

6.4 Section not applicable

This heading is not currently used in a CDA document.

6.5 Value Sets

The following table describes each of the value sets used to support the BFDR-E 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-E 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-E Vocabulary 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-e Profile

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
10 Min Apgar Score (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13	To reflect the 10 Min Apgar Score	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13	IHE BFDR
5 Min Apgar Score (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12	To reflect the 5 Min Apgar Score	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Anencephaly of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53	To reflect Anencephaly of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53	IHE BFDR
Antibiotic Administration Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178	To reflect Antibiotic Administration Procedure during labor and delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178	IHE BFDR
Antibiotics (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3	To reflect that antibiotics were received by the mother during delivery and by the newborn for suspected neonatal sepsis	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3	IHE BFDR
Antibiotics Received During Labor Finding (NCHS)	2.16.840.1.114222.4.11.7535	To identify findings that the mother has received antibiotics during labor.	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7535	IHE BFDR
Artificial or Intrauterine Inseminati on (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145	To reflect the Artificial or Intrauterine Insemination as a Risk Factor in Pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145	IHE BFDR
Assisted Ventilation (NCHS)	2.16.840.1.114222.4.11.7156	To reflect that the newborn was provided assisted ventilation reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7156	IHE BFDR
Assisted Ventilation Finding (NCHS)	2.16.840.1.114222.4.11.7533	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)	2.16.840.1.114222.4.11.7534	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

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Assistive Reproductive Technology (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146	To reflect the Assistive Reproductive Technology as a Risk Factor in Pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146	IHE BFDR
Augmentation of Labor Finding (NCHS)	2.16.840.1.114222.4.11.7532	To identify findings that labor was augmented	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7532	IHE BFDR
Augmentation of Labor - Medication (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23	To reflect a medication used for the of Augmentation of Labor	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23	IHE BFDR
Augmentation of Labor - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22	To reflect a procedure of Augmentation of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22	IHE BFDR
Autopsy Planned (NCHS)	2.16.840.1.114222.4.11.7140	To reflect that an autopsy was planned	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7140	IHE BFDR
Birth Plurality of Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132	To reflect the Plurality, which is the number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy. ("Reabsorbed" fetuses, those which are not "delivered" (expulsed or extracted from the mother) should not be counted.)	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132	IHE BFDR
Birth Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20	To reflect the Birth Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20	IHE BFDR
Birthplace Clinic Office (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197	To reflect the birth occurred in the at clinic or office	SNOMED-CT	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

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Birth Place Freestanding Birthing Center (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196	To reflect the birth occurred at a freestanding birthing enter	SNOMED-CT	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193	To reflect the birth occurred in the at home as intended	SNOMED-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
Birth Place Home Unintended (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194	To reflect the birth occurred in the at home as unintended	SNOMED-CT	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195	To reflect the birth occurred in the at home with intention unknown	SNOMED-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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192	To reflect the birth occurred in the hospital	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192	IHE BFDR
Birthplace Setting (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184	To reflect the birthplace of the newborn (setting)	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184	IHE BFDR
Body Weight (NCHS)	2.16.840.1.114222.4.11.7421	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41	To reflect Breastfed Infant at discharge	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41	IHE BFDR
Certified Midwife (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17	To reflect the Title of the Attendant responsible for the delivery Procedure as a Certified Midwife	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17	IHE BFDR
Cervical Cerclage (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125	To reflect Obstetric Procedures as Cervical Cerclage	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Chlamydia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93	To reflect Chlamydia as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93	IHE BFDR
Chorioamnionitis During Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24	To reflect a Chorioamnionitis During Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24	IHE BFDR
Cleft Lip with or without Cleft Palate (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58	To reflect Cleft Lip with/without Cleft Palate as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58	IHE BFDR
Cleft Lip without Cleft Palate (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60	To reflect Cleft Lip without Cleft Palate as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60	IHE BFDR
Cleft Palate Alone (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189	To reflect Cleft Palate alone as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189	IHE BFDR
Conception Date (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180	To reflect Conception Date	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180	IHE BFDR
Congenital Diaphragmatic Hernia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55	To reflect Congenital Diaphragmatic Hernia as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55	IHE BFDR
Cyanotic Congenital Heart Disease (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54	To reflect Cyanotic Congenital Heart Disease as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54	IHE BFDR
Cytomegalovirus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167	To reflect infection with Cytomegalovirus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167	IHE BFDR
Date of Last Live Birth (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67	To reflect the Date of Last Live Birth	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Date of Last Menses (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69	To reflect the Date of Last Menses	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69	IHE BFDR
Date of Last Other Pregnancy Outcome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70	To reflect the Date of Last Other Pregnancy Outcome such as spontaneous or induced losses or ectopic pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70	IHE BFDR
Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14	To reflect the Delivery Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14	IHE BFDR
Doctor of Osteopathic Medicine (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16	To reflect the Title of the Attendant responsible for the delivery Procedure as a Doctor of Osteopathic Medicine	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16	IHE BFDR
Downs Syndrome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61	To reflect Downs Syndrome as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61	IHE BFDR
Eclampsia (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140	To reflect Risk Factors of Eclampsia	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140	IHE BFDR
Epidural/Spinal Anesthesia - Medication (NCHS)	2.16.840.1.114222.4.11.7475	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27	To reflect an Epidural Anesthesia Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27	IHE BFDR
Estimated Time Of Fetal Death (NCHS)	2.16.840.1.114222.4.11.7426	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127	To reflect Obstetric Procedures as External Cephalic Version	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Facility Location ICU (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2	To reflect that the patient (mother) was treated in the ICU for complications associated with labor and delivery reflecting a maternal morbidity.	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2	IHE BFDR
Facility Location NICU (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	To reflect that the newborn was admitted to the NICU reflecting an abnormal condition of the newborn	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	IHE BFDR
Facility Location OR (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104	To reflect that the patient (mother) was treated in the OR for an unplanned operation for complications associated with labor and delivery reflecting unplanned operation	HL7 Service Delivery Location	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104	IHE BFDR
Female Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43	To reflect the Female Gender	HL7 Administrative Gender	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43	IHE BFDR
Fertility Enhancing Drugs Medications (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144	To reflect that Fertility Enhancing Drugs were administered as a risk factor for pregnancy	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144	IHE BFDR
Autopsy Performed (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	To reflect Autopsy was performed	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1	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.	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7112	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Fetal Presentation at Birth-Breech (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108	To reflect the Fetal Presentation at Birth-Breech method of delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108	IHE BFDR
Fetal Presentation at Birth-Cephalic (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109	To reflect the Fetal Presentation at Birth-Cephalic method of delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109	IHE BFDR
Fetal Presentation at Birth-Other (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110	To reflect the Fetal Presentation at Birth-Other	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110	IHE BFDR
Fever Greater Than 100.4 (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25	To reflect a Fever Greater Than 100.4 During Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25	IHE BFDR
First Prenatal Care Visit (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133	To reflect the Date of the First Prenatal Care Visit	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133	IHE BFDR
Fourth Degree Perineal Laceration (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101	To reflect Fourth Degree Perineal Laceration as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101	IHE BFDR
Gastroschisis of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62	To reflect Gastroschisis of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62	IHE BFDR
Gestational Diabetes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137	To reflect Risk Factors of Gestational Diabetes	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137	IHE BFDR
Gestational Hypertension (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139	To reflect Risk Factors of Gestational Hypertension	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139	IHE BFDR
Gonorrhea (NCHS)	2.16.840.1.114222.4.11.6071	To reflect Gonorrhea as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.6071	IHE BFDR
Group B Streptococcus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166	To reflect Infection with Group B Streptococcus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Height (NCHS)	2.16.840.1.114222.4.11.7155	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96	To reflect Hepatitis B as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96	IHE BFDR
Hepatitis C (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97	To reflect Hepatitis C as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97	IHE BFDR
Histological Placental Examination (NCHS)	2.16.840.1.114222.4.11.7138	To reflect the Histological Placental Examination for fetal death		https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7138	IHE BFDR
Hypospadias (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63	To reflect Hypospadias as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63	IHE BFDR
Hysterotomy Hysterectomy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150	To reflect hysterotomy/hysterectomy as the method of delivery in fetal death	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150	IHE BFDR
ICU Care (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188	To reflect that the mother was transferred to ICU following the birth	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188	IHE BFDR
IM Medication Administration Route (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5	To reflect that Intramuscular Medication Administration Route was used to administer a medication	HL7 Route of Administration	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5	IHE BFDR
Induction of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34	To reflect that there was an Induction of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34	IHE BFDR
Induction of Labor Finding (NCHS)	2.16.840.1.114222.4.11.7531	To identify findings that labor was induced	SNOMED-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	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
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 Administration	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4	IHE BFDR
Karyotype Confirmed (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56	To reflect Karyotype Confirmed as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56	IHE BFDR
Karyotype Determination (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154	To reflect Karyotype determination as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154	IHE BFDR
Karyotype Result (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59	To reflect Karyotyping to determine that the result is pending	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59	IHE BFDR
Limb Reduction Defect (NCHS)	6.1.4.1.19376.1.7.3.1.1.13.8.64	To reflect Limb Reduction Defect as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=6.1.4.1.19376.1.7.3.1.1.13.8.64	IHE BFDR
Listeria (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	To reflect Listeria as Infections present and treated during this pregnancy		https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	IHE BFDR
Male Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42	To reflect the Male Gender	HL7 AdministrativeGender	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42	IHE BFDR
Meningomyelocele/Spina Bifida - Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65	To reflect Meningomyelocele/Spina Bifida of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65	IHE BFDR
Method of Delivery Cesarean Finding (NCHS)	2.16.840.1.114222.4.11.7527	To identify findings of delivery of the entire fetus through the vaginal wall (cesarean)	SNOMED-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)	2.16.840.1.114222.4.11.7528	To identify findings of delivery of the fetus using vaginal forceps	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7528	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Method of Delivery Vaginal-Spon Finding (NCHS)	2.16.840.1.114222.4.11.7526	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.	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7526	IHE BFDR
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	SNOMED-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	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18	IHE BFDR
Mothers Delivery Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120	To reflect the Mother's Delivery Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120	IHE BFDR
Neonatal Death (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149	To reflect that the newborn died	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149	IHE BFDR
Neonatal Sepsis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6	To reflect that the newborn had suspected neonatal sepsis reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6	IHE BFDR
Newborn Receiving Surfactant Replacement Therapy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11	To reflect that the Newborn received Surfactant Replacement Therapy reflecting an abnormal condition of the newborn	RxNorm	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
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	SNOMED-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)	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7431	IHE BFDR
NICU Care (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198	To reflect the that the baby was transferred to NICU following the birth	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198	IHE BFDR
Number of Fetal Deaths This Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164	To reflect the Number of Fetal Deaths This Delivery	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164	IHE BFDR
Number of Live Births (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68	To reflect the Number of Live Births for the current pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68	IHE BFDR
Number of Preterm Births (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187	To reflect the number of preterm births in prior pregnancies	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187	IHE BFDR
Number of Previous Cesareans (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148	To reflect the Number of Previous Cesareans as a Risk Factor in Pregnancy	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148	IHE BFDR
Number of Previous Live Births Now Dead (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122	To reflect the 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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71	To reflect the Number of Prior Pregnancies	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Number Prenatal Care Visits (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135	To reflect the Number Prenatal Care Visits	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135	IHE BFDR
Obstetric Estimate of Gestation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	To reflect the Obstetric Estimate of Gestation of the newborn	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	IHE BFDR
Omphalocele of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66	To reflect Omphalocele of the Newborn as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66	IHE BFDR
Parvovirus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168	To reflect infection with Parvovirus	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168	IHE BFDR
Physician (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15	To reflect the Title of the Attendant responsible for the delivery Procedure as a Physician	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15	IHE BFDR
Precipitous Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130	To reflect Onset of labor with Precipitous Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130	IHE BFDR
Premature Rupture (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129	To reflect Onset of labor with Premature Rupture	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129	IHE BFDR
Prepregnancy Diabetes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136	To reflect Risk Factors of Prepregnancy Diabetes	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136	IHE BFDR
Prepregnancy Hypertension (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138	To reflect Risk Factors of Prepregnancy Hypertension	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138	IHE BFDR
Pre-Pregnancy Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118	To reflect the mother's Pre-Pregnancy Weight	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118	IHE BFDR
Preterm Birth (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141	To reflect Risk Factors of Preterm Birth (history)	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Previous Cesarean (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147	To reflect Risk Factors of Pregnancy Previous Cesarean	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7165	IHE BFDR
Previous Other Pregnancy Outcomes (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121	To reflect the Previous Other Pregnancy Outcomes	LOINC	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121	IHE BFDR
Problem Status Active (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119	To reflect the Problem Status Active	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119	IHE BFDR
Prolonged Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131	To reflect Onset of labor with Prolonged Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131	IHE BFDR
Route and Method of Delivery - Cesarean (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114	To reflect the Route and Method of Delivery as Cesarean Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114	IHE BFDR
Route and Method of Delivery - Forceps (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112	To reflect the Route and Method of Delivery as Forceps Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112	IHE BFDR
Route and Method of Delivery - Scheduled C (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116	To reflect the Route and Method of Delivery as Scheduled Cesarean	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116	IHE BFDR
Route and Method of Delivery - Spontaneous (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111	To reflect the Route and Method of Delivery as Spontaneous Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111	IHE BFDR
Route Method of Delivery - Trial of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115	To reflect the Route and Method of Delivery if Cesarean was as Trial of Labor Attempted	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115	IHE BFDR
Route and Method of Delivery - Vacuum (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113	To reflect the Route and Method of Delivery as Vacuum Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Ruptured Uterus (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102	IHE BFDR
Scheduled Cesarean Finding (NCHS)	2.16.840.1.114222.4.11.7530	To identify findings that a Cesarean Section was scheduled	SNOMED-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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10	To reflect that the newborn suffered a Seizure or Serious Neurologic Dysfunction reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10	IHE BFDR
Significant Birth Injury (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9	To reflect that the newborn suffered a Significant Birth Injury (skeletal fracture(s), peripheral nerve injury, and/ or soft tissue/solid organ hemorrhage which requires intervention) reflecting an abnormal condition of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9	IHE BFDR
Spinal Anesthesia - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29	To reflect a Spinal Anesthesia Procedure	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29	IHE BFDR
Spontaneous Onset of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35	To reflect that there was a Spontaneous Onset of Labor	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35	IHE BFDR
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	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7423	IHE BFDR
Suspected Chromosomal Disorder (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57	To reflect Suspected Chromosomal Disorder as an anomaly of the newborn	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
Syphilis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98	To reflect Syphilis as Infections present and treated during this pregnancy	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98	IHE BFDR
Third Degree Perineal Laceration (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100	To reflect Third Degree Perineal Laceration as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100	IHE BFDR
Tocolysis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128	To reflect Obstetric Procedures as Tocolysis	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128	IHE BFDR
Toxoplasmosis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169	To reflect infection with Toxoplasmosis	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169	IHE BFDR
Transfer In (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177	To reflect if the mother was transferred to this facility	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)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	To reflect if the infant was transferred within 24 hours of delivery to another facility	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	IHE BFDR
Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176	To reflect Transferred for Maternal Medical or Fetal Indications for Delivery	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176	IHE BFDR
Transfusion Whole Blood or Packed Red Bld (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99	To reflect Transfusion Whole Blood or Packed Red Blood as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99	IHE BFDR
Unplanned Hysterectomy (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103	IHE BFDR
Unplanned Operation (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105	To reflect Ruptured Uterus as a maternal morbidity	SNOMED-CT	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105	IHE BFDR

Name	Identifier	Purpose	Source	PHIN VADS URL	Groups
U.S. Territories (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19	To reflect the U.S. Territories	FIPS 5-2	https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19	IHE BFDR

6.5.2 Value Sets Defined by this profile

None

6.6 Data Mappings

This section defines mappings to and from the standard data elements defined in this profile.

6.6.1 Form Data Element Mappings from Pre-Pop Document

The data elements defined in this profile can be computed from data elements in the Labor and Delivery Summary (LDS) of the electronic health record that is used as the pre-pop document. The LDS mapping rules described below overlays these data elements typically presented to the birth registrar in a form. The Derivation Rule includes a specification defining the source section and entry along with the rules for examining the LDS content to determine whether or not the data element is satisfied. These rules may specify examination of one or more LDS locations to make a determination of the data element result. While any LDS document may be used to populate the form, the IHE PCC Labor and Delivery Summary Document as constrained by the LDS-VR will result in the maximum number of pre-populated data elements.

Table 6.6.1-1 describes the pre-population rules to derive the data elements in this profile from the LDS or LDR-VR. The Derivation Rule references the section where the logic and xpath source data is defined. The Value Sets reference the Value Subsets which are published and available from the Public Health Information Network Vocabulary Access and Distribution System (PHIN-VADS).

Table 6.6.1-1: Form Data Elements Data Mapped to Input Content Document Modules

Attribute code	Definition	Derivation Rule	Value Sets
ANTI	Any antibacterial drug given systemically (intravenous or intramuscular.) For example, penicillin, ampicillin, gentamicin, cefotoxine, etc.)	6.6.1.1.1.1 ANTI Derivation Rule	6.6.1.1.1.3 ANTI Value Sets
AVEN1	Infant given manual breaths with bag and mask or bag and endotracheal tube within the first several minutes from birth for any duration. Excludes oxygen only and laryngoscopy for aspiration of meconium.	6.6.1.1.2.1 AVEN1 Derivation Rule	6.6.1.1.2.3 AVEN1 Value Sets
AVEN6	Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).	6.6.1.1.3.1 AVEN6 Derivation Rule	6.6.1.1.3.3 AVEN6 Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
BINJ	Significant birth injury: (skeletal fracture(s), peripheral nerve injury and/or soft tissue/solid organ hemorrhage which requires intervention). Defined as present immediately following delivery or manifesting following delivery. Includes any bony fracture or weakness or loss of sensation but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and /or extremity ecchymossi accompanied by evidence of anemia and/or hypovolemia and or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma. All require confirmation by diagnostic imaging or exploratory laparotomy.	6.6.1.1.4.1 BINJ Derivation Rule	6.6.1.1.3.3 AVEN6 Value Sets
NICU	Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn.	6.6.1.1.5.1 NICU Derivation Rule	6.6.1.1.5.3 NICU Value Sets
SEIZ	Seizure defined as any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction defined as severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxicischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.	6.6.1.1.6.1 SEIZ Derivation Rule	6.6.1.1.6.3 SEIZ Value Sets
SURF	Newborn given surfactant replacement therapy: Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency either due to preterm birth or pulmonary injury resulting in decreased lung compliance (respiratory distress). Includes both artificial and extracted natural surfactant.	6.6.1.1.7.1 SURF Derivation Rule	6.6.1.1.7.1 SURF Derivation Rule
NOA54	None of the listed abnormal conditions of the newborn.	6.6.1.1.8.1 NOA54 Derivation Rule	6.6.1.1.8.3 NOA54 Value Sets
APGAR5	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. Enter the infant's Apgar score at 5 minutes.	6.6.1.1.10.1 APGAR5 Derivation Rule	6.6.1.1.10.3 APGAR5 Value Sets
APGAR10	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes	6.6.1.1.11.1 APGAR10 Derivation Rule	6.6.1.1.11.3 APGAR10 Value Sets
ATTENDN	The name of the attendant (the person responsible for delivering the child), their title, and their National Provider Identification (NPI) Number.	6.6.1.1.12.1 ATTENDN Derivation Rule	6.6.1.1.12.3 ATTENDN Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
ATTEND	The title of the person (attendant) responsible for delivering the child. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery. Titles include: M.D. (doctor of medicine); D.O. (doctor of osteopathy); CNM/CM (certified nurse midwife/certified midwife); Other midwife (midwife other than a CNM/CM); and Other (specify)	6.6.1.1.13.1 ATTEND Derivation Rule	6.6.1.1.13.3 ATTEND Value Sets
ATTENDS	The specific title of the person (attendant) responsible for delivering the child if not included in the list of provided titles. Examples include nurse, father, police officer, and EMS technician. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.	6.6.1.1.14.1 ATTENDS Derivation Rule	6.6.1.1.14.3 ATTENDS Value Sets
NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.	6.6.1.1.15.1 NPI Derivation Rule	6.6.1.1.15.3 NPI Value Sets
BWG	Infant's birthweight in grams.	6.6.1.1.16.1 BWG Derivation Rule	6.6.1.1.16.3 BWG Value Sets
BWO	Infant's birthweight in ounces.	6.6.1.1.17.1 BWO Derivation Rule	6.6.1.1.17.3 BWO Value Sets
BWP	Infant's birthweight in pounds.	6.6.1.1.18.1 BWP Derivation Rule	6.6.1.1.18.3 BWP Value Sets
ANTB	Antibiotics received by the mother during labor. Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxine, and Ceftriaxone. Information about the course of labor and delivery.	6.6.1.1.19.1 ANTB Derivation Rule	6.6.1.1.19.3 ANTB Value Sets
AUGL	Augmentation of labor: Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun). Information about the course of labor and delivery.	6.6.1.1.20.1 AUGL Derivation Rule	6.6.1.1.20.3 AUGL Value Sets
CHOR	Any recorded maternal temperature at or above 38oC (100.4oF) or clinical diagnosis of chorioamnionitis during labor made by the delivery attendant (usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, or fetal tachycardia). Information about the course of labor and delivery.	6.6.1.1.21.1 CHOR Derivation Rule	6.6.1.1.21.3 CHOR Value Sets
ESAN	Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body. Information about the course of labor and delivery.	6.6.1.1.22.1 ESAN Derivation Rule	6.6.1.1.22.3 ESAN Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
INDL	Induction of labor: Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun). Information about the course of labor and delivery.	6.6.1.1.23.1 INDL Derivation Rule	6.6.1.1.23.3 INDL Value Sets
STER	Steroids (glucocorticoids): For fetal lung maturation received by the mother before delivery. Includes: Betamethasone dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Does not include: Steroid medication given to the mother as an anti-inflammatory treatment before or after delivery. Information about the course of labor and delivery.	6.6.1.1.24.1 STER Derivation Rule	6.6.1.1.24.3 STER Value Sets
NOA04	None of the listed characteristics of labor and delivery that provide information about the course of labor and delivery.	6.6.1.1.25.1 NOA04 Derivation Rule	6.6.1.1.25.3 NOA04 Value Sets
IDOB_YR	The infant's date (year) of birth.	6.6.1.1.27.1 IDOB_YR Derivation Rule	6.6.1.1.27.3 IDOB_YR Value Sets
IDOB_MO	The infant's date (month) of birth.	6.6.1.1.28.1 IDOB_MO Derivation Rule	6.6.1.1.28.3 IDOB_MO Value Sets
IDOB_DY	The infant's date (day) of birth.	6.6.1.1.29.1 IDOB_DY Derivation Rule	6.6.1.1.29.3 IDOB_DY Value Sets
KIDFNAM	The legal name (first) of the child as provided by the parents.	6.6.1.1.30.1 KIDFNAME Derivation Rule	6.6.1.1.30.3 KIDFNAME Value Sets
KIDMNAME	The legal name (middle) of the child as provided by the parents.	6.6.1.1.31.1 KIDMNAME Derivation Rule	6.6.1.1.31.3 KIDMNAME Value Sets
KIDLNAME	The legal name (last) of the child as provided by the parents.	6.6.1.1.32.1 KIDLNAME Derivation Rule	6.6.1.1.32.3 KIDLNAME Value Sets
KIDSUFFX	The legal name (suffix) of the child as provided by the parents.	6.6.1.1.33.1 KIDSUFFX Derivation Rule	6.6.1.1.33.3 KIDSUFFX Value Sets
BFED	Information on whether the infant was being breast-fed during the period between birth and discharge from the hospital.	6.6.1.1.34.1 BFED Derivation Rule	6.6.1.1.34.3 BFED Value Sets
ILIV	Information on the infant's survival. Check "Yes" if the infant is living. Check "Yes" if the infant has already been discharged to home care. Check "No" if it is known that the infant has died. If the infant was transferred but the status is known, indicate the known status.	6.6.1.1.35.1 ILIV Derivation Rule	6.6.1.1.35.3 ILIV Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
IRECNUM	The medical record number assigned to the newborn.	6.6.1.1.36.1 IRECNUM Derivation Rule	6.6.1.1.36.3 IRECNUM Value Sets
ISEX	The sex of the infant.	6.6.1.1.37.1 ISEX Derivation Rule	6.6.1.1.37.3 ISEX Value Sets
ITRAN	Transfer status of the infant within 24 hours after delivery.	6.6.1.1.38.1 ITRAN Derivation Rule	6.6.1.1.38.3 ITRAN Value Sets
FTRAN	NA	6.6.1.1.39.1 FTRAN Derivation Rule	6.6.1.1.39.3 FTRAN Value Sets
TB	The infant's time of birth.	6.6.1.1.40.1 TB Derivation Rule	6.6.1.1.40.3 TB Value Sets
ANEN	Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain .Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).	6.6.1.1.41.1 ANEN Derivation Rule	6.6.1.1.41.3 ANEN Value Sets
CCHD	Congenital heart defects that cause cyanosis.	6.6.1.1.42.1 CCHD Derivation Rule	6.6.1.1.42.3 CCHD Value Sets
CDH	Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.	6.6.1.1.43.1 CDH Derivation Rule	6.6.1.1.43.3 CDH Value Sets
CDIC	Suspected chromosomal disorder karyotype confirmed	6.6.1.1.44.1 CDIC Derivation Rule	6.6.1.1.44.3 CDIC Value Sets
CDIS	Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure	6.6.1.1.45.1 CDIS Derivation Rule	6.6.1.1.45.3 CDIS Value Sets
'CDIP	Suspected chromosomal disorder karyotype pending.	6.6.1.1.46.1 CDIP Derivation Rule	6.6.1.1.46.3 CDIP Value Sets
CL	Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.	6.6.1.1.47.1 CL Derivation Rule	6.6.1.1.47.3 CL Value Sets
CP	Cleft palate refers to incomplete fusion of the palatal shelves. This may be limited to the soft palate or may also extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without cleft Palate" category, rather than here.	6.6.1.1.48.1 CP Derivation Rule	6.6.1.1.48.3 CP Value Sets
DOWC	Down Karyotype confirmed	6.6.1.1.49.1 DOWC Derivation Rule	6.6.1.1.49.3 DOWC Value Sets
DOWN	Down Syndrome: Trisomy 21	6.6.1.1.50.1 DOWN Derivation Rule	6.6.1.1.50.3 DOWN Value Sets
DOWP	Down Karyotype pending	6.6.1.1.51.1 DOWP Derivation Rule	6.6.1.1.51.3 DOWP Value Sets
GAST	An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.	6.6.1.1.52.1 GAST Derivation Rule	6.6.1.1.52.3 GAST Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
HYPO	Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree – on the glans ventral to the tip, second degree – in the coronal sulcus, and third degree – on the penile shaft.	6.6.1.1.53.1 HYPO Derivation Rule	6.6.1.1.53.3 HYPO Value Sets
LIMB	Limb reduction defect: (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.	6.6.1.1.54.1 LIMB Derivation Rule	6.6.1.1.54.3 LIMB Value Sets
MNSB	Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).	6.6.1.1.55.1 MNSB Derivation Rule	6.6.1.1.55.3 MNSB Value Sets
OMPH	A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.	6.6.1.1.56.1 OMPH Derivation Rule	6.6.1.1.56.3 OMPH Value Sets
NOA55	None of the listed congenital anomalies of the newborn or fetus.	6.6.1.1.57.1 NOA55 Derivation Rule	6.6.1.1.57.3 NOA55 Value Sets
YLLB	The year of birth of the last live-born infant.	6.6.1.1.59.1 YLLB Derivation Rule	6.6.1.1.59.3 YLLB Value Sets
MLLB	The month of birth of the last live-born infant.	6.6.1.1.60.1 MLLB Derivation Rule	6.6.1.1.60.3 MLLB Value Sets
DLMP_DY	The date the mother's last normal menstrual period began.	6.6.1.1.61.1 DLMP_DY Derivation Rule	6.6.1.1.61.3 DLMP_DY Value Sets
DLMP_MO	The date the mother's last normal menstrual period began.	6.6.1.1.62.1 DLMP_MO Derivation Rule	6.6.1.1.62.3 DLMP_MO Value Sets
DLMP_YR	The date the mother's last normal menstrual period began.	6.6.1.1.63.1 DLMP_YR Derivation Rule	6.6.1.1.63.3 DLMP_YR Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
YOPO	The date (year) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	6.6.1.1.64.1 YOPO Derivation Rule	6.6.1.1.64.3 YOPO Value Sets
MOPO	The date (month) that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	6.6.1.1.65.1 MOPO Derivation Rule	6.6.1.1.65.3 MOPO Value Sets
ADDRESS_D	NA	6.6.1.1.66.1 ADDRESS_D Derivation Rule	6.6.1.1.66.3 ADDRESS_D Value Sets
FNAME	The name of the facility where the delivery took place.	6.6.1.1.67.1 FNAME Derivation Rule	6.6.1.1.67.3 FNAME Value Sets
FNPI	National Provider Identifier.	6.6.1.1.68.1 FNPI Derivation Rule	6.6.1.1.68.3 FNPI Value Sets
CHAM	Chlamydia: A positive test for Chlamydia trachomatis. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.69.1 CHAM Derivation Rule	6.6.1.1.69.3 CHAM Value Sets
GON	Gonorrhea: A positive test/culture for Neisseria gonorrhea. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.70.1 GON Derivation Rule	6.6.1.1.70.3 GON Value Sets
HEPB	Hepatitis B (HBV, serum hepatitis): A positive test for the hepatitis B virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.71.1 HEPB Derivation Rule	6.6.1.1.71.3 HEPB Value Sets
HEPC	Hepatitis C (non-A, non-B hepatitis (HCV)): A positive test for the hepatitis C virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.72.1 HEPC Derivation Rule	6.6.1.1.72.3 HEPC Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
SYPH	Syphilis (also called lues) A positive test for Treponema pallidum. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.73.1 SYPH Derivation Rule	6.6.1.1.73.3 SYPH Value Sets
NOA02	None of the listed infections were present and treated during this pregnancy.	6.6.1.1.74.1 NOA02 Derivation Rule	6.6.1.1.74.3 NOA02 Value Sets
AINT	Admission to intensive care unit: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.75.1 AINT Derivation Rule	6.6.1.1.75.3 AINT Value Sets
MTR	Maternal transfusion: Includes infusion of whole blood or packed red blood cells within the period specified. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.76.1 MTR Derivation Rule	6.6.1.1.76.3 MTR Value Sets
PLAC	Third or fourth degree perineal laceration: 3rd degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4th degree laceration is all of the above with extension through the rectal mucosa. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.77.1 PLAC Derivation Rule	6.6.1.1.77.3 PLAC Value Sets
RUT	Ruptured Uterus: Tearing of the uterine wall. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.78.1 RUT Derivation Rule	6.6.1.1.78.3 RUT Value Sets
UHYS	Unplanned hysterectomy: Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.79.1 UHYS Derivation Rule	6.6.1.1.79.3 UHYS Value Sets
UOPR	Unplanned operating room procedure following delivery: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.80.1 UOPR Derivation Rule	6.6.1.1.80.3 UOPR Value Sets
NOA05	None of the listed serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.81.1 NOA05 Derivation Rule	6.6.1.1.81.3 NOA05 Value Sets
PRES	The physical process by which the complete delivery of the fetus was affected. Fetal presentation at birth - Cephalic: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP); Breech: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech; Other: Any other presentation not listed above.	6.6.1.1.82.1 PRES Derivation Rule	6.6.1.1.82.3 PRES Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
ROUT	Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head; Vaginal/vacuum Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head; or Cesarean: Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.	6.6.1.1.83.1 ROUT Derivation Rule	6.6.1.1.83.3 ROUT Value Sets
TLAB	If cesarean, indicate if a trial of labor was attempted (labor was allowed, augmented, or induced with plans for a vaginal delivery).	6.6.1.1.84.1 TLAB Derivation Rule	6.6.1.1.84.3 TLAB Value Sets
MFNAME	The current legal first name of the mother.	6.6.1.1.85.1 MFNAME Derivation Rule	6.6.1.1.85.3 MFNAME Value Sets
MMNAME	The current legal middle name of the mother.	6.6.1.1.86.1 MMNAME Derivation Rule	6.6.1.1.86.3 MMNAME Value Sets
MLNAME	The current legal last name of the mother.	6.6.1.1.87.1 MLNAME Derivation Rule	6.6.1.1.87.3 MLNAME Value Sets
MSUFF	The current legal name suffix of the mother.	6.6.1.1.88.1 MSUFF Derivation Rule	6.6.1.1.88.3 MSUFF Value Sets
HFT	Mother's height feet	6.6.1.1.89.1 HFT Derivation Rule	6.6.1.1.89.3 HFT Value Sets
HIN	Mother's height inches	6.6.1.1.90.1 HINT Derivation Rule	6.6.1.1.90.3 HIN Value Sets
MRECNUM	The mother's medical record number for this facility admission	6.6.1.1.91.1 MRECNUM Derivation Rule	6.6.1.1.91.3 MRECNUM Value Sets
PWGT	The mother's prepregnancy weight	6.6.1.1.92.1 PWGT Derivation Rule	6.6.1.1.92.3 PWGT Value Sets
NFACL	Indicates the name of the facility the mother was transferred from if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	6.6.1.1.93.1 NFACL Derivation Rule	6.6.1.1.93.3 NFACL Value Sets
TRAN	Indicates if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	6.6.1.1.94.1 TRAN Derivation Rule	6.6.1.1.94.3 TRAN Value Sets
DWGT	The mother's weight at the time of delivery	6.6.1.1.95.1 DWGT Derivation Rule	6.6.1.1.95.3 DWGT Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
POPO	Total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	6.6.1.1.96.1 POPO Derivation Rule	6.6.1.1.96.3 POPO Value Sets
PLBD	The total number of previous live-born infants now dead.	6.6.1.1.97.1 PLBD Derivation Rule	6.6.1.1.97.3 PLBD Value Sets
PLBL	The total number of previous live-born infants now living.	6.6.1.1.98.1 PLBL Derivation Rule	6.6.1.1.98.3 PLBL Value Sets
OWGEST	The best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred.	6.6.1.1.99.1 OWGEST Derivation Rule	6.6.1.1.99.3 OWGEST Value Sets
CERV	Cervical cerclage: Circumferential banding or suture of the cervix to prevent or treat dilation. Includes: MacDonald's suture; Shirodkar procedure; and Abdominal cerclage via laparotomy. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	6.6.1.1.100.1 CERV Derivation Rule	6.6.1.1.100.3 CERV Value Sets
ECVF	Failed External cephalic version: Failed attempt to convert a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	6.6.1.1.101.1 ECVF Derivation Rule	6.6.1.1.101.3 ECVF Value Sets
ECVS	Successful External cephalic version: Successful conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	6.6.1.1.102.1 ECVS Derivation Rule	6.6.1.1.102.3 ECVS Value Sets
TOC	Tocolysis: Administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Medications: Magnesium sulfate (for preterm labor); Terbutaline; Indocin (for preterm labor). Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	6.6.1.1.103.1 TOC Derivation Rule	6.6.1.1.103.3 TOC Value Sets
NOA03	None of the listed obstetric procedures were performed for medical treatment or invasive/manipulative procedures during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	6.6.1.1.104.1 NOA03 Derivation Rule	6.6.1.1.104.3 NOA03 Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
PROM	Premature Rupture of the Membranes (prolonged≥12 hours): Spontaneous tearing of the amniotic sac, (natural breaking of the "bag of waters"), 12 hours or more before labor begins. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.105.1 PROM Derivation Rule	6.6.1.1.105.3 PROM Value Sets
PRIC	Precipitous labor (<3hours): Labor that progresses rapidly and lasts for less than 3 hours. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.106.1 PRIC Derivation Rule	6.6.1.1.106.3 PRIC Value Sets
PROL	Prolonged labor (≥ 20 hours): Labor that progresses slowly and lasts for 20 hours or more. Serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.107.1 PROL Derivation Rule	6.6.1.1.107.3 PROL Value Sets
NOA05	None of the listed serious complications experienced by the mother associated with labor and delivery.	6.6.1.1.108.1 NOA05 Derivation Rule	6.6.1.1.108.3 NOA05 Value Sets
SFN	NA	6.6.1.1.109.1 SFN Derivation Rule	6.6.1.1.109.3 SFN Value Sets
FLOC	NA	6.6.1.1.110.1 FLOC Derivation Rule	6.6.1.1.110.3 FLOC Value Sets
CNAME	NA	6.6.1.1.111.1 CNAME Derivation Rule	6.6.1.1.111.3 CNAME Value Sets
CNTYO	NA	6.6.1.1.112.1 CNTYO Derivation Rule	6.6.1.1.112.3 CNTYO Value Sets
BPLACE	NA	6.6.1.1.113.1 BPLACE Derivation Rule	6.6.1.1.113.3 BPLACE Value Sets
PLUR	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.)	6.6.1.1.114.1 PLUR Derivation Rule	6.6.1.1.114.3 PLUR Value Sets
DOFP_MO	The month a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	6.6.1.1.115.1 DOFP_MO Derivation Rule	6.6.1.1.115.3 DOFP_MO Value Sets
DOFP_DY	The day a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	6.6.1.1.116.1 DOFP_DY Derivation Rule	6.6.1.1.116.3 DOFP_DY Value Sets
DOFP_YR	The year a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	6.6.1.1.117.1 DOFP_YR Derivation Rule	6.6.1.1.117.3 DOFP_YR Value Sets
NPREV	The total number of visits recorded in the record.	6.6.1.1.118.1 NPREV Derivation Rule	6.6.1.1.118.3 NPREV Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
PAY	The principal source of payment at the time of delivery: Includes: Private insurance (Blue Cross/Blue Shield, Aetna, etc.); Medicaid (or a comparable State program); Self-pay (no third party identified); Other (Indian Health Service, CHAMPUS/ TRICARE, other government [Federal, State, local]); Unknown	6.6.1.1.119.1 PAY Derivation Rule	6.6.1.1.119.3 PAY Value Sets
PDIAB	Prepregnancy Diabetes (diagnosis of glucose intolerance requiring treatment before this pregnancy).	6.6.1.1.120.1 PDIAB Derivation Rule	6.6.1.1.120.3 PDIAB Value Sets
GDIAB	Gestational Diabetes (diagnosis of glucose intolerance requiring treatment during this pregnancy).	6.6.1.1.121.1 GDIAB Derivation Rule	6.6.1.1.121.3 GDIAB Value Sets
PHYPE	Prepregnancy (Chronic) Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis prior to the onset of this pregnancy. Does not include gestational (pregnancy induced) hypertension (PIH).)	6.6.1.1.122.1 PHYPE Derivation Rule	6.6.1.1.122.3 PHYPE Value Sets
GHYPE	Gestational Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with diagnosis in this pregnancy (pregnancy-induced hypertension or preeclampsia).	6.6.1.1.123.1 GHYPE Derivation Rule	6.6.1.1.123.3 GHYPE Value Sets
EHYPE	Eclampsia Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with proteinuria with generalized seizures or coma. May include pathologic edema.	6.6.1.1.124.1 EHYPE Derivation Rule	6.6.1.1.124.3 EHYPE Value Sets
PPB	History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.	6.6.1.1.125.1 PPB Derivation Rule	6.6.1.1.126.3 PPB Value Sets
INFT	Any assisted reproductive treatment used to initiate the pregnancy. Includes: Drugs (such as Clomid, Pergonal); Artificial insemination; Technical procedures (such as in-vitro fertilization).	6.6.1.1.126.1 INFT Derivation Rule	6.6.1.1.126.3 INFT Value Sets
INFT_DRG	Fertility-enhancing drugs, artificial insemination or intrauterine insemination Any fertility enhancing drugs (e.g., Clomid, Pergonal), artificial insemination or intrauterine insemination used to initiate the pregnancy	6.6.1.1.127.1 INFT_DRG Derivation Rule	6.6.1.1.127.3 INFT_DRG Value Sets
INFT_ART	Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer GIFT)) Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy.	6.6.1.1.128.1 INFT_ART Derivation Rule	6.6.1.1.128.3 INFT_ART Value Sets
PCES	Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	6.6.1.1.129.1 PCES Derivation Rule	6.6.1.1.129.3 PCES Value Sets
NPCES	Number of previous deliveries extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	6.6.1.1.130.1 NPCES Derivation Rule	6.6.1.1.130.3 NPCES Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
NOA01	The patient had none of the listed risk factors in this pregnancy.	6.6.1.1.131.1 NOA01 Derivation Rule	6.6.1.1.131.3 NOA01 Value Sets
SORD	Order this infant was delivered in the set.	6.6.1.1.132.1 SORD Derivation Rule	6.6.1.1.132.3 SORD Value Sets
FSEX	The sex of the infant.	6.6.1.1.133.1 FSEX Derivation Rule	6.6.1.1.133.3 FSEX Value Sets
FDOD_YR	Date of Delivery (Fetus) Year	6.6.1.1.134.1 FDOD_YR Derivation Rule	6.6.1.1.134.3 FDOD_YR Value Sets
FDOD_MO	Date of Delivery (Fetus) Month	6.6.1.1.135 FDOD_MO Derivation Rule	6.6.1.1.135.2 FDOD_MO Value Sets
FDOD_DY	Date of Delivery (Fetus) Day	6.6.1.1.136.1 FDOD_DY Derivation Rule	6.6.1.1.136.3 FDOD_DY Value Sets
ETIME	Item to indicate when the fetus died with respect to labor and assessment.	6.6.1.1.137.1 ETIME Derivation Rule	6.6.1.1.137.3 ETIME Value Sets
LIVEB	Specify the number of infants in this delivery born alive	6.6.1.1.138.1 LIVEB Derivation Rule	6.6.1.1.138.3 LIVEB Value Sets
FDTH	Specify the number of fetal deaths in this delivery	6.6.1.1.139.1 FDTH Derivation Rule	6.6.1.1.139.3 FDTH Value Sets
HYST	Hysterotomy/Hysterectomy was the physical process by which the complete delivery of the fetus was affected. Hysterotomy: Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy: Surgical removal of the uterus. May be performed abdominally or vaginally.	6.6.1.1.140.1 HYST Derivation Rule	6.6.1.1.140.3 HYST Value Sets
TD	Hour and minute fetus was delivered.	6.6.1.1.141.1 TD Derivation Rule	6.6.1.1.141.3 TD Value Sets
AUTOP	Information on whether or not an autopsy was performed	6.6.1.1.142.1 AUTOP Derivation Rule	6.6.1.1.142.3 AUTOP Value Sets
FWO	Fetus' weight in ounces.	6.6.1.1.143.1 FWO Derivation Rule	6.6.1.1.143.3 FWO Value Sets
FWG	Fetus' weight in grams.	6.6.1.1.144.1 FWG Derivation Rule	6.6.1.1.144.3 FWG Value Sets
FWP	Fetus' weight in pounds.	6.6.1.1.145.1 FWP Derivation Rule	6.6.1.1.145.3 FWP Value Sets

Attribute code	Definition	Derivation Rule	Value Sets
LM	Listeria: A diagnosis of or positive test for Listeria monocytogenes. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.146.1 LM Derivation Rule	6.6.1.1.146.3 LM Value Sets
GBS	Group B Streptococcus: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.147.1 GBS Derivation Rule	6.6.1.1.147.3 GBS Value Sets
CMV	Cytomegalovirus (CMV): A diagnosis of or positive test for Cytomegalovirus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	6.6.1.1.148.1 CMV Derivation Rule	6.6.1.1.148.3 CMV Value Sets
B19	Parvovirus: A diagnosis of or positive test for Parvovirus B19. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record	6.6.1.1.149.1 B19 Derivation Rule	6.6.1.1.149.3 B19 Value Sets
HISTOP	Information on whether or not a histological placental examination was performed	6.6.1.1.150.1 HISTOP Derivation Rule	6.6.1.1.150.3 HISTOP Value Sets
TOXO	Toxoplasmosis: A diagnosis of or positive test for Toxoplasma gondii.	6.6.1.1.151.1 TOXO Derivation Rule	6.6.1.1.151.3 TOXO Value Sets
PNC	An indication that a physician or other healthcare professional has not examined and/or counselled the pregnant woman for the pregnancy.	6.6.1.1.152.1 PNC Derivation Rule	6.6.1.1.152.3 PNC Value Sets

6.6.1.1 Form Derivation Rules

Variable definitions within this section are only scoped within each rule. For this document, the convention is that Variable names begin with '$'.

6.6.1.1.1 ANTI

6.6.1.1.1.1 ANTI Derivation Rule

IF ($Indication CONTAINS ValueSet (*Neonatal Sepsis (NCHS)*) AND ($CodedProductName CONTAINS ValueSet (*Antibiotics (NCHS)*)) AND ($Route CONTAINS ValueSet (*IM Medication Administration Route (NCHS)*) OR ValueSet (*IV Medication Administration Route*

(NCHS))), OR IF $ProcedureCode CONTAINS ValueSet (*Antibiotic Administration Procedure (NCHS)*) THEN ANTI SHALL = "Y" ELSE "N.

6.6.1.1.1.2 ANTI LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Medications Administered Section

1.3.6.1.4.1.19376.1.5.3.1.3.21

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

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/consumable/manufacturedProduct/labeledDrug/code

$Route =

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

$Indication =

ClinicalDocument/component/structuredBody/component/section[[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]/ subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]/substanceAdministration/entryRelationship[@typeCode='RSON']/ act[cda:templateId/@root="1.3.6.1.4.1.19376.1.5.3.1.4.4.1]/code

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.1.3 ANTI FHIR Source and Logic Variables

$CodedProductName = MedicationAdministration.medication[x].medicationCodableConcept

$Route = MedicationAdministration.dosage.route

$Indication = MedicationAdministration.reasonReference

$ProcedureCode = partOf.Encounter.Resource (Procedure.code)

6.6.1.1.1.4 ANTI Value Sets

Antibiotics (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
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
Neonatal Sepsis (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6
Antibiotic Administration Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178
Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.2 AVEN1

6.6.1.1.2.1 AVEN1 Derivation Rule

IF ($ProcedureCode CONTAINS ValueSet (*Assisted Ventilation (NCHS)*) AND ($ProcedureStartTime -$BirthTime< 5 minutes)) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (PHVS_AssistedVentilationMinutesAfterBirth_NCHS) OR (**$ProblemCode** CONTAINS ValueSet (PHVS_AssistedVentilationMinutesAfterBirth_NCHS)) THEN AVEN1 SHALL = "Y" ELSE "N"

6.6.1.1.2.2 AVEN1 LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureStartTime =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

$BirthTime =

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/birthTime

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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/value

6.6.1.1.2.3 AVEN1 FHIR Source and Logic Variables

$ProblemCode = partOf.Encounter.Resource (Condition.code)

$ProcedureCode = partOf.Encounter.Resource (Procedure.code)

$ProcedureStartTime = partOf.Encounter.Resource (Performed[x].period)

$BirthTime = partOf.Encounter.Resource (Patient. birthdate)

$EventOutcomesObservationCode = NA (only review condition.code)

6.6.1.1.2.4 AVEN1 Value Sets

Assisted Ventilation (NCHS) 2.16.840.1.114222.4.11.7156

PHVS_AssistedVentilationMinutesAfterBirth_NCHS 2.16.840.1.114222.4.11.7144

6.6.1.1.3 AVEN6

6.6.1.1.3.1 AVEN6 Derivation Rule

IF ((**$ProcedureCode** CONTAINS ValueSet (*Assisted Ventilation (NCHS)*) AND (**$ProcedureEndTime** – **$ProcedureStartTime** >=6 hours)) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (PHVS_AssistedVentilationMoreThanSixHours_NCHS) OR (**$ProblemCode** CONTAINS ValueSet (PHVS_AssistedVentilationMoreThanSixHours_NCHS)) THEN AVEN6 SHALL = "Y" ELSE "N"

6.6.1.1.3.2 AVEN6 LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureStartTime =

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

$ProcedureEndTime =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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/value

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

id=idOfTheChild]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.3.3 AVEN6 FHIR Source and Logic Variables

$ProcedureCode = partOf.Encounter.Resource (Procedure.code)

$ProcedureStartTime = partOf.Encounter.Resource (Performed[x].period)

$ProcedureEndTime = partOf.Encounter.Resource (Performed[x].period)

$EventOutcomesObservationCode = NA (only review condition.code)

$ProblemCode = partOf.Encounter.Resource (Condition.code)

6.6.1.1.3.4 AVEN6 Value Sets

Assisted Ventilation (NCHS) 2.16.840.1.114222.4.11.7156

PHVS_AssistedVentilationMoreThanSixHours_NCHS 2.16.840.1.114222.4.11.7145

6.6.1.1.4 BINJ

6.6.1.1.4.1 BINJ Derivation Rule

IF **$ProblemObservation** CONTAINS ValueSet (*Significant Birth Injury (NCHS)*), THEN BINJ SHALL = "Y" ELSE "N"

6.6.1.1.4.2 BINJ LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$ProblemObservation =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] AND 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[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.5']] /observation/value

6.6.1.1.4.3 BINJ FHIR Source and Logic Variables

$ProblemObservation = partOf.Encounter.Resource (Condition.code)

6.6.1.1.4.4 BINJ Value Sets

Significant Birth Injury (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9

6.6.1.1.5 NICU

6.6.1.1.5.1 NICU Derivation Rule

IF (**$PatientTransferType** CONTAINS (*NICU Care (NCHS)*)), THEN NICU SHALL = "Y" ELSE "N"

6.6.1.1.5.2 NICU LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Patient Transfer Entry

1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1

$PatientTransferType=

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='1.3.6.1.4.1.19376.1.7.3.1.113.7']]/ entry[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

6.6.1.1.5.3 NICU Value Sets

NICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198

6.6.1.1.6 SEIZ

6.6.1.1.6.1 SEIZ Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Seizure or Serious Neurologic Dysfunction (NCHS)*)) THEN SEIZ SHALL = "Y" ELSE "N"

6.6.1.1.6.2 SEIZ LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.6.2 SEIZ FHIR Source and Logic Variables

$ProblemObservation = partOf.Encounter.Resource (Condition.code)

6.6.1.1.6.4 SEIZ Value Sets

Seizure or Serious Neurologic Dysfunction (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10

6.6.1.1.7 SURF

6.6.1.1.7.1 SURF Derivation Rule

IF **($CodedProductName** CONTAINS ValueSet (*Newborn Receiving Surfactant Replacement Therapy (NCHS)*) OR **$ProcedureCode** CONTAINS ValueSet (*Surfactant Replacement Therapy (NCHS)*)), THEN SURF SHALL = "Y" ELSE "N"

6.6.1.1.7.2 SURF LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Medications Administered Section

1.3.6.1.4.1.19376.1.5.3.1.3.21

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

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/consumable/manufacturedProduct/labeledDrug/code

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.7.3 SURF FHIR Source and Logic Variables

$CodedProductName = partOf.Encounter.Resource (MedicationAdministration.medication[x].medicationCodableConcept)

$ProcedureCode = partOf.Encounter.Resource (Procedure.code)

6.6.1.1.7.4 SURF Value Sets

Newborn Receiving Surfactant Replacement Therapy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11

Surfactant Replacement Therapy (NCHS) 2.16.840.1.114222.4.11.7431

6.6.1.1.8 NOA54

6.6.1.1.8.1 NOA54 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.8.2 NOA54 LDS Source and Logic Variables

NA

6.6.1.1.8.3 NOA54 Value Sets

NA

6.6.1.1.9 DNA54

6.6.1.1.9.1 DNA54 Derivation Rule

This section intentionally left blank.

6.6.1.1.9.2 DNA54 LDS Source and Logic Variables

This section intentionally left blank.

6.6.1.1.9.3 DNA54 Value Sets

This section intentionally left blank.

6.6.1.1.10 APGAR5

6.6.1.1.10.1 APGAR5 Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*5 Min Apgar Score (NCHS)*)), THEN "APGAR5" = (**$GeneralAppearanceObservationValue**)

6.6.1.1.10.2 APGAR5 LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

$GeneralAppearanceObservationValue =

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

6.6.1.1.10.3 APGAR5 FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = partOf.Encounter.Resource (Observation.code)

$GeneralAppearanceObservationValue = partOf.Encounter.Resource (Observation.code)

6.6.1.1.10.4 APGAR5 Value Sets

5 Min Apgar Score (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12

6.6.1.1.11 APGAR10

6.6.1.1.11.1 APGAR10 Derivation Rule

IF (“APGAR5” <6), AND (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*10 Min Apgar Score (NCHS)*), THEN “APGAR10” = (**$GeneralAppearanceObservationValue**)

6.6.1.1.11.2 APGAR10 LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

$GeneralAppearanceObservationValue =

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

6.6.1.1.11.3 APGAR10 FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = partOf.Encounter.Resource (Observation.code)

$GeneralAppearanceObservationValue = partOf.Encounter.Resource (Observation.code)

6.6.1.1.11.4 APGAR10 Value Sets

10 Min Apgar Score (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13

6.6.1.1.12 ATTENDN

6.6.1.1.12.1 ATTENDN Derivation Rule

"ATTENDN" SHALL be populated using **$ProviderName** WHERE **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*) WHERE the provider is the person responsible for delivering the child

6.6.1.1.12.2 ATTENDN LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProviderName =

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/assignedPerson/name

$ProcedureCode =

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

6.6.1.1.12.3 ATTENDN FHIR Source and Logic Variables

$ProviderName = procedure.performer.actor Refernce (Practitioner.name)

$ProcedureCode = procedure.code

6.6.1.1.12.4 ATTENDN Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.13 ATTEND

6.6.1.1.13.1 ATTEND Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*), THEN IF **$ProviderType** CONTAINS ValueSet (*Physician (NCHS)*), THEN "ATTEND" SHALL = "1", ELSE IF **$ProviderType** CONTAINS ValueSet (*Doctor of Osteopathic Medicine (NCHS)*), THEN "ATTEND" SHALL = "2", ELSE IF **$ProviderType** CONTAINS ValueSet (*Certified Midwife*

(NCHS)), THEN "ATTEND" SHALL = "3", ELSE IF **$ProviderType** CONTAINS ValueSet (*Midwife (NCHS)*), THEN "ATTEND" SHALL = "4", ELSE IF **$ProviderType** NOT NULL THEN "ATTEND" SHALL = "5", ELSE "ATTEND" SHALL = "9"

6.6.1.1.13.2 ATTEND LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProviderType

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/code

6.6.1.1.13.3 ATTEND FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProviderType = procedure.performer.role

6.6.1.1.13.4 ATTEND 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
Midwife (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
Delivery (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.14 ATTENDS

6.6.1.1.14.1 ATTENDS Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (Delivery (NCHS)) AND "ATTEND" = "5", THEN ATTENDS SHALL = **$ProviderType**

6.6.1.1.14.2 ATTENDS LDS Source and Logic Variables

Precondition: ATTEND

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProviderType

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/code

6.6.1.1.14.3 ATTENDS FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProviderType = procedure.performer.role

6.6.1.1.14.4 ATTENDS Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.15 NPI

6.6.1.1.15.1 NPI Derivation Rule

"NPI" SHALL be populated using the **$ProviderID** WHERE **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*) where the **$ProviderID** is expressed as the National Provider Identifier (NPI)

6.6.1.1.15.2 NPI LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProviderID =

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/@extension

6.6.1.1.15.2 NPI FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProviderID = procedure.performer.actor Refernce (Practitioner.identifier)

6.6.1.1.15.4 NPI Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.16 BWG

6.6.1.1.16.1 BWG Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*)= WHERE **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*), THEN "BWG" SHALL = **$VitalSignsResultValue** WHERE Result Value Units are expressed in grams

6.6.1.1.16.2 BWG LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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

$VitalSignsResultValue =

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

6.6.1.1.16.3 BWG FHIR Source and Logic Variables

$VitalSignsTypeCode = partOf.Encounter.Resource (Observation.code)

$VitalSignsMethodCode = partOf.Encounter.Resource (Observation.method)

$VitalSignsResultValue = partOf.Encounter.Resource (Observation.valueQuantity)

6.6.1.1.16.4 BWG Value Sets

Birth Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
Body Weight (NCHS)	2.16.840.1.114222.4.11.7421

6.6.1.1.17 BWO

6.6.1.1.17.1 BWO Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*)WHERE **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*), THEN "BWG" SHALL = **$VitalSignsResultValue** WHERE Result Value Units are expressed in ounces.

The preferred measure is in grams rather than ounces. Refer to BWG

6.6.1.1.17.2 BWO LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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

$VitalSignsResultValue =

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

6.6.1.1.17.3 BWO FHIR Source and Logic Variables

$VitalSignsTypeCode = partOf.Encounter.Resource (Observation.code)

$VitalSignsMethodCode = partOf.Encounter.Resource (Observation.method)

$VitalSignsResultValue = partOf.Encounter.Resource (Observation.valueQuantity)

6.6.1.1.17.4 BWO Value Sets

Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

6.6.1.1.18 BWP

6.6.1.1.18.1 BWP Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*)WHERE **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*), THEN "BWG" SHALL = **$VitalSignsResultValue** WHERE Result Value Units are expressed in pounds.

The preferred measure is in grams rather than pounds. Refer to BWG

6.6.1.1.18.2 BWP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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

$VitalSignsResultValue =

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

6.6.1.1.18.3 BWP FHIR Source and Logic Variables

$VitalSignsTypeCode = partOf.Encounter.Resource (Observation.code)

$VitalSignsMethodCode = partOf.Encounter.Resource (Observation.method)

$VitalSignsResultValue = partOf.Encounter.Resource (Observation.valueQuantity)

6.6.1.1.18.4 BWP Value Sets

Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

6.6.1.1.19 ANTB

6.6.1.1.19.1 ANTB Derivation Rule

IF ((**$CodedProductName** CONTAINS ValueSet (*Antibiotics (NCHS)*)) AND (**$Route** CONTAINS ValueSet (*IM Medication Administration Route (NCHS)*) OR ValueSet (*IV Medication Administration Route (NCHS)*)) AND (**$AdministrationTime** >= **$ProcedureStartTime** AND **$AdministrationTime** <=**$ProcedureEndTime**) WHERE **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*)) OR **$EventOutcomesObservationCode** CONTAINS ValueSet (Antibiotics Received During Labor Finding (NCHS)) THEN "ANTB" SHALL = "Y" ELSE "N"

6.6.1.1.19.2 ANTB LDS Source and Logic Variables

Medications Administered Section

1.3.6.1.4.1.19376.1.5.3.1.3.21

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/entry/substanceAdministration/consumable/manufacturedProduct/labeledDrug/code

$Route =

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

$AdministrationTime

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]/substanceAdministration/effectiveTme/low

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureStartTime =

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/effectiveTime/low

$ProcedureEndTime =

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/effectiveTime/high

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

6.6.1.1.19.3 ANTB FHIR Source and Logic Variables

$CodedProductName = MedicationAdministration.medication[x].medicationCodableConcept

$Route = MedicationAdministration.dosage.route

$AdministrationTime = MedicationAdministration.effective[x]

$ProcedureCode = Procedure.code

$ProcedureStartTime = Procedure.Performed[x].period

$ProcedureEndTime = Procedure.Performed[x].period

$EventOutcomesObservationCode = observation.code

6.6.1.1.19.4 ANTB Value Sets

Antibiotics (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3

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

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

Antibiotics Received During Labor Finding (NCHS) 2.16.840.1.114222.4.11.7535

6.6.1.1.20 AUGL

6.6.1.1.20.1 AUGL Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (*Augmentation of Labor - Procedure (NCHS)*) OR **$CodedProductName** CONTAINS (*Augmentation of Labor - Medication (NCHS)*) OR **$EventOutcomesObservationCode** CONTAINS ValueSet (Augmentation of Labor Finding (NCHS)) OR **$ProblemCode** CONTAINS ValueSet (Augmentation of Labor Finding (NCHS)), THEN "AUGL" SHALL ="Y" ELSE "N"

6.6.1.1.20.2 AUGL LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Medications Administered Section

1.3.6.1.4.1.19376.1.5.3.1.3.21

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]/entry/substanceAdministration/consumable/manufacturedProduct/labeledDrug/code

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.20.3 AUGL FHIR Source and Logic Variables

$ProcedureCode = Procedure.code

$CodedProductName = MedicationAdministration.medication[x].medicationCodableConcept

$EventOutcomesObservationCode = observation.code

$ProblemCode = condition.code

6.6.1.1.20.4 AUGL Value Sets

Augmentation of Labor - Procedure (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22
Augmentation of Labor - Medication (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23

Augmentation of Labor Finding (NCHS) 2.16.840.1.114222.4.11.7532

6.6.1.1.21 CHOR

6.6.1.1.21.1 CHOR Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet ((*Chorioamnionitis During Labor (NCHS)*) OR (*Fever Greater Than 100.4 (NCHS)*) THEN "CHOR" SHALL = "Y" ELSE "N"

6.6.1.1.21.2 CHOR LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.21.3 CHOR FHIR Source and Logic Variables

$ProblemCode = condition.code

6.6.1.1.21.4 CHOR Value Sets

Chorioamnionitis During Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24

Fever Greater Than 100.4 (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25

6.6.1.1.22 ESAN

6.6.1.1.22.1 ESAN Derivation Rule

IF (**$CodedProductName** CONTAINS ValueSet (Epidural/Spinal Anesthesia - Medication (NCHS)) OR(**$ProcedureCode** CONTAINS (Epidural Anesthesia - Procedure (NCHS)) OR (Spinal Anesthesia - Procedure (NCHS))) THEN "ESAN" SHALL be "Y" ELSE "N"

6.6.1.1.22.2 ESAN LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Medications Administered Section

1.3.6.1.4.1.19376.1.5.3.1.3.21

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]/entry/substanceAdministration/consumable/manufacturedProduct/labeledDrug/code

6.6.1.1.22.3 ESAN FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$CodedProductName = MedicationAdministration.medication[x].medicationCodableConcept

6.6.1.1.22.4 ESAN Value Sets

Epidural Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27

Spinal Anesthesia - Procedure (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29

Epidural/Spinal Anesthesia - Medication (NCHS) 2.16.840.1.114222.4.11.7475

6.6.1.1.23 INDL

6.6.1.1.23.1 INDL Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (Induction of Labor (NCHS)) OR **$EventOutcomesObservationCode** CONTAINS ValueSet (Induction of Labor Finding (NCHS)) OR **$ProblemCode** CONTAINS ValueSet (Induction of Labor Finding (NCHS))) THEN "INDL" SHALL = "Y" ELSE "N"

6.6.1.1.23.2 INDL LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.23.3 INDL FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.23.4 INDL Value Sets

Induction of Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34

Induction of Labor Finding (NCHS) 2.16.840.1.114222.4.11.7531

6.6.1.1.24 STER

6.6.1.1.24.1 STER Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (*Steroids For Fetal Lung Maturation (NCHS)*)) THEN "STER" SHALL ="Y"ELSE "N"

6.6.1.1.24.2 STER LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.24.3 STER FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.24.4 STER Value Sets

Steroids For Fetal Lung Maturation (NCHS) 2.16.840.1.114222.4.11.7423

6.6.1.1.25 NOA04

6.6.1.1.25.1 NOA04 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.25.2 NOA04 LDS Source and Logic Variables

NA

6.6.1.1.25.3 NOA04 Value Sets

NA

6.6.1.1.26 DNA04

6.6.1.1.26.1 DNA04 Derivation Rule

This section intentionally left blank.

6.6.1.1.26.2 DNA04 LDS Source and Logic Variables

This section intentionally left blank.

6.6.1.1.26.3 DNA04 Value Sets

This section intentionally left blank.

6.6.1.1.27 IDOB_YR

6.6.1.1.27.1 IDOB_YR Derivation Rule

"IDOB_YR" SHALL be populated using the Year part of **$BirthTime** WHERE the Year is represented using 4-digits

6.6.1.1.27.2 IDOB_YR LDS Source and Logic Variables

$BirthTime 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/birthTime

6.6.1.1.27.3 IDOB_YR FHIR Source and Logic Variables

$BirthTime = partOf.Encounter.Resource (Patient. birthdate)

6.6.1.1.27.4 IDOB_YR Value Sets

NA

6.6.1.1.28 IDOB_MO

6.6.1.1.28.1 IDOB_MO Derivation Rule

"IDOB_MO" SHALL be populated using the Year part of **$BirthTime** WHERE the Month is represented using 2-digits

6.6.1.1.28.2 IDOB_MO LDS Source and Logic Variables

$BirthTime

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/birthTime

6.6.1.1.28.3 IDOB_MO FHIR Source and Logic Variables

$BirthTime = partOf.Encounter.Resource (Patient. birthdate)

6.6.1.1.28.4 IDOB_MO Value Sets

NA

6.6.1.1.29 IDOB_DY

6.6.1.1.29.1 IDOB_DY Derivation Rule

"IDOB_DY" SHALL be populated using the Year part of **$BirthTime** WHERE the Day is represented using 2-digits

6.6.1.1.29.2 IDOB_DY LDS Source and Logic Variables

$BirthTime
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/birthTime

6.6.1.1.29.3 IDOB_DY FHIR Source and Logic Variables

$BirthTime = partOf.Encounter.Resource (Patient. birthdate)

6.6.1.1.29.4 IDOB_DY Value Sets

NA

6.6.1.1.30 KIDFNAME

6.6.1.1.30.1 KIDFNAME Derivation Rule

"KIDFNAME" SHALL be populated using the First Name part of **$ChildName**

6.6.1.1.30.2 KIDFNAME LDS Source and Logic Variables

$ChildName =

ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ subject/name/given[1]

6.6.1.1.30.3 KIDFNAME FHIR Source and Logic Variables

$ChildName = partOf.Encounter.Resource (patient.name)

6.6.1.1.30.4 KIDFNAME Value Sets

NA

6.6.1.1.31 KIDMNAME

6.6.1.1.31.1 KIDMNAME Derivation Rule

"KIDMNAME" SHALL be populated using the Middle Name part of **$ChildName.**

6.6.1.1.31.2 KIDMNAME LDS Source and Logic Variables

$ChildName =

ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/ subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/ subject/name/given[2]

6.6.1.1.31.3 KIDMNAME FHIR Source and Logic Variables

$ChildName = partOf.Encounter.Resource (patient.name)

6.6.1.1.31.4 KIDMNAME Value Sets

NA

6.6.1.1.32 KIDLNAME

6.6.1.1.32.1 KIDLNAME Derivation Rule

"KIDLNAME" SHALL be populated using the Last Name part of **$ChildName**.

6.6.1.1.32.2 KIDLNAME LDS Source and Logic Variables

$ChildName =

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

6.6.1.1.32.3 KIDLNAME FHIR Source and Logic Variables

$ChildName = partOf.Encounter.Resource (patient.name)

6.6.1.1.32.4 KIDLNAME Value Sets

NA

6.6.1.1.33 KIDSUFFX

6.6.1.1.33.1 KIDSUFFX Derivation Rule

"KIDSUFFX" SHALL be populated using the Suffix part of **$ChildName**.

6.6.1.1.33.2 KIDSUFFX LDS Source and Logic Variables

$ChildName =

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

6.6.1.1.33.3 KIDSUFFX FHIR Source and Logic Variables

$ChildName = partOf.Encounter.Resource (patient.name)

6.6.1.1.33.4 KIDSUFFX Value Sets

NA

6.6.1.1.34 BFED

6.6.1.1.34.1 BFED Derivation Rule

IF **$ProblemCode** CONTAINS ValueSet (*Breastfed Infant (NCHS)*) THEN BFED SHALL be "Y".

6.6.1.1.34.2 BFED LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.34.3 BFED FHIR Source and Logic Variables

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.34.4 BFED Value Sets

Breastfed Infant (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41

6.6.1.1.35 ILIV

6.6.1.1.35.1 ILIV Derivation Rule

IF (NOT (**$ProblemObservationCode** CONTAINS ValueSet(*Neonatal Death (NCHS)*) OR ($DeceasedIndicator = 'True'))) THEN "ILIV" SHALL = 'Y' ELSE 'N'

6.6.1.1.35.2 ILIV LDS Source and Logic Variables

Labor and Delivery Summary Header

$DeceasedIndicator =

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/sdtc:deceasedInd

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$ProblemObservationCode =

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/value

6.6.1.1.35.3 ILIV FHIR Source and Logic Variables

$DeceasedIndicator = partOf.Encounter.Resource (patient.deceased[x].deceasedBoolean)

$ProblemObservationCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.35.4 ILIV Value Sets

Neonatal Death (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149

6.6.1.1.36 IRECNUM

6.6.1.1.36.1 IRECNUM Derivation Rule

"IRECNUM" SHALL = **$BabyMedRecNum**

6.6.1.1.36.2 IRECNUM LDS Source and Logic Variables

$BabyMedRecNum

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]]/sdtc:id

6.6.1.1.36.3 IRECNUM FHIR Source and Logic Variables

$BabyMedRecNum = partOf.Encounter.Resource (patient.identifier)

6.6.1.1.36.4 IRECNUM Value Sets

NA

6.6.1.1.37 ISEX

6.6.1.1.37.1 ISEX Derivation Rule

IF **$Gender** CONTAINS ValueSet(*Male Gender (NCHS)*) THEN "ISEX" SHALL ='M' ELSE IF **$Gender** CONTAINS ValueSet(*Female Gender (NCHS)*) THEN "ISEX" SHALL ='F' ELSE THEN "ISEX" SHALL ='N'

6.6.1.1.37.2 ISEX LDS Source and Logic Variables

$Gender

ClinicalDocument/component/structuredBody/component/section[templateId[@root='2.16.840.1.113883.10.20.1.21']]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/subject/relatedSubject/subject/administrativeGenderCode

6.6.1.1.37.3 ISEX Value Sets

Male Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42
Female Gender (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43

6.6.1.1.38 ITRAN

6.6.1.1.38.1 ITRAN Derivation Rule

$PatientTransferType CONTAINS ValueSet (*Transfer to (NCHS)*) and (Coded **$PatientTransferType** – **$BirthTime**) <= 24 hours THEN ITRAN SHALL = "Y" ELSE ITRAN SHALL = "N"

6.6.1.1.38.2 ITRAN LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Patient Transfer Entry

1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1

$PatientTransferType=

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[templateId[@root=' 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

$PatientTransferTime =

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[templateId[@root=' 1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/effectiveTime[high]

$BirthTime =

/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/birthTime

6.6.1.1.38.3 ITRAN FHIR Source and Logic Variables

$PatientTransferType= partOf.Encounter.Resource (procedure.code)

$PatientTransferTime = partOf.Encounter.Resource (procedure. Performed[x].period)

$BirthTime = partOf.Encounter.Resource (patient.birthDate)

6.6.1.1.38.4 ITRAN Value Sets

Transfer to Facility (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

6.6.1.1.39 FTRAN

6.6.1.1.39.1 FTRAN Derivation Rule

IF **$PatientTransferType** CONTAINS ValueSet (*Institution Referred to (NCHS)*) and
4225 **($PatientTransferTime – $BirthTime**) <= 24 hours THEN FTRAN SHALL = **$PatientInstitutionTransferName**

6.6.1.1.39.2 FTRAN LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

4230 Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Patient Transfer Entry

1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1

$PatientTransferType =

4235 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/entryRelationship/observation/code

$PatientTransferInstitutionName =

4240 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/entryRelationship/observation/value

$ PatientTransferTime =

4245 ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.7.3.1.1.13.7']]/component/section[templateId[@root= '1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']]/entry/act/entryRelationship/observation/effectiveTime[high]

$BirthTime =

4250 /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]/sub/ect/birthTime

6.6.1.1.39.3 FTRAN FHIR Source and Logic Variables

$PatientTransferType= partOf.Encounter.Resource (procedure.code)

$PatientTransferTime = partOf.Encounter.Resource (procedure. Performed[x].period)

$PatientTransferInstitutionName = partOf.Encounter.Resource (procedure.value)

$BirthTime = partOf.Encounter.Resource (patient.birthDate)

6.6.1.1.39.4 FTRAN Value Sets

Institution Referred to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.191

6.6.1.1.40 TB

6.6.1.1.40.1 TB Derivation Rule

"TB" SHALL = Time part of **$BirthTime**

6.6.1.1.40.2 TB LDS Source and Logic Variables

$BirthTime =

/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/birthTime

6.6.1.1.40.3 TB FHIRSource and Logic Variables

$BirthTime = partOf.Encounter.Resource (patient.birthDate)

6.6.1.1.40.4 TB Value Sets

NA

6.6.1.1.41 ANEN

6.6.1.1.41.1 ANEN Derivation Rule

IF (**$NervousSystemObservationCode** CONTAINS ValueSet (*Anencephaly of the Newborn (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Anencephaly of the Newborn (NCHS)*) THEN "ANEN" SHALL = "Y" ELSE

6.6.1.1.41.2 ANEN LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Nervous System Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.35

$NervousSystemObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.41.3 ANEN FHIR Source and Logic Variables

$NervousSystemObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.41.4 ANEN Value Sets

Anencephaly of the Newborn (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53

6.6.1.1.42 CCHD

6.6.1.1.42.1 CCHD Derivation Rule

IF (**$HeartSystemObservationCode** CONTAINS ValueSet (*Cyanotic Congenital Heart Disease (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Cyanotic Congenital Heart Disease (NCHS)*)) THEN "CCHD" SHALL = "Y" ELSE "N".

6.6.1.1.42.2 CCHD LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Heart System

1.3.6.1.4.1.19376.1.5.3.1.1.9.29

$HeartSystemObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.42.3 CCHD FHIR Source and Logic Variables

$HeartSystemObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.42.4 CCHD Value Sets

Cyanotic Congenital Heart Disease (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54

6.6.1.1.43 CDH

6.6.1.1.43.1 CDH Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Congenital Diaphragmatic Hernia (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Congenital Diaphragmatic Hernia (NCHS)*) THEN "CDH" **SHALL** = "Y" ELSE "N".

6.6.1.1.43.2 CDH LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.43.3 CDH FHIR Source and Logic Variables

$GeneralAppearanceObservationCode =N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.43.4 CDH Value Sets

Congenital Diaphragmatic Hernia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55

6.6.1.1.44 CDIC

6.6.1.1.44.1 CDIC Derivation Rule

IF ((**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Karyotype Confirmed (NCHS)*) AND **$GeneralAppearanceObservationCode** Code CONTAINS ValueSet(*Suspected Chromosomal Disorder (NCHS)*)) OR (**$ProblemCode** CONTAINS ValueSet (*Karyotype Confirmed (NCHS)*) AND (**$ProblemCode** Code CONTAINS ValueSet(*Suspected Chromosomal Disorder (NCHS)*)))) THEN "CDIC" **SHALL** = "Y" ELSE "N".

6.6.1.1.44.2 CDIC LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.44.3 CDIC FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = =N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.44.4 CDIC Value Sets

Suspected Chromosomal Disorder (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

6.6.1.1.45 CDIS

6.6.1.1.45.1 CDIS Derivation Rule

IF (NOT(**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Karyotype Confirmed (NCHS)*) AND (**$GeneralAppearanceObservationCode** Code CONTAINS ValueSet (*Suspected Chromosomal Disorder (NCHS)*))) OR (NOT(**$ProblemCode** CONTAINS ValueSet (*Karyotype Confirmed (NCHS)*) AND (**$ProblemCode** Code CONTAINS ValueSet (*Suspected Chromosomal Disorder (NCHS)*))) THEN "CDIS" **SHALL** = "Y" ELSE "N"

6.6.1.1.45.2 CDIS LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.45.3 CDIS FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.45.4 CDIS Value Sets

Karyotype Confirmed (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56
Suspected Chromosomal Disorder (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

6.6.1.1.46 CDIP

6.6.1.1.46.1 CDIP Derivation Rule

IF ((**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Suspected Chromosomal Disorder (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Suspected Chromosomal Disorder (NCHS)*)) AND (**$ProcedureCode** Contains (*Karyotype Determination (NCHS)*) AND act classCode='ACT' moodCode='INT') AND (NOT **$CodedResultCode** (*Karyotype Result (NCHS)*)) THEN "CDIP" SHALL = "Y" ELSE "N".

6.6.1.1.46.2 CDIP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Results Section

1.3.6.1.4.1.19376.1.5.3.1.3.28

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$CodedResultCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] AND 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[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.13']]/observation/code

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.46.3 CDIP FHIR Source and Logic Variables

$ProcedureCode = partOf.Encounter.Resource (procedure.code)

$CodedResultCode = partOf.Encounter.Resource (observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsKaryotype))

$GeneralAppearanceObservationCode = N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.46.4 CDIP Value Sets

Suspected Chromosomal Disorder (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Karyotype Determination (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
Karyotype Result (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59

6.6.1.1.47 CL

6.6.1.1.47.1 CL Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Cleft Lip with or without Cleft Palate (NCHS)*)) OR (**$ProblemCode** CONTAINS ValueSet (*Cleft Lip with or without Cleft Palate (NCHS)*)) THEN"CL" SHALL = "Y" ELSE "N".

6.6.1.1.47.2 CL LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.47.3 CL FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.47.4 CL Value Sets

Cleft Lip with or without Cleft Palate (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58

6.6.1.1.48 CP

6.6.1.1.48.1 CP Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Cleft Palate Alone (NCHS)*)) OR (**$ProblemCode** CONTAINS ValueSet (*Cleft Palate Alone (NCHS)*)) THEN "CP" SHALL = "Y" ELSE "N".

6.6.1.1.48.2 CP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.48.3 CP FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.48.4 CP Value Sets

Cleft Palate Alone (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.189

6.6.1.1.49 DOWC

6.6.1.1.49.1 DOWC Derivation Rule

IF ((**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Karyotype Confirmed (NCHS)*) AND (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Downs Syndrome (NCHS)*)) THEN "DOWC" SHALL = "Y" ELSE "N"

6.6.1.1.49.2 DOWC LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

6.6.1.1.49.3 DOWC FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.49.4 DOWC Value Sets

Karyotype Confirmed (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56
Downs Syndrome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

6.6.1.1.50 DOWN

6.6.1.1.50.1 DOWN Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Downs Syndrome (NCHS)*)) THEN "DOWN" SHALL = "Y" ELSE "N"

6.6.1.1.50.2 DOWN LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1']]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.16']]/entry//observation/value

6.6.1.1.50.3 DOWN FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.50.4 DOWN Value Sets

Downs Syndrome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

6.6.1.1.51 DOWP

6.6.1.1.51.1 DOWP Derivation Rule

IF (**$GeneralAppearanceObservationCode** CONTAINS ValueSet (*Downs Syndrome (NCHS)*) AND (**$ProcedureCode** CONTAINS (*Karyotype Determination (NCHS)*) AND act classCode='ACT' moodCode='INT') AND (NOT **$CodedResultCode** (*Karyotype Result (NCHS)*)) THEN DOWP" SHALL = "Y" ELSE "N"

6.6.1.1.51.2 DOWP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

General Appearance Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.16

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$GeneralAppearanceObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Results Section

1.3.6.1.4.1.19376.1.5.3.1.3.28

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$CodedResultCode =

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/observation/code

6.6.1.1.51.3 DOWP FHIR Source and Logic Variables

$GeneralAppearanceObservationCode = N/A- only verified by condition.code

$ProcedureCode = partOf.Encounter.Resource (procedure.code)

$CodedResultCode = partOf.Encounter.Resource (observation.code constrained by: http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsKaryotype))

6.6.1.1.51.4 DOWP Value Sets

Downs Syndrome (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
Karyotype Determination (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
Karyotype Result (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59

6.6.1.1.52 GAST

6.6.1.1.52.1 GAST Derivation Rule

IF (**$AbdomenObservationCode** CONTAINS ValueSet (*Gastroschisis of the Newborn (NCHS)*)) OR (**$ProblemCode** CONTAINS ValueSet (*Gastroschisis of the Newborn (NCHS)*)) THEN "GAST" SHALL = "Y" ELSE "N".

6.6.1.1.52.2 GAST LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Abdomen

1.3.6.1.4.1.19376.1.5.3.1.1.9.31

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$AbdomenObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]/ subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1']]/component/section[templateId[@root=' 1.3.6.1.4.1.19376.1.5.3.1.1.9.31']]/entry//observation/valueNewborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.52.3 GAST FHIR Source and Logic Variables

$AbdomenObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.52.3 GAST Value Sets

Value Sets

Gastroschisis of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62

6.6.1.1.53 HYPO

6.6.1.1.53.1 HYPO Derivation Rule

If (**$RenoGenitaliaObservationCode** = CONTAINS ValueSet (*Hypospadias (NCHS)*)) OR (**$ProblemCode** = CONTAINS ValueSet (*Hypospadias (NCHS)*)) THEN "HYPO" SHALL = "Y" ELSE "N".

6.6.1.1.53.2 HYPO LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Genitalia

1.3.6.1.4.1.19376.1.5.3.1.1.9.36

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$RenoGenitaliaObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.53.3 HYPO Value Sets

Hypospadias (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63

6.6.1.1.54 LIMB

6.6.1.1.54.1 LIMB Derivation Rule

IF (**$MusculoskeletalObservationCode** CONTAINS ValueSet (*Limb Reduction Defect (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Limb Reduction Defect (NCHS)*) THEN "LIMB" SHALL = "Y" ELSE "N".

6.6.1.1.54.2 LIMB LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Musculoskeletal System

1.3.6.1.4.1.19376.1.5.3.1.1.9.34

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$MusculoskeletalObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']]/ subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1']]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.34']]/entry//observation/valueNewborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.54.3 LIMB FHIR Source and Logic Variables

$MusculoskeletalObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.54.4 LIMB Value Sets

Limb Reduction Defect (NCHS) 6.1.4.1.19376.1.7.3.1.1.13.8.64

6.6.1.1.55 MNSB

6.6.1.1.55.1 MNSB Derivation Rule

IF (**$NeurologicSystemObservationCode** CONTAINS ValueSet (*Meningomyelocele/Spina Bifida - Newborn (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Meningomyelocele/Spina Bifida - Newborn (NCHS)*) THEN "MNSB" SHALL = "Y" ELSE "N".

6.6.1.1.55.2 MNSB LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Neurologic System

1.3.6.1.4.1.19376.1.5.3.1.1.9.35

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$NeurologicSystemObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.55.3 MNSB FHIR Source and Logic Variables

$NeurologicSystemObservationCode = N/A- only verified by condition.code

$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.55.3 MNSB Value Sets

Meningomyelocele/Spina Bifida - Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65

6.6.1.1.56 OMPH

6.6.1.1.56.1 OMPH Derivation Rule

IF (**$AbdomenObservationCode** CONTAINS ValueSet (*Omphalocele of the Newborn (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Omphalocele of the Newborn (NCHS)*) THEN "OMPH" SHALL = "Y" ELSE "N".

6.6.1.1.56.2 OMPH LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Abdomen

1.3.6.1.4.1.19376.1.5.3.1.1.9.31

Problem Observation

1.3.6.1.4.1.19376.1.5.3.1.4.5

$AbdomenObservationCode =

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

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

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

6.6.1.1.56.3 OMPH FHIR Source and Logic Variables

$AbdomenObservationCode = N/A- only verified by condition.code
$ProblemCode = partOf.Encounter.Resource (condition.code)

6.6.1.1.56.4 OMPH Value Sets

Omphalocele of the Newborn (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66

6.6.1.1.57 NOA55

6.6.1.1.57.1 NOA55 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.57.2 NOA55 LDS Source and Logic Variables

Data Entry Required

6.6.1.1.57.3 NOA55 Value Sets

NA

6.6.1.1.58 DNA55

6.6.1.1.58.1 DNA55 Derivation Rule

This section intentionally left blank.

6.6.1.1.58.2 DNA55 LDS Source and Logic Variables

This section intentionally left blank.

6.6.1.1.58.3 DNA55 Value Sets

This section intentionally left blank.

6.6.1.1.59 YLLB

6.6.1.1.59.1 YLLB Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Live Birth (NCHS)*), THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "YLLB" SHALL = the Year part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date AND WHERE the Year is represented using 4-digits ELSE "YLLB" SHALL = '8888') ELSE "YLLB" SHALL = '9999'

6.6.1.1.59.2 YLLB LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry /observation/code Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry /observation/value

6.6.1.1.59.3 YLLB FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLLB)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.59.4 YLLB Value Sets

Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

6.6.1.1.60 MLLB

6.6.1.1.60.1 MLLB Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Live Birth (NCHS)*), THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "MLLB" SHALL = the Month part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date AND WHERE the Month is represented using 2-digits ELSE "MLLB" SHALL = '88') ELSE "YLLB" SHALL = '99'

6.6.1.1.60.2 MLLB LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/ observation/value

6.6.1.1.60.3 MLLB FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLLB)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.60.4 MLLB Value Sets

Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67

6.6.1.1.61 DLMP_DY

6.6.1.1.61.1 DLMP_DY Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Menses (NCHS)*), THEN "DLMP_DY" SHALL = Day part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date

6.6.1.1.61.2 DLMP_DY LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.61.3 DLMP_DY FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLMP)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.61.4 DLMP_DY Value Sets

NA

6.6.1.1.62 DLMP_MO

6.6.1.1.62.1 DLMP_MO Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Menses (NCHS)*), THEN "DLMP_MO" SHALL = Month part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date

6.6.1.1.62.2 DLMP_MO LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/ observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.62.3 DLMP_MO FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code constrained by: (
4960 http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLMP)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.62.4 DLMP_MO Value Sets

Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

6.6.1.1.63 DLMP_YR

4965 #### 6.6.1.1.63.1 DLMP_YR Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Menses (NCHS)*), THEN "DLMP_YR" SHALL = Year part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date

6.6.1.1.63.2 DLMP_YR LDS Source and Logic Variables

4970 Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

4975 ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

4980 #### 6.6.1.1.63.3 DLMP_YR FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLMP)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.63.4 DLMP_YR Value Sets

4985 Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69

6.6.1.1.64 YOPO

6.6.1.1.64.1 YOPO Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Other Pregnancy Outcome (NCHS)*), THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "YOPO" SHALL = the Year part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date AND WHERE the Year is represented using 4-digits ELSE YOPO" SHALL = '8888') ELSE "YOPO" SHALL = '9999'

6.6.1.1.64.2 YOPO LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.64.3 YOPO FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsOPO)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.64.4 YOPO Value Sets

Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70

6.6.1.1.65 MOPO

6.6.1.1.65.1 MOPO Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Date of Last Other Pregnancy Outcome (NCHS)*), THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "MOPO" SHALL = the Month part of **$PregnancyHistoryObservationValue** WHERE **$PregnancyHistoryObservationValue** is expressed as Date AND WHERE the Month is represented using 2-digits ELSE MOPO" SHALL = '88') ELSE "MOPO" SHALL = '99'

6.6.1.1.65.2 MOPO LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.65.3 MOPO FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsOPO)

$PregnancyHistoryObservationValue = observation.valueDateTime

6.6.1.1.65.4 MOPO Value Sets

Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70

6.6.1.1.66 ADDRESS_D

6.6.1.1.66.1 ADDRESS_D Derivation Rule

"Facility Address" SHALL be populated using the **$ChildFacilityAddress**

6.6.1.1.66.2 ADDRESS_D LDS Source and Logic Variables

Labor and Delivery Summary Header

$ChildFacilityAddress

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

6.6.1.1.66.3 ADDRESS_D FHIR Source and Logic Variables

$ChildFacilityAddress = encounter.serviceProvider(organization.name)

6.6.1.1.66.4 ADDRESS_D Value Sets

NA

6.6.1.1.67 FNAME

6.6.1.1.67.1 FNAME Derivation Rule

FNAME" SHALL be populated using the **$ChildFacilityName**

6.6.1.1.67.2 FNAME LDS Source and Logic Variables

Labor and Delivery Summary Header

$ChildFacilityName

ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/location/name

6.6.1.1.67.3 FNAME FHIR Source and Logic Variables

$ChildFacilityAddress = encounter.serviceProvider(organization.name)

6.6.1.1.67.4 FNAME Value Sets

NA

6.6.1.1.68 FNPI

6.6.1.1.68.1 FNPI Derivation Rule

"FNPI" SHALL be populated using the **$ChildFacilityNPI**

6.6.1.1.68.2 FNPI LDS Source and Logic Variables

Labor and Delivery Summary Header

$ChildFacilityNPI

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

6.6.1.1.68.3 FNPI FHIR Source and Logic Variables

$ChildFacilityAddress = encounter.serviceProvider(organization.identifier)

6.6.1.1.68.4 FNPI Value Sets

NA

6.6.1.1.69 CHAM

6.6.1.1.69.1 CHAM Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Chlamydia (NCHS)*)) OR
(**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Chlamydia (NCHS)*))

THEN "CHAM" **SHALL** = "Y" ELSE "N".

6.6.1.1.69.2 CHAM LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.69.3 CHAM FHIR Source and Logic Variables

$ProblemCode = condition.code

$InfectionHistoryProblemCode = N/A- only verified by condition.code

6.6.1.1.69.4 CHAM Value Sets

Chlamydia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93

6.6.1.1.70 GON

6.6.1.1.70.1 GON Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Gonorrhea (NCHS)*) OR
(**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Gonorrhea (NCHS)*))

THEN "GON" **SHALL** = "Y" ELSE "N".

6.6.1.1.70.2 GON LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.70.3 GON FHIR Source and Logic Variables

$ProblemCode = condition.code

$InfectionHistoryProblemCode = N/A- only verified by condition.code

6.6.1.1.70.4 GON Value Sets

Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071

6.6.1.1.71 HEPB

6.6.1.1.71.1 HEPB Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Hepatitis B (NCHS)*) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Hepatitis B (NCHS)*)) THEN "HEPB" SHALL = "Y" ELSE "N".

6.6.1.1.71.2 HEPB LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.71.3 HEPB FHIR Source and Logic Variables

$ProblemCode = condition.code

$InfectionHistoryProblemCode = N/A- only verified by condition.code

6.6.1.1.71.4 HEPB Value Sets

Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96

6.6.1.1.72 HEPC

6.6.1.1.72.1 HEPC Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Hepatitis C (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Hepatitis C (NCHS)*)) THEN "HEPC" **SHALL** = "Y" ELSE "N".

6.6.1.1.72.2 HEPC LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.72.3 HEPC FHIR Source and Logic Variables

$ProblemCode = condition.code

$InfectionHistoryProblemCode = N/A- only verified by condition.code

6.6.1.1.72.4 HEPC Value Sets

Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

6.6.1.1.73 SYPH

6.6.1.1.73.1 SYPH Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Syphilis (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Syphilis (NCHS)*)) THEN "SYPH" **SHALL** ="Y" ELSE "N".

6.6.1.1.73.2 SYPH LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.73.3 SYPH FHIR Source and Logic Variables

$ProblemCode = condition.code

$InfectionHistoryProblemCode = N/A- only verified by condition.code

6.6.1.1.73.4 SYPH Value Sets

Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98

6.6.1.1.74 NOA02

6.6.1.1.74.1 NOA02 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.74.2 NOA02 LDS Source and Logic Variables

Data Entry Required

6.6.1.1.74.3 NOA02 Value Sets

NA

6.6.1.1.75 AINT

6.6.1.1.75.1 AINT Derivation Rule

IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*ICU Care (NCHS)*) THEN "AINT" SHALL be "Y" ELSE "N".

6.6.1.1.75.2 AINT LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

6.6.1.1.75.3 AINT FHIR Source and Logic Variables

$EventOutcomesObservationCode = procedure.code

6.6.1.1.75.4 AINT Value Sets

ICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.188

6.6.1.1.76 MTR

6.6.1.1.76.1 MTR Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (*Transfusion Whole Blood or Packed Red Bld (NCHS)*) THEN "MTR" **SHALL** be "Y" ELSE "N"

6.6.1.1.76.2 MTR LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.76.3 MTR FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.76.4 MTR Value Sets

Transfusion Whole Blood or Packed Red Bld (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99

6.6.1.1.77 PLAC

6.6.1.1.77.1 PLAC Derivation Rule

IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Third Degree Perineal Laceration (NCHS)*) OR (*Fourth Degree Perineal Laceration (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Third Degree Perineal Laceration (NCHS)*) OR (*Fourth Degree Perineal Laceration (NCHS)*THEN "PLAC" SHALL be "Y" ELSE "N"

6.6.1.1.77.2 PLAC LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

CodeClinicalDocument/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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.77.3 PLAC FHIR Source and Logic Variables

$EventOutcomesObservationCode = procedure.code

$ProblemCode = condition.code

6.6.1.1.77.4 PLAC Value Sets

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

6.6.1.1.78 RUT

6.6.1.1.78.1 RUT Derivation Rule

IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Ruptured Uterus (NCHS)*) OR (**$ProblemCode** CONTAINS ValueSet (*Ruptured Uterus (NCHS)*) THEN "RUT" SHALL be "Y" ELSE "N"

6.6.1.1.78.2 RUT LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

CodeClinicalDocument/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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.78.3 RUT FHIR Source and Logic Variables

$EventOutcomesObservationCode = procedure.code

$ProblemCode = condition.code

6.6.1.1.78.4 RUT Value Sets

Ruptured Uterus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102

6.6.1.1.79 UHYS

6.6.1.1.79.1 UHYS Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (*Unplanned Hysterectomy (NCHS)*)) THEN "UHYS" SHALL be "Y" ELSE "N"

6.6.1.1.79.2 UHYS LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.79.3 UHYS FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.79.4 UHYS Value Sets

Unplanned Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103

6.6.1.1.80 UOPR

6.6.1.1.80.1 UOPR Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet (*Unplanned Operation (NCHS)*) "UOPR" **SHALL** be "Y" ELSE "N"

6.6.1.1.80.2 UOPR LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.80.3 UOPR FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.80.4 UOPR Value Sets

Unplanned Operation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105

6.6.1.1.81 NOA05

6.6.1.1.81.1 NOA05 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.81.2 NOA05 LDS Source and Logic Variables

Data Entry Required

6.6.1.1.81.3 NOA05 Value Sets

NA

6.6.1.1.82 PRES

6.6.1.1.82.1 PRES Derivation Rule

IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Fetal Presentation at Birth-Cephalic (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Fetal Presentation at Birth-Cephalic (NCHS))* THEN "PRES" **SHALL** = "1" ELSE IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Fetal Presentation at Birth-Breech (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Fetal Presentation at Birth- Breech (NCHS)))* THEN "PRES" **SHALL** = "2" ELSE IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Fetal Presentation at Birth- Other (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Fetal Presentation at Birth- Other (NCHS)*)) THEN "PRES" **SHALL** = "3" ELSE "PRES" **SHALL** = "9"

6.6.1.1.82.2 PRES LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.82.3 PRES FHIR Source and Logic Variables

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.82.4 PRES Value Sets

Fetal Presentation at Birth- Breech (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108
Fetal Presentation at Birth- Cephalic (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109
Fetal Presentation at Birth- Other (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110

6.6.1.1.83 ROUT

6.6.1.1.83.1 ROUT Derivation Rule

IF ((**$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Spontaneous (NCHS)*) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (Method of Delivery Vaginal-Spon Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (Method of Delivery Vaginal-Spon Finding (NCHS))) THEN "ROUT" SHALL = "1" ELSE IF (**$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Forceps (NCHS)*) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (Method of Delivery Vaginal Forceps Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (Method of Delivery Vaginal Forceps Finding (NCHS))) THEN "ROUT" SHALL = "2" ELSE IF (**$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Vacuum (NCHS*)) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (Method of Delivery Vaginal Vacuum Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (Method of Delivery Vaginal Vacuum Finding (NCHS))) THEN "ROUT" SHALL = "3" ELSE IF (**$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Cesarean (NCHS)*) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (Method of Delivery Cesarean Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (Method of Delivery Cesarean Finding (NCHS))) THEN "ROUT" SHALL = "4" ELSE "ROUT" SHALL = "9".

6.6.1.1.83.2 ROUT LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

6.6.1.1.83.3 ROUT FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.83.4 ROUT Value Sets

Route and Method of Delivery - Spontaneous (NCHS)
1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111Route and Method of Delivery - Forceps (NCHS)
1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112

Route and Method of Delivery - Vacuum (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113

Route and Method of Delivery - Cesarean (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114

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

Method of Delivery Cesarean Finding (NCHS) 2.16.840.1.114222.4.11.7527

6.6.1.1.84 TLAB

6.6.1.1.84.1 TLAB Derivation Rule

IF ((**$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Cesarean (NCHS)*) OR (**$EventOutcomesObservationCode** CONTAINS ValueSet (Scheduled Cesarean Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (Scheduled Cesarean Finding (NCHS)) THEN (IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (Method of Delivery Trial Labor Finding (NCHS)) OR (**$ProblemCode** CONTAINS ValueSet (*Route Method of Delivery - Trial of Labor (NCHS)*)) THEN "TLAB" SHALL be "Y" ELSE IF NOT **$ProcedureCode** CONTAINS ValueSet (*Route and Method of Delivery - Scheduled C (NCHS)*) THEN "TLAB" SHALL NOT be available for data entry and SHALL = "X" ELSE IF =NULL THEN "U") ELSE "N".

6.6.1.1.84.2 TLAB LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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='1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1']/act/code

6.6.1.1.84.3 TLAB FHIR Source and Logic Variables

$ProblemCode = condition.code

$ProcedureCode = procedure.code

$EventOutcomesObservationCode = procedure.code

6.6.1.1.84.4 TLAB Value Sets

Route Method of Delivery - Trial of Labor (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115
Route and Method of Delivery - Scheduled C (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116
Route and Method of Delivery - Cesarean (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114

Scheduled Cesarean Finding (NCHS) 2.16.840.1.114222.4.11.7530

6.6.1.1.85 MFNAME

6.6.1.1.85.1 MFNAME Derivation Rule

"MFNAME" **SHALL** be populated using the First Name part of **$MotherName**

6.6.1.1.85.2 MFNAME LDS Source and Logic Variables

Labor and Delivery Summary Header

$MotherName

/ClinicalDocument/ recordTarget/patientRole/patient/name

6.6.1.1.85.3 MFNAME FHIR Source and Logic Variables

$MotherName = patient.name

6.6.1.1.85.4 MFNAME Value Sets

NA

6.6.1.1.86 MMNAME

6.6.1.1.86.1 MMNAME Derivation Rule

"MMNAME" **SHALL** be populated using the Middle Name part of part **$MotherName**

6.6.1.1.86.2 MMNAME LDS Source and Logic Variables

Labor and Delivery Summary Header

$MotherName

/ClinicalDocument/ recordTarget/patientRole/patient/name/given[2]

6.6.1.1.86.3 MMNAME FHIR Source and Logic Variables

$MotherName = patient.name

6.6.1.1.86.4 MMNAME Value Sets

NA

6.6.1.1.87 MLNAME

6.6.1.1.87.1 MLNAME Derivation Rule

"MLNAME" **SHALL** be populated using the Last Name part of part of **$MotherName**

6.6.1.1.87.2 MLNAME LDS Source and Logic Variables

Labor and Delivery Summary Header

$MotherName

/ClinicalDocument/ recordTarget/patientRole/patient/name/family

6.6.1.1.87.3 MLNAME FHIR Source and Logic Variables

$MotherName = patient.name

6.6.1.1.87.4 MLNAME Value Sets

NA

6.6.1.1.88 MSUFF

6.6.1.1.88.1 MSUFF Derivation Rule

"MSUFF" **SHALL** be populated using the Last Name Suffix part of part of **$MotherName**

6.6.1.1.88.2 MSUFF LDS Source and Logic Variables

Labor and Delivery Summary Header

$MotherName

/ClinicalDocument/ recordTarget/patientRole/patient/name/suffix

6.6.1.1.88.3 MSUFF FHIR Source and Logic Variables

$MotherName = patient.name

6.6.1.1.88.4 MSUFF Value Sets

NA

6.6.1.1.89 HFT

6.6.1.1.89.1 HFT Derivation Rule

IF (**$VitalSignsTypeCode** CONTAINS ValueSet (*Height (NCHS)*), THEN "HFT" **SHALL** = feet part of **$VitalSignsResultValue** WHERE **$VitalSignsResultUnits** are expressed in Feet and Inches

6.6.1.1.89.2 HFT LDS Source and Logic Variables

Labor and Delivery Summary

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

$VitalSignsTypeCode =

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

$VitalSignsResultValue =

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/value

$VitalSignsResultUnits =

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/value[@units]

6.6.1.1.89.3 HFT FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsHT)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.89.4 HFT Value Sets

Height (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

6.6.1.1.90 HIN

6.6.1.1.90.1 HIN Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (Height (NCHS)), THEN "HIN" **SHALL** = Inches part of **$VitalSignsResultValue** WHERE **$VitalSignsResultUnits** are expressed in Feet and Inches

6.6.1.1.90.2 HIN LDS Source and Logic Variables

Labor and Delivery Summary

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

$VitalSignsTypeCode =

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

$VitalSignsResultValue =

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/value

$VitalSignsResultUnits =

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/value[@units]

6.6.1.1.90.3 HIN FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsHT)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.904 HIN Value Sets

Height (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190

6.6.1.1.91 MRECNUM

6.6.1.1.91.1 MRECNUM Derivation Rule

"MRECNUM" **SHALL** be populated using **$MotherMedRecNum**

6.6.1.1.91.2 MRECNUM LDS Source and Logic Variables

Labor and Delivery Summary Mother's Metadata

$MotherMedRecNum =

/ClinicalDocument/patientRole/id

6.6.1.1.91.3 MRECNUM FHIR Source and Logic Variables

$MotherMedRecNum = patient.identifier

6.6.1.1.91.4 MRECNUM Value Sets

NA

6.6.1.1.92 PWGT

6.6.1.1.92.1 PWGT Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*) where **$VitalSignsMethodCode** CONTAINS ValueSet (*Pre-Pregnancy Weight (NCHS)*), THEN "PWGT" SHALL = **$VitalSignsResultValue**

6.6.1.1.92.2 PWGT LDS Source and Logic Variables

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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/methodCode

$VitalSignsResultValue =

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/value

6.6.1.1.92.3 PWGT FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsHT)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsMethodCode = Observation.method

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.92.4 PWGT Value Sets

Body Weight (NCHS) 2.16.840.1.114222.4.11.7421

Pre-Pregnancy Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118

6.6.1.1.93 NFACL

6.6.1.1.93.1 NFACL Derivation Rule

IF **$AdmitSrc** CONTAINS value set (*Transfer In (NCHS)*) OR **$ProblemCode** Contains Value Set (*Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)*), THEN **NFACL SHALL** = **$ReferringFacilityName** ELSE **NFACL SHALL** = NULL'

6.6.1.1.93.2 NFACL LDS Source and Logic Variables

Labor and Delivery Summary Encompassing Encounter

$AdmitSrc =

encompassingEncounter/sdtc:admissionSourceReferralCode

$ReferringFacilityName =

/encompassingEncouter/encounterParticipant[@typeCode='REF']/assignedEntity/representedOrganization

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.93.3 NFACL FHIR Source and Logic Variables

$AdmitSrc = encounter.hospitalization.admitSource

$ReferringFacilityName = encounter.hospitalization.origin(location.name)

$ProblemCode = condition.code

6.6.1.1.93.4 NFACL Value Sets

Transfer In (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

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

6.6.1.1.94 TRAN

6.6.1.1.94.1 TRAN Derivation Rule

IF **$AdmitSrc** CONTAINS Value Set (*Transfer In (NCHS)*) OR **$ProblemCode** CONTAINS Value Set (*Transferred for Maternal Medical or Fetal Indications for Delivery (NCHS)*), THEN "TRAN" SHALL = "Y" ELSE IF **$AdmitSrc** NOT NULL, THEN TRAN SHALL = "N" ELSE TRAN SHALL = "U".

6.6.1.1.94.2 TRAN LDS Source and Logic Variables

Labor and Delivery Summary Encompassing Encounter

$AdmitSrc =

encompassingEncounter/sdtc:admissionSourceReferralCode

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.94.3 TRAN FHIR Source and Logic Variables

$AdmitSrc = encounter.hospitalization.admitSource

$ProblemCode = condition.code

6.6.1.1.94.3 TRAN Value Sets

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

Transfer In (NCHS)
1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

6.6.1.1.95 DWGT

6.6.1.1.95.1 DWGT Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*) where **$VitalSignsMethodCode** CONTAINS ValueSet (*Mothers Delivery Weight (NCHS)*), THEN "DWGT" SHALL = **$VitalSignsResultValue**

6.6.1.1.95.2 DWGT LDS Source and Logic Variables

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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/methodCode

$VitalSignsResultValue =

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/value

6.6.1.1.95.3 DWGT FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsWT)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsMethodCode = Observation.method

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.95.4 DWGT Value Sets

Body Weight (NCHS) 2.16.840.1.114222.4.11.7421

Mothers Delivery Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120

6.6.1.1.96 POPO

6.6.1.1.96.1 POPO Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Previous Other Pregnancy Outcomes (NCHS)*), THEN "POPO" **SHALL** = **$PregnancyHistoryObservationValue**

6.6.1.1.96.2 POPO LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.96.3 POPO FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Previous Other Pregnancy Outcomes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121)

$PregnancyHistoryObservationValue = observation.valueCodableConcept

6.6.1.1.96.4 POPO Value Sets

Previous Other Pregnancy Outcomes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121

6.6.1.1.97 PLBD

6.6.1.1.97.1 PLBD Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Number of Previous Live Births Now Dead (NCHS)*), THEN "PLBD" **SHALL** = **$PregnancyHistoryObservationValue**

6.6.1.1.97.2 PLBD LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.97.3 PLBD FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122)

$PregnancyHistoryObservationValue = observation.valueQuantity

6.6.1.1.97.4 PLBD Value Sets

Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122

6.6.1.1.98 PLBL

6.6.1.1.98.1 PLBL Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (Number of Previous Live Births Now Living (NCHS)), THEN "PLBL" **SHALL** = **$PregnancyHistoryObservationValue**

6.6.1.1.98.2 PLBL LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root=/1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/entry/ observation/value

6.6.1.1.98.3 PLBL FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123)

$PregnancyHistoryObservationValue = observation.valueQuantity

6.6.1.1.98.4 PLBL Value Sets

Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123

6.6.1.1.99 OWGEST

6.6.1.1.99.1 OWGEST Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (Obstetric Estimate of Gestation (NCHS)), THEN "OWGEST" **SHALL** = **$PregnancyHistoryObservationValue**

6.6.1.1.99.2 OWGEST LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.99.3 OWGEST FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124)

$PregnancyHistoryObservationValue = observation.valueQuantity

6.6.1.1.99.4 OWGEST Value Sets

Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124

6.6.1.1.100 CERV

6.6.1.1.100.1 CERV Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*Cervical Cerclage (NCHS)*), THEN "CERV" **SHALL** = 'Y' ELSE "CERV" **SHALL** = 'N'

6.6.1.1.100.2 CERV LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.100.3 CERV FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.100.4 CERV Value Sets

Cervical Cerclage (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125

6.6.1.1.101 ECVF

6.6.1.1.101.1 ECVF Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*External Cephalic Version (NCHS)*) as 'INT' and Negation=TRUE, THEN "ECVF" **SHALL** = 'Y' ELSE "ECVF" **SHALL** = 'N'

6.6.1.1.101.2 ECVF LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.101.3 ECVF FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.101.4 ECVF Value Sets

External Cephalic Version (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

6.6.1.1.102 ECVS

6.6.1.1.102.1 ECVS Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*External Cephalic Version (NCHS)*), AND **NOT ('INT' and Negation)=TRUE**, THEN "ECVS" **SHALL** = 'Y' ELSE "ECVS" **SHALL** = 'N'

6.6.1.1.102.2 ECVS LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.102.3 ECVS FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.102.4 ECVS Value Sets

External Cephalic Version (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

6.6.1.1.103 TOC

6.6.1.1.103.1 TOC Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*Tocolysis (NCHS)*), THEN "TOC" **SHALL** = 'Y' ELSE "TOC" **SHALL** = 'N'

6.6.1.1.103.2 TOC LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.103.3 TOC FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.103.4 TOC Value Sets

Tocolysis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128

6.6.1.1.104 NOA03

6.6.1.1.104.1 NOA03 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.104.2 NOA03 LDS Source and Logic Variables

Data Entry Required

6.6.1.1.104.3 NOA03 Value Sets

NA

6.6.1.1.105 PROM

6.6.1.1.105.1 PROM Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Premature Rupture (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Premature Rupture (NCHS)*),, THEN "PROM" **SHALL** = 'Y' ELSE "PROM" SHALL = 'N'

6.6.1.1.105.2 PROM LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.105.3 PROM FHIR Source and Logic Variables

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.105.4 PROM Value Sets

Premature Rupture (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129

6.6.1.1.106 PRIC

6.6.1.1.106.1 PRIC Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Precipitous Labor (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Precipitous Labor (NCHS)*), THEN "PRIC" **SHALL** = 'Y' ELSE "PRIC" SHALL = 'N'

6.6.1.1.106.2 PRIC LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.106.3 PRIC FHIR Source and Logic Variables

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.106.4 PRIC Value Sets

Precipitous Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130

6.6.1.1.107 PROL

6.6.1.1.107.1 PROL Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Prolonged Labor (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Prolonged Labor (NCHS)*), THEN "PROL" SHALL = 'Y' ELSE "PROL" SHALL = 'N'

6.6.1.1.107.2 PROL LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Problem Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5

$EventOutcomesObservationCode =

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

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.107.3 PROL FHIR Source and Logic Variables

$EventOutcomesObservationCode = condition.code

$ProblemCode = condition.code

6.6.1.1.107.4 PROL Value Sets

Prolonged Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131

6.6.1.1.108 NOA05

6.6.1.1.108.1 NOA05 Derivation Rule

This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list

6.6.1.1.108.2 NOA05 LDS Source and Logic Variables

Data Entry Required

6.6.1.1.108.3 NOA05 Value Sets

NA

6.6.1.1.109 SFN

6.6.1.1.109.1 SFN Derivation Rule

"SFN" SHALL be populated using **$BabyFacilityStateID**

6.6.1.1.109.2 SFN LDS Source and Logic Variables

Labor and Delivery Summary Header

$BabyFacilityStateID

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

6.6.1.1.109.3 SFN FHIR Source and Logic Variables

$BabyFacilityStateID= encounter.serviceProvider(organization.identifier)

6.6.1.1.109.4 SFN Value Sets

NA

6.6.1.1.110 FLOC

6.6.1.1.110.1 FLOC Derivation Rule

Derivation Rule

"FLOC" SHALL = City/Town part of **$BabyFacilityLocation**

6.6.1.1.110.2 FLOC LDS Source and Logic Variables

$BabyFacilityLocation

ClinicalDocument/component/structuredBody

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

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

6.6.1.1.110.3 FLOC FHIR Source and Logic Variables

$BabyFacilityStateID= encounter.serviceProvider(organization.address)

6.6.1.1.110.4 FLOC Value Sets

NA

6.6.1.1.111 CNAME

6.6.1.1.111.1 CNAME Derivation Rule

"CNAME" SHALL = County name part of **$BabyFacilityLocation**

6.6.1.1.111.2 CNAME LDS Source and Logic Variables

$BabyFacilityLocation

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

6.6.1.1.111.3 CNAME FHIR Source and Logic Variables

$BabyFacilityStateID= encounter.serviceProvider(organization.address)

6.6.1.1.111.4 CNAME Value Sets

NA

6.6.1.1.112 CNTYO

6.6.1.1.112.1 CNTYO Derivation Rule

"CNTYO" SHALL = County Code part of **$BabyFacilityLocation**

6.6.1.1.112.2 CNTYO LDS Source and Logic Variables

$BabyFacilityLocation

This derivation rule is subject to Realm specificity. For example, in the US, a value set lookup using the code from CNTYO.

6.6.1.1.112.3 CNTYO FHIR Source and Logic Variables

$BabyFacilityStateID= encounter.serviceProvider(organization.address)

6.6.1.1.112.4 CNTYO Value Sets

NA

6.6.1.1.113 BPLACE

6.6.1.1.113.1 BPLACE Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Birthplace Setting (NCHS)*) THEN IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birthplace Hospital (NCHS)*) THEN BPLACE SHALL = '1' ELSE IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birth Place Freestanding Birthing Center (NCHS)*) THEN BPLACE SHALL = '2' ELSE IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birth Place Home Intended (NCHS)*) THEN BPLACE SHALL = '3' ELSE IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birth Place Home Unintended (NCHS)*) THEN BPLACE SHALL = '4' ELSE IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birth Place Home Unknown Intention (NCHS)*) THEN BPLACE SHALL = '5' ELSE IF **$EventOutcomesObservationValue** CONTAINS ValueSet (*Birthplace Clinic Office (NCHS)*) THEN BPLACE SHALL = '6' ELSE BPLACE SHALL = '7'

6.6.1.1.113.2 BPLACE LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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

$EventOutcomesObservationValue =

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/value

6.6.1.1.113.3 BPLACE FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsBPLACE)

$EventOutcomesObservationValue =observation.valueCodableConcept

6.6.1.1.113.4 BPLACE Value Sets

Birthplace Setting (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
Birthplace Hospital (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192
Birth Place Home Intended (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193
Birth Place Home Unintended (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194
Birth Place Home Unknown Intention (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195
Birthplace Clinic Office (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197
Birth Place Freestanding Birthing Center (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196

6.6.1.1.114 PLUR

6.6.1.1.114.1 PLUR Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Birth Plurality of Delivery (NCHS)*), THEN "PLUR" SHALL = **$EventOutcomesObservationValue**

6.6.1.1.114.2 PLUR LDS Source and Logic Variables

Labor and Delivery Events

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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

$EventOutcomesObservationValue =

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/value

6.6.1.1.114.3 PLUR FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by:
(http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsPLUR)

$EventOutcomesObservationValue =observation.valueQuantity

6.6.1.1.114.4 PLUR Value Sets

Birth Plurality of Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132

6.6.1.1.115 DOFP_MO

6.6.1.1.115.1 DOFP_MO Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*First Prenatal Care Visit (NCHS)*) THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "DOFP_MO" SHALL = the Month part of **$PregnancyHistoryObservationValue** WHERE the Month is represented using 2-digits ELSE DOFP_MO" SHALL = '88') ELSE "DOFP_MO" SHALL = '99'

6.6.1.1.115.2 DOFP_MO LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.115.3 DOFP_MO FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by:
(http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsDOFP)

$EventOutcomesObservationValue =observation.valueDateTime

6.6.1.1.115.4 DOFP_MO Value Sets

First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133

6.6.1.1.116 DOFP_DY

6.6.1.1.116.1 DOFP_DY Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*First Prenatal Care Visit (NCHS)*) THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "DOFP_DY" SHALL CONTAINS the Day part of **$PregnancyHistoryObservationValue** WHERE the Day is represented using 2-digits ELSE DOFP_DY" SHALL = '88') ELSE "DOFP_DY" SHALL = '99'

6.6.1.1.116.2 DOFP_DY LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.116.3 DOFP_DY FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsDOFP)

$EventOutcomesObservationValue =observation.valueDateTime

6.6.1.1.116.4 DOFP_DY Value Sets

First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133

6.6.1.1.117 DOFP_YR

6.6.1.1.117.1 DOFP_YR Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*First Prenatal Care Visit (NCHS)*), THEN (IF **$PregnancyHistoryObservationValue** NOT NULL THEN "DOFP_YR" SHALL = the Year part of **$PregnancyHistoryObservationValue** WHERE the Year is represented using 4-digits ELSE DOFP_YR" SHALL = '8888') ELSE "DOFP_YR" SHALL = '9999'

6.6.1.1.117.2 DOFP_YR LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.117.3 DOFP_YR FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsDOFP)

$EventOutcomesObservationValue =observation.valueDateTime

6.6.1.1.117.4 DOFP_YR Value Sets

First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133

6.6.1.1.118 NPREV

6.6.1.1.118.1 NPREV Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Number Prenatal Care Visits (NCHS)*), THEN "NPREV" **SHALL** = **$PregnancyHistoryObservationValue**

6.6.1.1.118.2 NPREV LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]]/entry/observation/value

6.6.1.1.118.3 NPREV FHIR Source and Logic Variables

$EventOutcomesObservationCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsNPREV)

$EventOutcomesObservationValue =observation.valueQuantity

6.6.1.1.118.4 NPREV Value Sets

Number Prenatal Care Visits (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135

6.6.1.1.119 PAY

6.6.1.1.119.1 PAY Derivation Rule

NOTE: The US-Specific codes associated with this value set are not yet mapped to the form data from HITSP selected ANSI X12 Values. Until such time as these codes are mapped, this attribute will require implementation-specific mapping.

6.6.1.1.119.2 PAY LDS Source and Logic Variables

Payers

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7

Coverage Entry

1.3.6.1.4.1.19376.1.5.3.1.4.17

6.6.1.1.119.3 PAY FHIR Source and Logic Variables

Coverage.type

6.6.1.1.119.3 PAY Value Sets

NA

6.6.1.1.120 PDIAB

6.6.1.1.120.1 PDIAB Derivation Rule

IF $**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Prepregnancy Diabetes (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Prepregnancy Diabetes (NCHS)*), THEN "PDIAB" **SHALL** = 'Y' ELSE "PDIAB" **SHALL** = 'N'

6.6.1.1.120.2 PDIAB LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/ entry /observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.120.3 PDIAB FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.120.4 PDIAB Value Sets

Prepregnancy Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136

6.6.1.1.121 GDIAB

6.6.1.1.121.1 GDIAB Derivation Rule

IF $**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Gestational Diabetes (NCHS)*) OR **$ProbemCode** CONTAINS ValueSet (*Gestational Diabetes (NCHS)*), THEN "GDIAB" **SHALL** = 'Y' ELSE "GDIAB" **SHALL** = 'N'

6.6.1.1.121.2 GDIAB LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/
component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/ entry /observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.121.3 GDIAB FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.121.4 GDIAB Value Sets

Gestational Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137

6.6.1.1.122 PHYPE

6.6.1.1.122.1 PHYPE Derivation Rule

IF ($**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Prepregnancy Hypertension (NCHS)* OR **$ProblemCode** CONTAINS ValueSet (*Prepregnancy Hypertension (NCHS)*) AND NOT ($**PregnancyHistoryObservationValue** CONTAINS (*Gestational Hypertension (NCHS)*) OR **$ProblemCode** CONTAINS (*Gestational Hypertension (NCHS))*) THEN "PHYPE" **SHALL** = 'Y' ELSE "PHYPE" **SHALL** = 'N'

6.6.1.1.122.2 PHYPE LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/
component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/ entry/ observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.122.3 PHYPE FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.122.4 PHYPE Value Sets

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

6.6.1.1.123 GHYPE

6.6.1.1.123.1 GHYPE Derivation Rule

IF ($**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Gestational Hypertension (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Gestational Hypertension (NCHS))*) AND NOT ($**PregnancyHistoryObservationValue** CONTAINS (*Prepregnancy Hypertension (NCHS)*) OR **$ProblemCode** CONTAINS (*Prepregnancy Hypertension (NCHS*))) THEN "GHYPE" **SHALL** = 'Y' ELSE "GHYPE" **SHALL** = 'N'

6.6.1.1.123.2 GHYPE LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/
component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/
entry/ observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.123.3 GHYPE FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.123.4 GHYPE Value Sets

Gestational Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139

Prepregnancy Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138

6.6.1.1.124 EHYPE

6.6.1.1.124.1 EHYPE Derivation Rule

IF ($**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Eclampsia (NCHS)*) *)* OR **$ProblemCode** CONTAINS ValueSet (*Eclampsia (NCHS)*)), THEN "EHYPE" **SHALL** = 'Y' ELSE "EHYPE" **SHALL** = 'N'

6.6.1.1.124.2 EHYPE LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/
component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/
entry/ observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.124.3 EHYPE FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.124.4 EHYPE Value Sets

Eclampsia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140

6.6.1.1.125 PPB

6.6.1.1.125.1 PPB Derivation Rule

IF **$ PregnancyHistoryObservationValue** CONTAINS ValueSet(*Preterm Birth (NCHS)*) *OR* ***$*ProblemCode** CONTAINS ValueSet(*Preterm Birth (NCHS)*) OR (**$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Number of Preterm Births (NCHS)*) AND **$PregnancyHistoryObservationValue** >0)THEN "PPB" **SHALL** = 'Y' ELSE "PPB" **SHALL** = 'N'

6.6.1.1.125.2 PPB LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.125.3 PPB FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.125.4 PPB Value Sets

Preterm Birth (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141
Number of Preterm Births (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187

6.6.1.1.126 INFT

6.6.1.1.126.1 INFT Derivation Rule

IF $**PregnancyHistoryObservationValue** CONTAINS ValueSet (*Infertility Treatment (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Infertility Treatment (NCHS)*) THEN "INFT" **SHALL** = 'Y' ELSE "INFT" **SHALL** = 'N'

6.6.1.1.126.2 INFT LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.126.3 INFT FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.126.4 INFT Value Sets

Infertility Treatment (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143

6.6.1.1.127 INFT_DRG

6.6.1.1.127.1 INFT_DRG Derivation Rule

IF **$CodedProductName** CONTAINS ValueSet (*Fertility Enhancing Drugs Medications (NCHS)*)THEN "INFT_DRG" **SHALL** = 'Y' ELSE IF $**PregnancyHistoryObservationValue** CONTAINS (*Artificial or Intrauterine Insemination (NCHS)*) THEN "INFT_DRG" SHALL = 'Y' ELSE IF (**$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Pregnancy Resulting From Fertility Enhancing Drugs (NCHS)*) OR **$ProblemCode** CONTAINS (*Artificial or Intrauterine Insemination (NCHS))*) THEN INFT_DRG SHALL = 'Y' ELSE "INFT_DRG" **SHALL** = 'N'

6.6.1.1.127.2 INFT_DRG LDS Source and Logic Variables

Admission Medication History Section

1.3.6.1.4.1.19376.1.5.3.1.3.20

Medication Entry

1.3.6.1.4.1.19376.1.5.3.1.4.7

$CodedProductName =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.21']]/entry/substanceAdministration/consumable/manufacturedProduct/labeledDrug/code

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/
component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.127.3 INFT_DRG FHIR Source and Logic Variables

$CodedProductName = MedicationStatement.medication[x].medicationCodableConcept

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.127.4 INFT_DRG Value Sets

Fertility Enhancing Drugs Medications (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144

Artificial or Intrauterine Insemination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145

Pregnancy Resulting From Fertility Enhancing Drugs (NCHS) 2.16.840.1.114222.4.11.7423

6.6.1.1.128 INFT_ART

6.6.1.1.128.1 INFT_ART Derivation Rule

IF **$PregnancyHistoryObservationValue** CONTAINS ValueSet (*Assistive Reproductive Technology (NCHS)*) OR **$ProblemCode** CONTAINS ValueSet (*Assistive Reproductive Technology (NCHS)*) THEN "INFT_ART" **SHALL** = 'Y' ELSE "INFT_ART" **SHALL** = 'N'

6.6.1.1.128.2 INFT_ART LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.128.3 INFT_ART FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.128.4 INFT_ART Value Sets

Assistive Reproductive Technology (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146

6.6.1.1.129 PCES

6.6.1.1.129.1 PCES Derivation Rule

IF **$PregnancyHistoryObservationValue** CONTAINS ValueSet (*Previous Cesarean (NCHS)*) OR **$PregnancyHistoryObservationValue** CONTAINS ValueSet (*Previous Cesarean (NCHS)*) THEN "PCES" **SHALL** = 'Y' ELSE "PCES" **SHALL** = 'N'

6.6.1.1.129.2 PCES LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/ observation/value

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

6.6.1.1.129.3 PCES FHIR Source and Logic Variables

$PregnancyHistoryObservationValue = condition.code

$ProblemCode = condition.code

6.6.1.1.129.4 PCES Value Sets

Previous Cesarean (NCHS) 2.16.840.1.114222.4.11.7165

6.6.1.1.130 NPCES

6.6.1.1.130.1 NPCES Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*Number of Previous Cesareans (NCHS)*), THEN "NPCES" SHALL = **$PregnancyHistoryObservationValue**

6.6.1.1.130.2 NPCES LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/ omponent/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/ entry/ observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/ component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4]']/ entry/ observation/value

6.6.1.1.130.3 NPCES FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148) constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsNPCES)

$PregnancyHistoryObservationValue = observation.valueQuantity

6.6.1.1.130.4 NPCES Value Sets

Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148

6.6.1.1.131 NOA01

6.6.1.1.131.1 NOA01 Derivation Rule

This attribute SHALL NOT be determined by default. If there are no other risk factors identified through other attributes, the form manager SHALL require data entry to assure the accuracy of the data.

6.6.1.1.131.2 NOA01 LDS Source and Logic Variables

NA

6.6.1.1.131.3 NOA01 Value Sets

NA

6.6.1.1.132 SORD

6.6.1.1.132.1 SORD Derivation Rule

IF **$MultipleBirthInd**=’true’ THEN “SORD” **SHALL** be populated using **$MultipleBirthOrder** AND using ‘99’ where not known ELSE IF Multiple Birth =’false’ “SORD” **SHALL** = ‘88’

6.6.1.1.132.2 SORD LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

$MultipleBirthInd

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

$MultipleBirthOrder

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:multipleBirthOrderNumber

6.6.1.1.132.3 SORD FHIR Source and Logic Variables

$MultipleBirthInd = patient.multipleBirth[x].multipleBirthBoolean

$MultipleBirthOrder= patient.multipleBirth[x].multipleBirthInteger

6.6.1.1.132.4 SORD Value Sets

NA

6.6.1.1.133 FSEX

6.6.1.1.133.1 FSEX Derivation Rule

IF **$Gender** CONTAINS ValueSet (*Male Gender (NCHS)*) THEN "FSEX" SHALL ='M' ELSE IF **$Gender** CONTAINS ValueSet(*Female Gender (NCHS)*) THEN "FSEX" SHALL ='F' ELSE THEN "FSEX" SHALL ='N'

6.6.1.1.133.2 FSEX LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

$Gender

ClinicalDocument/component/structuredBody/component/section[templateId[@root='2.16.840.1.113883.10.20.1.21.2.4']]/subject/relatedSubject/code[@code='NCHILD' AND id=idOfTheChild]/subject/relatedSubject/subject/administrativeGenderCode

6.6.1.1.133.3 FSEX FHIR Source and Logic Variables

$Gender = patient.gender

6.6.1.1.133.4 FSEX Value Sets

Male Gender (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42

Female Gender (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43

6.6.1.1.134 FDOD_YR

6.6.1.1.134.1 FDOD_YR Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*) THEN "FDOD_YR" **SHALL** = Year part of Procedure Date/Time

6.6.1.1.134.2 FDOD_YR LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureEndTime =

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/effectiveTime/high

6.6.1.1.134.3 FDOD_YR Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.135 FDOD_MO Derivation Rule

6.6.1.1.135.1 FDOD_MO Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (*Delivery (NCHS)*) THEN "FDOD_MO" SHALL = Month part of **$ProcedureEndTime**

6.6.1.1.135.2 FDOD_MO LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureEndTime =

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/effectiveTime/high

6.6.1.1.135.3 FDOD_MO FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProcedureEndTime = procedure.period

6.6.1.1.135.4 FDOD_MO Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.136 FDOD_DY

6.6.1.1.136.1 FDOD_DY Derivation Rule

IF **$ProcedureCode** CONTAINS ValueSet (Delivery (NCHS)) THEN "FDOD_DYYR"
SHALL = Day part of **$ProcedureEndTime**

6.6.1.1.136.2 FDOD_DY LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureEndTime =

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/effectiveTime/high

6.6.1.1.136.3 FDOD_DY FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProcedureEndTime = procedure.period

6.6.1.1.136.4 FDOD_DY Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.137 ETIME

6.6.1.1.137.1 ETIME Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Estimated Time Of Fetal Death (NCHS)*), THEN "ETIME" SHALL = **$EventOutcomesObservationValue** WHERE **$EventOutcomesObservationValue** contains ValueSet (*Fetal Death Time Point (NCHS)*)

6.6.1.1.137.2 ETIME LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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

$EventOutcomesObservationValue =

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/value

6.6.1.1.137.3 ETIME FHIR Source and Logic Variables

$EventOutcomesObservationCode == observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsETIME)

$EventOutcomesObservationValue = observation.valueDateTime

6.6.1.1.137.4 ETIME Value Sets

Estimated Time Of Fetal Death (NCHS)	2.16.840.1.114222.4.11.7426
Fetal Death Time Point (NCHS) -	2.16.840.1.114222.4.11.7112

6.6.1.1.138 LIVEB

6.6.1.1.138.1 LIVEB Derivation Rule

$EventOutcomesObservationCode CONTAINS ValueSet (*Number of Live Births (NCHS)*), THEN SHALL = $EventOutcomesObservationValue

6.6.1.1.138.2 LIVEB LDS Source and Logic Variables

Labor and Delivery Events

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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

$EventOutcomesObservationValue =

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

6.6.1.1.138.3 LIVEB FHIR Source and Logic Variables

$EventOutcomesObservationCode == observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLIVEB)

$EventOutcomesObservationValue = observation.valueQuantity

6.6.1.1.138.4 LIVEB Value Sets

Number of Live Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68

6.6.1.1.139 FDTH

6.6.1.1.139.1 FDTH Derivation Rule

IF **$EventOutcomesObservationCode** CONTAINS ValueSet (*Number of Fetal Deaths This Delivery (NCHS)*), THEN **SHALL = $EventOutcomesObservationValue**

6.6.1.1.139.2 FDTH LDS Source and Logic Variables

Labor and Delivery Events

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

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

$EventOutcomesObservationValue =

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

6.6.1.1.139.3 FDTH FHIR Source and Logic Variables

$EventOutcomesObservationCode == observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsFDTH)

$EventOutcomesObservationValue = observation.valueQuantity

6.6.1.1.139.4 FDTH Value Sets

Number of Fetal Deaths This Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164

6.6.1.1.140 HYST

6.6.1.1.140.1 HYST Derivation Rule

IF Labor and Delivery Procedures and Interventions

$ProcedureCode CONTAINS ValueSet (Hysterotomy Hysterectomy (NCHS)), THEN "HYST" **SHALL** = 'Y', ELSE "HYST" **SHALL** = 'N'.

6.6.1.1.140.2 HYST LDS Source and Logic Variables

Labor and Delivery Summary

Labor and Delivery

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions

ProcedureCode

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

$ProcedureCode
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

6.6.1.1.140.3 HYST FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.140.4 HYST Value Sets

Hysterotomy Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150

6.6.1.1.141 TD

6.6.1.1.141.1 TD Derivation Rule

IF Labor and Delivery Summary Labor and Delivery Procedures and Interventions

$ProcedureCode CONTAINS ValueSet (*Delivery (NCHS)*), THEN "TD" SHALL = **$ProcedureEndTime**

6.6.1.1.141.2 TD LDS Source and Logic Variables

Labor and Delivery Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

$ProcedureEndTime =

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/effectiveTime/high

6.6.1.1.141.3 TD FHIR Source and Logic Variables

$ProcedureCode = procedure.code

$ProcedureEndTime = procedure.period

6.6.1.1.141.4 TD Value Sets

Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

6.6.1.1.142 AUTOP

6.6.1.1.142.1 AUTOP Derivation Rule

IF (**$ProcedureCode** CONTAINS ValueSet CONTAINS ValueSet (*Autopsy Performed (NCHS)*) THEN "AUTOP" SHALL = "Y" ELSE IF **$ProcedureCode** CONTAINS ValueSet CONTAINS ValueSet (*Autopsy Planned (NCHS)*) THEN "AUTOP" SHALL = "P" ELSE "N".

6.6.1.1.142.2 AUTOP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Procedures and Interventions Section

1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11

Procedure Entry

1.3.6.1.4.1.19376.1.5.3.1.4.19

$ProcedureCode =

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

6.6.1.1.142.3 AUTOP FHIR Source and Logic Variables

$ProcedureCode = procedure.code

6.6.1.1.142.4 AUTOP Value Sets

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

6.6.1.1.143 FWO

6.6.1.1.143.1 FWO Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*) where **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*) THEN "FWO" **SHALL** = **$VitalSignsResultValue** WHERE units are specified in Ounces

The preferred measure is in grams rather than ounces. Refer to FWG

6.6.1.1.143.2 FWO LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

$VitalSignsTypeCode =

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

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

$VitalSignsResultValue =

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

6.6.1.1.143.3 FWO FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsFW)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.143.4 FWO Value Sets

Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

6.6.1.1.144 FWG

6.6.1.1.144.1 FWG Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*) where **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*) THEN "FWG"
SHALL = **$VitalSignsResultValue** WHERE units are specified in Grams

6.6.1.1.144.2 FWG LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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

$VitalSignsResultValue =

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

component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1']]/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2']]/entry/organizer/component/observation/value

6.6.1.1.144.3 FWG FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsFW)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.144.4 FWG Value Sets

Body Weight (NCHS)	2.16.840.1.114222.4.11.7421
Birth Weight (NCHS)	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

6.6.1.1.145 FWP

6.6.1.1.145.1 FWP Derivation Rule

IF **$VitalSignsTypeCode** CONTAINS ValueSet (*Body Weight (NCHS)*) where **$VitalSignsMethodCode** CONTAINS ValueSet (*Birth Weight (NCHS)*) THEN "FWP" **SHALL** = **$VitalSignsResultValue** WHERE units are specified in Pounds

The preferred measure is in grams rather than ounces. Refer to FWG

6.6.1.1.145.2 FWP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Detailed Physical Examination Section

1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1

Coded Vital Signs Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2

Vital Signs Organizer

1.3.6.1.4.1.19376.1.5.3.1.4.13.1

$VitalSignsTypeCode =

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

$VitalSignsMethodCode =

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

$VitalSignsResultValue =

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

6.6.1.1.145.3 FWP FHIR Source and Logic Variables

$VitalSignsTypeCode = observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsFW)

$VitalSignsResultUnits =observation.valueQuantity

$VitalSignsResultValue = Observation. valueQuantity

6.6.1.1.145.4 FWP Value Sets

Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20

6.6.1.1.146 LM

6.6.1.1.146.1 LM Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Listeria (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Listeria (NCHS)*)) THEN "LM" SHALL = "Y" ELSE "N".

6.6.1.1.146.2 LM LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument//component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.146.3 LM FHIR Source and Logic Variables

$ProblemCode = problem.code

$InfectionHistoryProblemCode = problem.code

6.6.1.1.146.4 LM Value Sets

Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147

6.6.1.1.147 GBS

6.6.1.1.147.1 GBS Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Group B Streptococcus (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Group B Streptococcus (NCHS)*)) THEN "GBS" SHALL = "Y" ELSE "N".

6.6.1.1.147.2 GBS LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.147.3 GBS FHIR Source and Logic Variables

$ProblemCode = problem.code

$InfectionHistoryProblemCode = problem.code

6.6.1.1.147.4 GBS Value Sets

Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166

6.6.1.1.148 CMV

6.6.1.1.148.1 CMV Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Cytomegalovirus (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Cytomegalovirus (NCHS)*)) THEN "CMV" SHALL = "Y" ELSE "N".

6.6.1.1.148.2 CMV LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.148.3 CMV FHIR Source and Logic Variables

$ProblemCode = problem.code

$InfectionHistoryProblemCode = problem.code

6.6.1.1.148.4 CMV Value Sets

Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167

6.6.1.1.149 B19

6.6.1.1.149.1 B19 Derivation Rule

IF (**$ProblemCode** CONTAINS ValueSet (*Parvovirus (NCHS)*)) OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet (*Parvovirus (NCHS)*)) THEN "B19" SHALL = "Y" ELSE "N".

6.6.1.1.149.2 B19 LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.149.3 B19 FHIR Source and Logic Variables

$ProblemCode = problem.code

$InfectionHistoryProblemCode = problem.code

6.6.1.1.149.4 B19 Value Sets

Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

6.6.1.1.150 HISTOP

6.6.1.1.150.1 HISTOP Derivation Rule

IF (**$EventOutcomesObservationCode** CONTAINS ValueSet (*Histological Placental Examination (NCHS)*) THEN "HISTOP" SHALL = **$EventOutcomesObservationValue**

6.6.1.1.150.2 HISTOP LDS Source and Logic Variables

Newborn Delivery Information Section

1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4

Coded Event Outcomes Section

1.3.6.1.4.1.19376.1.7.3.1.1.13.7

Simple Observation

1.3.6.1.4.1.19376.1.5.3.1.4.13

$EventOutcomesObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] AND 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[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.13']]/observation/code

$EventOutcomesObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'] AND 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[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.4.13']]/observation/value

6.6.1.1.150.3 HISTOP FHIR Source and Logic Variables

$EventOutcomesObservationCode == partOf.Encounter (observation.code constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsHISTOP))

$EventOutcomesObservationValue = observation.valueBoolean

6.6.1.1.150.4 HISTOP Value Sets

Histological Placental Examination (NCHS)	2.16.840.1.114222.4.11.7138
Histological Placental Examination Performed (NCHS)	2.16.840.1.114222.4.11.7430

6.6.1.1.151 TOXO

6.6.1.1.151.1 TOXO Derivation Rule

IF **($ProblemCode** CONTAINS ValueSet *(Toxoplasmosis (NCHS)))* OR (**$InfectionHistoryProblemCode** CONTAINS ValueSet *(Toxoplasmosis (NCHS)))* THEN "TOXO" SHALL = "Y" ELSE "N".

6.6.1.1.151.2 TOXO LDS Source and Logic Variables

Active Problems Section

1.3.6.1.4.1.19376.1.5.3.1.3.6

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$ProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.6']]/entry/act/entryRelationship/observation/value

Coded History of Infection Section

1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1

Problem Concern Entry

1.3.6.1.4.1.19376.1.5.3.1.4.5.2

$InfectionHistoryProblemCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1']] /entry/act/entryRelationship/observation/value

6.6.1.1.151.3 TOXO FHIR Source and Logic Variables

$ProblemCode = problem.code

$InfectionHistoryProblemCode = problem.code

6.6.1.1.151.4 TOXO Value Sets

Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

6.6.1.1.152 PNC

6.6.1.1.152.1 PNC Derivation Rule

IF **$PregnancyHistoryObservationCode** CONTAINS ValueSet (*No Prenatal Care Visit (NCHS)*) THEN (IF **$PregnancyHistoryObservationValue** = 'True' THEN PNC SHALL =

'Y' ELSE IF **$PregnancyHistoryObservationValue** = 'False'"PNC" SHALL = 'N') ELSE Data Entry SHALL be required to capture PNC.

6.6.1.1.152.2 PNC LDS Source and Logic Variables

Pregnancy History Section

1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4

Pregnancy Observation Entry

1.3.6.1.4.1.19376.1.5.3.1.4.13.5

$PregnancyHistoryObservationCode =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/code

$PregnancyHistoryObservationValue =

ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']]/entry/observation/value

6.6.1.1.152.3 PNC FHIR Source and Logic Variables

$PregnancyHistoryObservationCode = observation.code in value set (Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148) constrained by: (http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPNC)

$PregnancyHistoryObservationValue = observation.valueBoolean

6.6.1.1.115.4 PNC Value Sets

No Prenatal Care Visit (NCHS) 2.16.840.1.114222.4.11.7352

6.6.2 Form Data Element Mappings to Output Content Document

This section identifies the mapping of the data elements defined for this form and the specified template for the output CDA Document. For all cases where the attribute indicates an entry of "UNKNOWN" to represent where desired information is not available, this concept is captured, within the HL7 CDA implementation guide, through use of the nullFlavor - UNK". The value sets for this implementation guide include concepts from the HL7 NullFlavor code system as well as from other code systems, e.g., SNOMED CT. The UNK from the NullFlavor code systems is used to convey this information when a coded value is not used.

Table 6.6.2-1: Form Data Elements Data Mapped to Output Content Document Modules for Birth

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn [Observation: templateId 2.16.840.1.113883.10. 20.26.13]	IF ANTI = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName=' Abnormal conditions of the Newborn' AND /value@code= Code='434621000124103', CodeSystemName='SNOMED CT', DisplayName=' Antibiotics Received for Suspected Neonatal Sepsis'
AVEN1	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10. 20.26.13)	IF AVEN1 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='PHC1250', CodeSystemName= 'PHIN VS (CDC Local Coding System)', DisplayName=' Assisted ventilation required immediately following Delivery'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
AVEN6	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF AVEN6 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='PHC1251', CodeSystemName= 'PHIN VS (CDC Local Coding System)', DisplayName='Assisted ventilation required for more than six hours'
BINJ	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF BINJ = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code=' 56110009', CodeSystemName= 'SNOMED CT', DisplayName='Birth trauma of fetus'
NICU	Abnormal conditions of the newborn: Admission to NICU	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF NICU = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='405269005', CodeSystemName= 'SNOMED CT', DisplayName=' Neonatal intensive care unit'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
SEIZ	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF SEIZ = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code=' 91175000', CodeSystemName= 'SNOMED CT', DisplayName='Seizure'
SURF	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF SURF = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='43470100012410', CodeSystemName= 'SNOMED CT', DisplayName=' Surfactant replacement therapy'
NOA54	Abnormal conditions of the newborn: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Abnormal Condition of the Newborn (templateId: 2.16.840.1.113883.10.20.26.13)	IF NOA54 = 'Y' then /code@code= Code='73812-0, CodeSystemName= 'LOINC', DisplayName='Abnormal conditions of the Newborn' AND /value@code= Code='260413007', CodeSystemName= 'SNOMED CT', DisplayName='None'

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

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BWG	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Newborn's Vital Signs Observation [templateId: 2.16.840.1.113883.10. 20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWG(PQ) /value/@unit= 'gm'
BWO	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Weight [Observation: templateId 2.16.840.1.113883.10. 20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWO(PQ) /value/@unit= 'oz' NOTE: Preferred measure of weight is in Grams.
BWP	Birth weight (Infant's)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10) Newborn's Vital Signs Section (templateId: 2.16.840.1.113883.10.20.26.11)	Weight [Observation: templateId 2.16.840.1.113883.10. 20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= BWP(PQ) /value/@unit= 'lb' NOTE: Preferred measure of weight is in Grams.

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ANTB	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF ANTB = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code=' 634771000124114', CodeSystemName= 'SNOMED CT', DisplayName='Antibiotics received during labor'
AUGL	Characteristics of labor and delivery: Augmentation of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF AUGL = 'Y' then) /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='237001001', CodeSystemName= 'SNOMED CT', DisplayName= 'Augmentation of labor'
CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF CHOR = 'Y' then /code@code= Code=73813-8', CodeSystemName= 'LOINC', DisplayName='Characteristics of labor and delivery' AND /value@code= Code='11612004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chorioamnionitis'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ESAN	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF ESAN = 'Y' then /code@code= Code=73813-8’, CodeSystemName= ‘LOINC’, DisplayName=’Characteristics of labor and delivery’ AND /value@code= Code=’ 231064003’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Intrathecal injection of local anesthetic agent’
INDL	Characteristics of labor and delivery: Induction of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF INDL = 'Y' then /code@code= Code=73813-8’, CodeSystemName= ‘LOINC’, DisplayName=’Characteristics of labor and delivery’ AND /value@code= Code=’ 236958009’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Induction of labor’
STER	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31) Characteristic of Labor and Delivery (templateId: 2.16.840.1.113883.10.20.26.18)	IF STER = 'Y' then /code@code= Code=73813-8’, CodeSystemName= ‘LOINC’, DisplayName=’Characteristics of labor and delivery’ AND /value@code= Code=’634621000124113’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Steroids (glucocorticoids) for fetal lung maturation (procedure)’

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
KIDFNAME	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name/given[1] contains KIDFNAME
KIDMNAME	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name/given[2] contains KIDMNAME
KIDLNAME	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name/family contains KIDLNAME
KIDSUFFX	Child's Last Name Suffix:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/name/family contains KIDSUFFX

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
BFED	Child: Infant being breastfed?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Infant Breastfed (templateId: 2.16.840.1.113883.10.20.26.27)	/code@code= Code='3756-9', CodeSystemName= 'LOINC', DisplayName=' Infant is being breastfed at discharge' AND /value@value= Boolean form of BFED
ILIV	Child: Infant living at time of report?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Infant Living (templateId: 2.16.840.1.113883.10.20.26.28)	/code@code= Code='73757-7', CodeSystemName= 'LOINC', DisplayName='Infant living at time of report' AND /value@value= Boolean form of ILIV
IRECNUM	Child: Newborn Medical Record Number	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/sdtc:Id = IRECNUM
ISEX	Child: (infant) Sex -	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/administrativeGenderCode = ISEX

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ITRAN	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	infant Transfer (templateId: 2.16.840.1.113883.10.20.26.29)	/code@code= Code='73758-5', CodeSystemName= 'LOINC', DisplayName= 'Infant was transferred within 24 hours of delivery' AND /value@value= Boolean form of ITRAN
FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	infant Transfer (templateId: 2.16.840.1.113883.10.20.26.29)	/participant/participantRole/name = FTRAN
TB	Child: Time of Birth	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)		/subject/relatedSubject/subject/birthTime = TB
ANEN	Congenital anomalies of the Newborn: Anencephaly	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF ANEN = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code=' 89369001', CodeSystemName= 'SNOMED CT', DisplayName= 'Anencephalus'

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

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

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
CP	Congenital anomalies of the Newborn: Cleft Palate alone	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '87979003', CodeSystemName= 'SNOMED CT', DisplayName= 'Cleft palate'
DOWC	Congenital anomalies of the Newborn: Down Karyotype Confirmed	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF DOWC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '70156005', CodeSystemName= 'SNOMED CT', DisplayName= 'Anomaly of chromosome pair 21' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
GAST	Congenital anomalies of the Newborn: Gastroschisis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF GAST = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '72951007', CodeSystemName= 'SNOMED CT', DisplayName= 'Gastroschisis'
HYPO	Congenital anomalies of the Newborn: Hypospadias	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF HYPO = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '416010008', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypospadias'
LIMB	Congenital anomalies of the Newborn: Limb reduction defect	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF LIMB = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '67341007', CodeSystemName= 'SNOMED CT', DisplayName= 'Longitudinal deficiency of limb'

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

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
DLMP_YR	Date last Normal Menses began:	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33)	/code@code= Code=' 8665-2', CodeSystemName= 'LOINC', DisplayName=' Date last menstrual period' AND /value@value contains DLMP_YR
YOPO	Date of Last Other Pregnancy Outcome: Year	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains YOPO
MOPO	Date of Last Other Pregnancy Outcome: Month	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains MOPO
ADDRESS_D	Facility Address	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr = ADDRESS_D

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
FNAME	Facility Name (if Not institution, give street and number)	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10. 20.26.31]	/participant/participantRole/playingEntity/name = FNAME
FNPI	Facility National Provider Identifier	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10. 20.26.31]	/participant/participantRole/id = FNPI
CHAM	Infections present and treated during this pregnancy: Chlamydia	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present - Live Birth (templateId: 2.16.840.1.113883.10. 20.26.30)	IF CHAM = 'Y' then /code@code= Code= ‘72519-2’, CodeSystemName= ‘LOINC’, DisplayName= ‘Infections present and or treated during this pregnancy for live birth’ AND /value@code= Code= ‘105629000’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Chlamydia infection’
GON	Infections present and treated during this pregnancy: Gonorrhea	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10. 20.26.30)	IF GON = 'Y' then /code@code= Code= ‘72519-2’, CodeSystemName= ‘LOINC’, DisplayName= ‘Infections present and or treated during this pregnancy for live birth’ AND /value@code= Code= ‘1562800’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Gonorrhea’

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
HEPB	Infections present and treated during this pregnancy: Hepatitis B	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPB = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '66071002', CodeSystemName= 'SNOMED CT', DisplayName= 'Type B viral hepatitis'
HEPC	Infections present and treated during this pregnancy: Hepatitis C	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPC = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '50711007', CodeSystemName= 'SNOMED CT', DisplayName= 'Viral hepatitis C'
SYPH	Infections present and treated during this pregnancy: Syphilis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF SYPH = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '76272004', CodeSystemName= 'SNOMED CT', DisplayName= 'Syphilis'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NOA02	Infections present and treated during this pregnancy: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] History of Infection - Live Birth Section [Section: templateId 2.16.840.1.113883.10.20.26.5]	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF NOA02 = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
AINT	Maternal Morbidity: - Admission to Intensive care [unit]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF AINT = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '309904001', CodeSystemName= 'SNOMED CT', DisplayName= 'Intensive care unit'
MTR	Maternal Morbidity: Maternal Transfusion	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF MTR = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '116859006', CodeSystemName= 'SNOMED CT', DisplayName= 'Maternal Transfusion'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PLAC	Maternal Morbidity: [Third or fourth degree] perineal laceration	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF PLAC = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '398019008', CodeSystemName= 'SNOMED CT', DisplayName= 'Perineal laceration during delivery'
RUT	Maternal Morbidity: Ruptured Uterus	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF RUT = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '34430009', CodeSystemName= 'SNOMED CT', DisplayName= 'Rupture of uterus'
UHYS	Maternal Morbidity: Unplanned hysterectomy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UHYS = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '625654015', CodeSystemName= 'SNOMED CT', DisplayName= 'Emergency cesarean hysterectomy'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
UOPR	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UOPR = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '177217006', CodeSystemName= 'SNOMED CT', DisplayName= 'Immediate repair of obstetric laceration'
NOA05	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF NOA05 = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'

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

ROUT	Method of Delivery: [Final]Route and method of delivery	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF ROUT = '1' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '48782003', CodeSystemName= 'SNOMED CT', DisplayName= 'Delivery normal' ELSE IF ROUT = '2' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '302383004', CodeSystemName= 'SNOMED CT', DisplayName= 'Forceps delivery' ELSE IF ROUT = '3' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '61586001', CodeSystemName= 'SNOMED CT', DisplayName= 'Delivery by vacuum extraction' ELSE IF ROUT = '4' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '11466000', CodeSystemName= 'SNOMED CT', DisplayName= 'Cesarean section' ELSE IF ROUT = '9' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code=

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
				'261665006', CodeSystemName= 'SNOMED CT', DisplayName= 'Unknown category'
TLAB	Method of Delivery: Trial of labor attempted	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF TLAB = 'Y' then /code@code= Code= '72149-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery method' AND entryRelationship /code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND /entryRelationship/value@code= Code= '11466000, CodeSystemName= 'SNOMED CT', DisplayName= 'Cesarean section' AND /entryRelationship/entryRelationship/code@code = Code= '73760-1', CodeSystemName= 'LOINC', DisplayName= 'If cesarean, a trial of labor was attempted' AND /entryRelationship /entryRelationship/value@code= Boolean form of TLAB

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PWGT	Mother's pre-pregnancy weight	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Mother's Vital Signs Observation (templateId: 2.16.840.1.113883.10.20.26.46)	/code@code= Code='56077-1', CodeSystemName= 'LOINC', DisplayName= 'Body weight -- pre current pregnancy' AND /value@value= PWGT(PQ) /value/@unit= 'lb'
NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31)	Maternal Transfer [Observation: templateId 2.16.840.1.113883.10.20.26.35]	/participant/participantRole/scopingEntity/name = NFACL
TRAN	Mother transferred for maternal medical or fetal indications for delivery?	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Process (templateId: 2.16.840.1.113883.10.20.26.31)	Maternal Transfer [Observation: templateId 2.16.840.1.113883.10.20.26.35]	/code@code= Code='73763-5', CodeSystemName= 'LOINC', DisplayName=' Mother was transferred for maternal medical or fetal indications for delivery' AND /value@value= Boolean form of TRAN

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

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
ECVF	Obstetric procedures: Failed External cephalic Version	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	PENDING
ECVS	Obstetric procedures: Successful External cephalic version	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF ECVS = 'Y' then /code@code= Code= '240278000', CodeSystemName= 'SNOMED CT', DisplayName= 'External Cephalic Version' /@negationInd = false
TOC	Obstetric procedures: Tocolysis	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF TOC = 'Y' then /code@code= Code= '103747003', CodeSystemName= 'SNOMED CT', DisplayName= 'Tocolysis' /@negationInd = false

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NOA03	Obstetric procedures: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8) Labor and Delivery Procedure Section (templateId: 2.16.840.1.113883.10.20.26.7)	Obstetric Procedure (templateId: 2.16.840.1.113883.10.20.26.39)	IF NOA03 = 'Y' then /code@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None' /@negationInd = false
PROM	Onset of labor: Premature Rupture	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PROM = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '44223004', CodeSystemName= 'SNOMED CT', DisplayName= 'Premature rupture of membranes'
PRIC	Onset of labor: Precipitous Labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PRIC = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '51920004', CodeSystemName= 'SNOMED CT', DisplayName= 'Precipitate labor'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PROL	Onset of labor: Prolonged Labor	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF PROL = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '53443007', CodeSystemName= 'SNOMED CT', DisplayName= Prolonged labor'
NOA05	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Onset of Labor [Observation: templateId 2.16.840.1.113883.10.20.26.32]	IF NOA05 = 'Y' then /code@code= Code= '73774-2', CodeSystemName= 'LOINC', DisplayName= 'Onset of labor' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
SFN	Place where birth occurred: State Facility Number	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = SFN
FLOC	Place where birth occurred: Facility City/Town	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains FLOC

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

BPLACE	Place where birth occurred: Birth Place	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	IF BPLACE = '1' then /participant/participantRole/code@code = Code= '22232009', CodeSystemName= 'SNOMED CT', DisplayName= 'Hospital' ELSE IF BPLACE = '2' then /participant/participantRole/code@code = Code= '91154008', CodeSystemName= 'SNOMED CT', DisplayName= 'Free-standing birthing center' ELSE IF BPLACE = '3' then (/participant/participantRole/code@code = Code= '169813005', CodeSystemName= 'SNOMED CT', DisplayName= 'Home birth' AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= '73765-0', CodeSystemName= 'LOINC', DisplayName= 'Home birth' /value@code = '1') ELSE IF BPLACE = '4' then (/participant/participantRole/code@code = Code= '169813005', CodeSystemName= 'SNOMED CT', DisplayName= 'Home birth' AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= '73765-0', CodeSystemName= 'LOINC', DisplayName= 'Home birth' /value@code = '0') ELSE IF BPLACE = '5' then (/participant/participantRole/code@code = Code= '169813005', CodeSystemName= 'SNOMED CT', DisplayName= 'Home birth'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
				AND /entryRelationship/component/[home Birth Plan [Observation: templateId 2.16.840.1.113883.10.20.26.26]] /code@code = Code= '73765-0', CodeSystemName= 'LOINC', DisplayName= 'Home birth' /value@code = NULL Flavor) ELSE IF BPLACE = '6' then /participant/participantRole/code@code = Code= '67190003', CodeSystemName= 'SNOMED CT', DisplayName= 'Free-standing clinic' ELSE IF BPLACE = '7' then /participant/participantRole/code@code = Code= '394841004', CodeSystemName= 'SNOMED CT', DisplayName= 'Other'
PLUR	Plurality	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.10]	Plurality [Observation: templateId 2.16.840.1.113883.10.20.26.41]	/code@code= Code='57722-1', CodeSystemName= 'LOINC', DisplayName= 'Birth plurality' AND /value@value= PLUR(int)

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

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/entryRelationship/observation/code@code= Code='68493-6', CodeSystemName= 'LOINC', DisplayName= 'Prenatal visits for this pregnancy' AND /value@value= NPREV(int)
PAY	Principal source of payment for this delivery	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	entryRelationship/observation/ code@code= Code= '68461-3', CodeSystemName= 'LOINC', DisplayName= 'Payment source' AND /value@code = PAY using Value Set 'Birth and Fetal Death Financial Class (NCHS) (2.16.840.1.114222.4.11.7163)
PDIAB	Risk factors in this pregnancy: Prepregnancy Diabetes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '73211009', CodeSystemName= 'SNOMED CT', DisplayName= 'Diabetes mellitus'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '11687002', CodeSystemName= 'SNOMED CT', DisplayName= 'Gestational diabetes mellitus'
PHYPE	Risk factors in this pregnancy: Prepregnancy Hypertension	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '38341003', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypertensive disorder, systemic arterial'
GHYPE	Risk factors in this pregnancy: Gestational Hypertension	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '48194001', CodeSystemName= 'SNOMED CT', DisplayName= 'Pregnancy-induced hypertension'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
EHYPE	Risk factors in this pregnancy: Eclampsia	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF EHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '15938005', CodeSystemName= 'SNOMED CT', DisplayName= 'Eclampsia'
PPB	Risk factors in this pregnancy: Previous preterm births	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '161765003', CodeSystemName= 'SNOMED CT', DisplayName= 'History of - premature delivery'
INFT	Risk factors in this pregnancy: Infertility treatment	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '65046005', CodeSystemName= 'SNOMED CT', DisplayName= 'Infertility Therapy'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
INFT_DRG	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT_DRG = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '58533008', CodeSystemName= 'SNOMED CT', DisplayName= 'Artificial insemination'
INFT_ART	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean'
PCES	Risk factors in this pregnancy: Previous cesarean	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NPCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean'

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
NPCES	Risk factors in this pregnancy: Number of previous cesareans	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean' /entryRelationship/observation/code@code= Code= '68497-7', CodeSystemName= 'LOINC', DisplayName= 'Previous cesarean deliveries' AND /value@value= NPCES(int)
NOA01	Risk factors in this pregnancy: None of the above	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF NOA01 = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
SORD	Set Order	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1 Newborn Delivery Section (templateId: 2.16.840.1.113883.10.20.26.10)	Birth Order (templateId: 2.16.840.1.113883.10.20.26.16)	/code@code= Code='73771-8', CodeSystemName= 'LOINC', DisplayName= 'Birth order' AND /value@value= SORD(int)

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
FSEX	Child: (infant) Sex -	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.6]		/subject/relatedSubject/subject/administrativeGender = FSEX
FDOD_YR		NA	NA	
FDOD_MO		NA	NA	
FDOD_DY		NA	NA	
ETIME	Estimated Time of Fetal Death	NA	NA	
LIVEB	Not single birth - specify number of infants in this delivery born alive.	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Newborn Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.10]	Number of Infants Born Alive (templateId: 2.16.840.1.113883.10.20.26.37)"	/code@code= Code='73773-4', CodeSystemName= 'LOINC', DisplayName= 'Number of infants in this delivery born alive' AND /value@value= LIVEB(int)
FDTH	Number of fetal deaths	NA	NA	
HYST	Method of Delivery: Hysterotomy/Hysterectomy?	NA	NA	
TD	Time of delivery	NA	NA	
AUTOP	Was an autopsy performed?	NA	NA	

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
FWO	Weight of Fetus (in ounces)	NA	NA	
FWG	Weight of Fetus (grams preferred, specify unit)	NA	NA	
FWP	Weight of Fetus (in pounds)	NA	NA	
LM	Infections present and treated during this pregnancy: Listeria	NA	NA	
GBS	Infections present and treated during this pregnancy: Group B Streptococcus	NA	NA	
CMV	Infections present and treated during this pregnancy: Cytomeglovirus	NA	NA	
B19	Infections present and treated during this pregnancy: Parvovirus	NA	NA	
HISTOP	Was a Histological Placental Examination performed?	NA	NA	
TOXO	Infections present and treated during this pregnancy: Toxoplasmosis	NA	NA	

Form Data Element <V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Birth CDA	Derivation Rule
PNC	An indication that a physician or other healthcare professional has not examined an/or counselled the pregnant woman for the pregnancy	Reporting Birth Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.1] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/code@code= Code='73776-7', CodeSystemName= 'LOINC', DisplayName=' No-prenatal care indicator' AND /value@value= Boolean form of PNC

Table 6.6.2-2: Form Data Elements Data Mapped to Output Content Document Modules for Fetal Death

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
AVEN1	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	NA	NA	NA
AVEN6	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	NA	NA	NA
BINJ	Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
NICU	Abnormal conditions of the newborn: Admission to NICU	NA	NA	NA
SEIZ	Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	NA	NA	NA
SURF	Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	NA	NA	NA
NOA54	Abnormal conditions of the newborn: None of the above	NA	NA	NA
APGAR5	Apgar Score: 5 Minute	NA	NA	NA
APGAR10	Apgar Score: 10 Minute	NA	NA	NA

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
BWG	Birth weight (Infant's)	NA	NA	NA
BWO	Birth weight (Infant's)	NA	NA	NA
BWP	Birth weight (Infant's)	NA	NA	NA
ANTB	Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	NA	NA	NA
AUGL	Characteristics of labor and delivery: Augmentation of labor	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	NA	NA	NA
ESAN	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia [during labor]	NA	NA	NA
INDL	Characteristics of labor and delivery: Induction of labor	NA	NA	NA
STER	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	NA	NA	NA
NOA04	Characteristics of labor and delivery: None of the above	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
IDOB_YR	Child: Date of Birth: Year	NA	NA	NA
IDOB_MO	Child: Date of Birth: Month	NA	NA	NA
IDOB_DY	Child: Date of Birth: Day	NA	NA	NA
KIDFNAME	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name/given[1] contains KIDFNAME
KIDMNAME	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name/given[2] contains KIDMNAME
KIDLNAME	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name/family contains KIDLNAME

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
KIDSUFFX	Child's Last Name Suffix:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]		/subject/relatedSubject/subject/name contains KIDSUFFX
BFED	Child: Infant being breastfed?	NA	NA	NA
ILIV	Child: Infant living at time of report?	NA	NA	NA
IRECNUM	Child: Newborn Medical Record Number	NA	NA	NA
ISEX	Child: (infant) Sex -	NA	NA	NA
ITRAN	Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility	NA	NA	NA
TB	Child: Time of Birth	NA	NA	NA
ANEN	Congenital anomalies of the Newborn: Anencephaly	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF ANEN = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code=' 89369001', CodeSystemName= 'SNOMED CT', DisplayName= 'Anencephalus'
CCHD	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CCHD = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='12770006', CodeSystemName= 'SNOMED CT', DisplayName= 'Cyanotic congenital heart disease'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CDH	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDH = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='17190001', CodeSystemName= 'SNOMED CT', DisplayName= 'Congenital diaphragmatic hernia'
CDIC	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIC = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code=' 442124003', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype evaluation abnormal'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CDIS	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIS = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder'
'CDIP	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF CDIP = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code='409709004', CodeSystemName= 'SNOMED CT', DisplayName= 'Chromosomal Disorder' AND /entryRelationship/code@code Code=' 73778-3', CodeSystemName= 'LOINC', DisplayName=' Suspected chromosomal disorder karyotype status' /entryRelationship/value@code Code='312948004', CodeSystemName= 'SNOMED CT', DisplayName= 'Karyotype determination'

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

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

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
HYPO	Congenital anomalies of the Newborn: Hypospadias	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF HYPO = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code= ‘416010008’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Hypospadias’
LIMB	Congenital anomalies of the Newborn: Limb reduction defect	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF LIMB = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code= ‘67341007’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Longitudinal deficiency of limb’
MNSB	Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF MNSB = 'Y' then /code@code= Code= ‘73780-9’, CodeSystemName= ‘LOINC’, DisplayName=’Congenital anomalies of the newborn’ AND /value@code= Code= ‘67341007’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘Longitudinal deficiency of limb’

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
OMPH	Congenital anomalies of the Newborn: Omphalocele	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF OMPH = 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '18735004', CodeSystemName= 'SNOMED CT', DisplayName= 'Congenital omphalocele'
NOA55	Congenital anomalies of the Newborn: None of the anomalies listed above	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Congenital Anomaly [Observation: templateId 2.16.840.1.113883.10.20.26.19]	IF NOA55= 'Y' then /code@code= Code= '73780-9', CodeSystemName= 'LOINC', DisplayName='Congenital anomalies of the newborn' AND /value@code= Code= '260413007', CodeSystemName= 'SNOMED CT', DisplayName= 'None'
YLLB	Date of last live birth:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= YLLB
MLLB	Date of last live birth:	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Date of Last Live Birth (templateId: 2.16.840.1.113883.10.20.26.20)	/code@code= Code='68499-3', CodeSystemName= 'LOINC', DisplayName='Date last live birth' AND /value@value= MLLB

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
MOPO	Date of Last Other Pregnancy Outcome: Month	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section (templateId: 2.16.840.1.113883.10.20.26.12)	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName='Other pregnancy outcomes' AND /effectiveTime contains MOPO
ADDRESS_D	Facility Address	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr = ADDRESS_D
FNAME	Facility Name (if Not institution, give street and number)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/playingEntity/name = FNAME
FNPI	Facility National Provider Identifier	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = FNPI

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CHAM	Infections present and treated during this pregnancy: Chlamydia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF CHAM = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '105629000', CodeSystemName= 'SNOMED CT', DisplayName= 'Chlamydia infection'
GON	Infections present and treated during this pregnancy: Gonorrhea	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF GON = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '1562800', CodeSystemName= 'SNOMED CT', DisplayName= 'Gonorrhea'
HEPB	Infections present and treated during this pregnancy: Hepatitis B	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present (templateId: 2.16.840.1.113883.10.20.26.30)	IF HEPB = 'Y' then /code@code= Code= '72519-2', CodeSystemName= 'LOINC', DisplayName= 'Infections present and or treated during this pregnancy for live birth' AND /value@code= Code= '66071002', CodeSystemName= 'SNOMED CT', DisplayName= 'Type B viral hepatitis'

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

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
RUT	Maternal Morbidity: Ruptured Uterus	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF RUT = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '34430009', CodeSystemName= 'SNOMED CT', DisplayName= 'Rupture of uterus'
UHYS	Maternal Morbidity: Unplanned hysterectomy	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UHYS = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '625654015', CodeSystemName= 'SNOMED CT', DisplayName= 'Emergency cesarean hysterectomy'
UOPR	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF UOPR = 'Y' then /code@code= Code= '73781-7', CodeSystemName= 'LOINC', DisplayName= 'Maternal morbidity' AND /value@code= Code= '177217006', CodeSystemName= 'SNOMED CT', DisplayName= 'Immediate repair of obstetric laceration'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
NOA05	Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Morbidity (templateId: 2.16.840.1.113883.10.20.26.34)	IF NOA05 = 'Y' then /code@code= Code= ‘73781-7’, CodeSystemName= ‘LOINC’, DisplayName= ‘Maternal morbidity’ AND /value@code= Code= ‘260413007’, CodeSystemName= ‘SNOMED CT’, DisplayName= ‘None’

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

ROUT	Method of Delivery: [Final]Route and method of delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF ROUT = '1' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '48782003', CodeSystemName= 'SNOMED CT', DisplayName= 'Delivery normal' ELSE IF ROUT = '2' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '302383004', CodeSystemName= 'SNOMED CT', DisplayName= 'Forceps delivery' ELSE IF ROUT = '3' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '61586001', CodeSystemName= 'SNOMED CT', DisplayName= 'Delivery by vacuum extraction' ELSE IF ROUT = '4' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND entryRelationship/value@code= Code= '11466000', CodeSystemName= 'SNOMED CT', DisplayName= 'Cesarean section' ELSE IF ROUT = '9' then entryRelationship/code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
				delivery' AND entryRelationship/value@code= Code= '261665006', CodeSystemName= 'SNOMED CT', DisplayName= 'Unknown category'
TLAB	Method of Delivery: Trial of labor attempted	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery [Procedure: templateId 2.16.840.1.113883.10.20.26.45]	IF TLAB = 'Y' then /code@code= Code= '72149-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery method' AND entryRelationship /code@code= Code= '73762-7', CodeSystemName= 'LOINC', DisplayName= 'Final route and method of delivery' AND /entryRelationship/value@code= Code= '11466000, CodeSystemName= 'SNOMED CT', DisplayName= 'Cesarean section' AND /entryRelationship/entryRelationship/code@code= Code= '73760-1', CodeSystemName= 'LOINC', DisplayName= 'If cesarean, a trial of labor was attempted' AND /entryRelationship /entryRelationship/value@code= Boolean form of TLAB
MFNAME	Mother's Current Legal Name: First Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name/given [1] contains MFNAME

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
MMNAME	Mother's Current Legal Name: Middle Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name/given [2] contains MMNAME
MLNAME	Mother's Current Legal Name: Last Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name/family contains MLNAME
MSUFF	Mother's Current Legal Name: suffix	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		/recordtarget/patientRole/patient/name contains MSUFF
HFT	Mother's Height: Feet	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Height (templateId: 2.16.840.1.113883.10.20.26.25)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HFT(PQ) /value/@unit= 'ft'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
HIN	Mother's Height: Inches	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Height (templateId: 2.16.840.1.113883.10.20.26.25)	/code@code= Code='3137-7', CodeSystemName= 'LOINC', DisplayName='Body height' AND /value@value= HIN(PQ) /value/@unit= 'in'
MRECNUM	Mother's medical record number	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]		recordTarget/patientRole/id = MRECNUM
PWGT	Mother's pre-pregnancy weight	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	Pre-pregnancy Body Weight [Observation: templateId 2.16.840.1.113883.10.20.26.43]	/code@code= Code='56077-1', CodeSystemName= 'LOINC', DisplayName= 'Body weight -- pre current pregnancy' AND /value@value= PWGT(PQ) /value/@unit= 'lb'
NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Transfer templateId: 2.16.840.1.113883.10.20.26.35)	/participant/participantRole/scopingEntity/name = NFACL

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
TRAN	Mother transferred for maternal medical or fetal indications for delivery?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Maternal Transfer templateId: 2.16.840.1.113883.10.20.26.35)	/code@code= Code='73763-5', CodeSystemName= 'LOINC', DisplayName=' Mother was transferred for maternal medical or fetal indications for delivery' AND /value@value= Boolean form of TRAN
DWGT	Mother's weight at delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Mother's Vital Signs Section [Section: templateId 2.16.840.1.113883.10.20.26.9]	Body Weight at Delivery (templateId: 2.16.840.1.113883.10.20.26.17)	/code@code= Code='69461-2', CodeSystemName= 'LOINC', DisplayName= 'Body weight mother -- at delivery' AND /value@value= DWGT(PQ) /value/@unit= 'lb'
POPO	Number of other pregnancy outcomes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Other Pregnancy Outcome (templateId: 2.16.840.1.113883.10.20.26.40)	/code@code= Code='69043-8', CodeSystemName= 'LOINC', DisplayName= 'Other pregnancy outcomes' AND /value@value= POPO(int)

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
PLBD	Number of previous live births now dead (do not include this child)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Live Births now Dead (templateId: 2.16.840.1.113883.10.20.26.38)	/code@code= Code='68496-9', CodeSystemName= 'LOINC', DisplayName= 'Live births now dead' AND /value@value= PLBD(int)
PLBL	Number of previous live births now living (do not include this child)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Number of Births Now Living (templateId: 2.16.840.1.113883.10.20.26.36)	/code@code= Code='11638-4', CodeSystemName= 'LOINC', DisplayName= 'Births still living' AND /value@value= PLBL(int)
OWGEST	Obstetric Estimate of Gestation	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Prior Pregnancy History Section [Section: templateId 2.16.840.1.113883.10.20.26.12]	Estimate of Gestation (templateId: 2.16.840.1.113883.10.20.26.21)	/code@code= Code='11884-4', CodeSystemName= 'LOINC', DisplayName= 'Gestational age Estimated' AND /value@value= OWGEST(int)
CERV	Obstetric procedures: Cervical cerclage	NA	NA	IF CERV = 'Y' then /code@code= Code= '265636007', CodeSystemName= 'SNOMED CT', DisplayName= 'Cerclage of cervix' /@negationInd = false

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
ECVF	Obstetric procedures: Failed External cephalic Version	NA	NA	PENDING
ECVS	Obstetric procedures: Successful External cephalic version	NA	NA	NA
TOC	Obstetric procedures: Tocolysis	NA	NA	NA
NOA03	Obstetric procedures: None of the above	NA	NA	NA
PROM	Onset of labor: Premature Rupture	NA	NA	NA
PRIC	Onset of labor: Precipitous Labor	NA	NA	NA
PROL	Onset of labor: Prolonged Labor	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
NOA05	Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	NA	NA	NA
SFN	Place where birth occurred: State Facility Number	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/id = SFN
FLOC	Place where birth occurred: Facility City/Town	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains FLOC
CNAME	Place where birth occurred: County Name	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNAME

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
CNTYO	Place where birth occurred: County Code	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [templateId: 2.16.840.1.113883.10.20.26.8]	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31]	/participant/participantRole/addr contains CNTYO
BPLACE	Place where birth occurred: Birth Place	NA	NA	NA
PLUR	Plurality	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.4]	Plurality [Observation: templateId 2.16.840.1.113883.10.20.26.41]	/code@code= Code='57722-1', CodeSystemName= 'LOINC', DisplayName= 'Birth plurality' AND /value@value= PLUR(int)
DOFP_MO	Prenatal care visits: Date of first prenatal care visit: Month	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime/low

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
DOFP_DY	Date of first prenatal care visit: Day	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime/low
DOFP_YR	Date of first prenatal care visit: Year	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/effectiveTime/low
NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/entryRelationship/observation/code@code= Code='68493-6', CodeSystemName= 'LOINC', DisplayName= 'Prenatal visits for this pregnancy' AND /value@value= NPREV(int)
PAY	Principal source of payment for this delivery	NA	NA	NA

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
PDIAB	Risk factors in this pregnancy: Prepregnancy Diabetes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '73211009', CodeSystemName= 'SNOMED CT', DisplayName= 'Diabetes mellitus'
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GDIAB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '11687002', CodeSystemName= 'SNOMED CT', DisplayName= 'Gestational diabetes mellitus'
PHYPE	Risk factors in this pregnancy: Prepregnancy Hypertension	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '38341003', CodeSystemName= 'SNOMED CT', DisplayName= 'Hypertensive disorder, systemic arterial'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
GHYPE	Risk factors in this pregnancy: Gestational Hypertension	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF GHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '48194001', CodeSystemName= 'SNOMED CT', DisplayName= 'Pregnancy-induced hypertension'
EHYPE	Risk factors in this pregnancy: Eclampsia	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF EHYP = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '15938005', CodeSystemName= 'SNOMED CT', DisplayName= 'Eclampsia'
PPB	Risk factors in this pregnancy: Previous preterm births	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PPB = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '161765003', CodeSystemName= 'SNOMED CT', DisplayName= 'History of - premature delivery'

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
INFT	Risk factors in this pregnancy: Infertility treatment	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '65046005', CodeSystemName= 'SNOMED CT', DisplayName= 'Infertility Therapy'
INFT_DRG	Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF INFT_DRG = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '58533008', CodeSystemName= 'SNOMED CT', DisplayName= 'Artificial insemination'
INFT_ART	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section (templateId: 2.16.840.1.113883.10.20.26.8)	Labor and Delivery Process [Act: templateId 2.16.840.1.113883.10.20.26.31] Pregnancy Risk Factor (templateId: 2.16.840.1.113883.10.20.26.44)	IF PCES = 'Y' then /code@code= Code= '73775-9', CodeSystemName= 'LOINC', DisplayName= 'Risk factors in this pregnancy' AND /value@code= Code= '200144004', CodeSystemName= 'SNOMED CT', DisplayName= 'Deliveries by cesarean'

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

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

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
FDTH	Number of fetal deaths	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	Number of Fetal Deaths Delivered [Observation: templateId 2.16.840.1.113883.10.20.26.52]	/code@code= Code='73772-6', CodeSystemName= 'LOINC', DisplayName='Number of fetal deaths delivered' AND /value@value= FDTH(int)
HYST	Method of Delivery: Hysterotomy/Hysterectomy?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Labor and Delivery Section [Section: templateId 2.16.840.1.113883.10.20.26.8] Labor and Delivery Procedure Section [Section: templateId 2.16.840.1.113883.10.20.26.7]	Method of Delivery (templateId: 2.16.840.1.113883.10.20.26.45)	/entryrelationship/code@code='73759-3;, CodeSystemName= 'LOINC', DisplayName= 'Hysterotomy or hysterectomy was performed at delivery; /value@value = HYST
TD	Time of delivery	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2]	Fetal Delivery Time [Observation: templateId 2.16.840.1.113883.10.20.26.23]	/code@code='11778-8', CodeSystemName= 'LOINC', DisplayName= 'Delivery date for patient selected by practitioner using all pertinent information' /value@value contains TD

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
AUTOP	Was an autopsy performed?	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Autopsy Performance (templateId: 2.16.840.1.113883.10.20.26.15)	/code@code= '73768-4', CodeSystemName= 'LOINC', DisplayName= 'Autopsy was performed' /value@value = IF AUTOP='Y' THEN '29240004', CodeSystemName=SNOMED-CT, DisplayName='Autopsy Examination' IF AUTOP='P' THEN '434661000124109', CodeSystemName=SNOMED-CT, DisplayName='Autopsy Planned' IF AUTOP='N' THEN '434661000124109', CodeSystemName=SNOMED-CT, DisplayName='Autopsy not performed'
FWO	Weight of Fetus (in ounces)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= FWO(PQ) /value/@unit= 'oz' NOTE: Preferred measure of weight is in Grams.
FWG	Weight of Fetus (grams preferred, specify unit)	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Fetal Delivery Section (templateId: 2.16.840.1.113883.10.20.26.4)	Weight [Observation: templateId 2.16.840.1.113883.10.20.26.46]	/code@code= Code=' 8339-4', CodeSystemName= 'LOINC', DisplayName='Body Weight^at birth' AND /value@value= FWG(PQ) /value/@unit= 'gm' NOTE: Preferred measure of weight is in Grams.

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

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

Form Data Element < V1 X.7>	Form Data Element Name	Section Level Map (if specific)	Entry Level Map to Fetal Death CDA	Derivation Rule
TOXO	Infections present and treated during this pregnancy: Toxoplasmosis	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] History of Infection - Fetal Death Section (templateId: 2.16.840.1.113883.10.20.26.48)	Infection Present - Fetal Death (templateId: 2.16.840.1.113883.10.20.26.49)	IF TOXO = 'Y' then /code@code= Code= '73769-2', CodeSystemName= 'LOINC', DisplayName=' Infections present and or treated during this pregnancy for fetal death' AND /value@code= Code= '187192000', CodeSystemName='SNOMED CT', DisplayName= 'Toxoplasmosis'
PNC	An indication that a physician or other healthcare professional has not examined an/or counselled the pregnant woman for the pregnancy	Reporting Fetal Death Information from a clinical setting to vital records [ClinicalDocument: templateId 2.16.840.1.113883.10.20.26.2] Antenatal Testing and Surveillance Section [Section: templateId 2.16.840.1.113883.10.20.26.3]	Pre-Natal Care [Act: templateId 2.16.840.1.113883.10.20.26.42]	/code@code= Code='73776-7', CodeSystemName= 'LOINC', DisplayName=' No-prenatal care indicator' AND /value@value= Boolean form of PNC

7085

6.6.3 Form Data Element Mappings to Output HL7 Message

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

Table 6.6.3-1: Form Data Elements Data Mapped to Output Message Segments

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

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BINJ			Y	Y			Y			Abnormal conditions of the newborn: Significant birth injury [(skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 56110009^Birth trauma of fetus	OBX|1|CWE|73812-0^Abnormal conditions of the Newborn ^LN||56110009^Birth trauma of fetus^SNM ||||||F
NICU			Y	Y			Y			Abnormal conditions of the newborn: Admission to NICU	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 405269005^Neonatal intensive care unit	OBX|1|CWE|73812-0^Abnormal conditions of the Newborn ^LN||405269005^ Neonatal intensive care unit^SNM ||||||F
SEIZ			Y	Y			Y			Abnormal conditions of the newborn: Seizure or serious neurologic dysfunction	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 91175000^Seizure	OBX|1|CWE|73812-0^Abnormal conditions of the Newborn ^LN||91175000^ Seizure^SNM ||||||F
SURF			Y	Y			Y			Abnormal conditions of the newborn:[Newborn given] Surfactant replacement therapy	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 434701000124101^Surfactant replacement therapy	OBX|1|CWE|73812-0^Abnormal conditions of the Newborn ^LN||434701000124101^ Surfactant replacement therapy ^SNM ||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
NOA54			Y	Y			Y			Abnormal conditions of the newborn: None of the above	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73812-0^Abnormal conditions of the newborn OBX-5 SHALL contain 260413007 None (qualifier value)	OBX|1|CWE|73812-0^Abnormal conditions of the Newborn ^LN||260413007^None (qualifier value)^SNM |||||F
APGAR5			Y	Y			Y			Apgar Score: 5 Minute	OBX-2 SHALL contain NM OBX-3 SHALL contain 9274-2^Score^5M post birth OBX-5 SHALL contain the 5-minute Apgar Score	OBX|1|NM|9274-2^ Score^5M post birth ^LN||4
APGAR10			Y	Y			Y			Apgar Score: 10 Minute	OBX-2 SHALL contain NM OBX-3 SHALL contain 9271-8 ^Score^10M post birth OBX-5 SHALL contain the 10-minute Apgar Score	OBX|1|NM|9271-8|^ Score^10M post birth ^LN||8
ATTEND N			Y	Y	Y	Y	Y	Y		Attendant's name	OBX-2 SHALL contain XCN OBX-3 SHALL contain 87286-1 ^ Birth attendant OBX-5 SHALL contain Name and identifier information for the person attending the birth.	OBX|1|XCN| 87286-1 |^ Birth attendant ^LN||^Walshingham^Albert^DR^^Good Health Hospital^^^NPI

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
ATTEND			Y	Y	Y	Y	Y	Y		Attendant's title:	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73764-3^Birth Attendant Title OBX-5 SHALL contain a value selected from value the set Birth Attendant Title (Birth Attendant Titles) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7111	OBX|1|CWE|73764-3^Birth Attendant^LN||76231001^ Osteopath^SNM ||||||F
ATTENDS			Y	Y	Y	Y	Y	Y		Attendant: Other specified	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73764-3^Attendants's Title OBX-5 SHALL contain OTH^ Other(specify) ^NullFlavor OBX-5 SHALL contain the Text Description of the Attendant's Title in Alternate Text 73764-3^ Birth attendant title	OBX|3|CWE|73764-3^Attendants's Title^LN|| OTH^ Other(specify) ^NullFlavor ^^Chief Birthing Specialist||||||F
NPI			Y	Y	Y	Y	Y	Y		Attendant's NPI	OBX-2 SHALL contain XCN OBX-3 SHALL contain 87286-1 ^ Birth attendant OBX-5 SHALL contain Name and identifier information for the person attending the birth.	OBX|1|XCN| 87286-1 |^ Birth attendant details ^LN||^Walshingham^Albert^DR^^Good Health Hospital^^^NPI |

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BWG			Y	Y			Y			Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Body weight^at birth OBX-5 SHALL contain the birthweight in Grams OBX-6 SHALL indicate grams using UCUM units: SHALL contain gm	OBX|24|NM|8339-4 ^ Body weight^at birth^LN||1200|gm
BWO			Y	Y			Y			Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Body weight^at birth OBX-5 SHALL contain the birthweight in Ounces OBX-6 SHALL indicate ounces using UCUM units: SHALL contain oz NOTE: it is preferred to send in grams (see BWG)	OBX|24|NM|8339-4 ^Body weight^at birth^LN||1200|oz
BWP			Y	Y			Y			Birth weight (Infant's)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^ Body weight^at birth OBX-5 SHALL contain the birthweight in Pounds OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb NOTE: it is preferred to send in grams (see BWG)	OBX|24|NM|8339-4 ^Body weight^at birth ^LN||1200|lb

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
ANTB			Y	Y			Y			Characteristics of labor and delivery: Antibiotics[received by the mother during labor]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 434691000124101^Antibiotics received during labor	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||434691000124101^ Antibiotics received during labor^SNM|||||F
AUGL			Y	Y			Y			Characteristics of labor and delivery: Augmentation of labor	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 237001001^Augmentation of Labor	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||237001001^ Augmentation of Labor^SNM|||||F
CHOR			Y	Y			Y			Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 11612004^ Chorioamnionitis	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||11612004^ Chorioamnionitis^SNM|||||F
ESAN			Y	Y			Y			Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 231064003^ Intrathecal injection of local anesthetic agent	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||231064003^ Intrathecal injection of local anesthetic agent^SNM|||||F
INDL			Y	Y			Y			Characteristics of labor and delivery: Induction of labor	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 236958009^Induction of labor	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||236958009^Induction of labor^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
STER			Y	Y			Y			Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 434611000124106 ^Maternal antenatal administration of corticosteroids for fetal lung maturation	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||434611000124106 ^Maternal antenatal administration of corticosteroids for fetal lung maturation ^SNM|||||F
NOA04			Y	Y			Y			Characteristics of labor and delivery: None of the above	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73813-8^ Characteristics of labor and delivery OBX-5 SHALL contain 260413007^ None (qualifier value)	OBX|23|CWE|73813-8^Characteristics of labor and delivery^LN||260413007^ None (qualifier value)^SNM|||||F
IDOB_YR			Y	Y			Y			Child: Date of Birth: Year	PID-29 SHALL contain the Newborn's date and time of birth	PID|1||123456688^^^^MRN||Johnson^Baby|| 20110313|F||||||||||N
IDOB_MO			Y	Y			Y			Child: Date of Birth: Month	PID-7 SHALL contain the Newborn's date and time of birth	PID|1||123456688^^^^MRN||Johnson^Baby|| 20110313|F||||||||||N
IDOB_DY			Y	Y			Y			Child: Date of Birth: Day	PID-7 SHALL contain the Newborn's date and time of birth	PID|1||123456688^^^^MRN||Johnson^Baby|| 20110313|F||||||||||N

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
KIDFNAME	Y	Y	Y	Y	Y	Y	Y	Y	Y	Child's First Name/ Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents Using PID-5. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F||||||||||||N

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
KIDMNAME	Y	Y	Y	Y	Y	Y	Y	Y	Y	Child's Middle Name / Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents using PID-5. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
KIDLNAME	Y	Y	Y	Y	Y	Y	Y	Y	Y	Child's Last Name / Name of Fetus(optional at the discretion of the parents)	PID-5 SHALL contain the New born name. In the case of fetal death reporting, a name may be provided at the discretion of the parents using PID-5. When the name is not provided, a value must still be placed in this field since the field is required. In that case, HL7 recommends the following: |~^^^^^^U|. The "U" for the name type code in the second name indicates that it is unspecified. Since there may be no name components populated, this means there is no legal name, nor is there an alias. This guide will interpret this sequence to mean there is no newborn or fetus name.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N

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

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
IRECNUM	Y		Y	Y			Y		Y	Child: Newborn Medical Record Number	PID-3 In the case of fetal death reporting, a medical record number may be provided at the discretion of the parents using PID-3.	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
ISEX			Y	Y			Y		Y	Child: (infant) Sex -	PID-8	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N
ITRAN			Y	Y			Y			Child: Infant transferred within 24 hours of delivery/name the facility FTRAN	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73758-5^Infant was transferred within 24 hours of delivery OBX-5 SHALL contain a value selected from value the set from PHVS_YesNoUnknown_CDC Yes No Unknown (YNU)	OBX|32|CWE|73758-5^ Infant was transferred within 24 hours of delivery ^LN||N^No^ PHVS_YesNoUnknown_CDC ||||||F
FTRAN			Y	Y			Y			Child: Infant transferred within 24 hours of delivery/name the facility	OBX-2 SHALL contain XON OBX-3 SHALL contain 73770-0^ Name of facility infant transferred to OBX-5 SHALL contain the name of the facility the infant was transferred to. (Only value if the infant was transferred within 24 hours of delivery.)	OBX|32|XON|73770-0^ Name of facility infant transferred to^LN|| Good Health Hospital^L^^^^&2.16.840.1.113883.19.4.6^ISO^XX^^^1234 |||||F
TB			Y	Y			Y			Child: Time of Birth	PID-7 SHALL contain the Newborn's date and time of birth,	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||||||||||N

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
ANEN			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Anencephaly	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 89369001^Anencephalus	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||89369001^Anencephalus^SNM |||||F
CCHD			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Cyanotic congenital heart disease	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 12770006^Cyanotic congenital heart disease	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||12770006^Cyanotic congenital heart disease^SNM |||||F
CDH			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 17190001^Congenital diaphragmatic hernia	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||17190001^Congenital diaphragmatic hernia^SNM |||||F
CDIS			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Suspected chromosomal disorder	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CDIC			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Suspected chromosomal Disorder karyotype confirmed	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder (disorder) AND a second OBX segment WHERE: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73778-3^Suspected chromosomal disorder karyotype status OBX-5 SHALL contain 442124003^Karyotype evaluation abnormal	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM |||||F OBX|27|CWE|73778-3 ^Suspected chromosomal disorder karyotype status^LN||442124003^Karyotype evaluation abnormal^SNM |||||F
CDIP			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 409709004^Chromosomal disorder (disorder) AND a second OBX segment WHERE: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73778-3^Suspected chromosomal disorder karyotype status OBX-5 SHALL contain 312948004^ Karyotype determination	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||409709004^Chromosomal disorder^SNM |||||F OBX|27|CWE|73778-3^Suspected chromosomal disorder karyotype ^LN||312948004^ Karyotype determination^SNM |||||F

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

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
DOWN			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Down Syndrome	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 70156005^Anomaly of chromosome pair 21	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||70156005^Anomaly of chromosome pair 21^SNM ||||||F
DOWP			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Down Karyotype Pending	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 70156005^Anomaly of chromosome pair 21 AND a second OBX segment WHERE: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73779-1^Down syndrome karyotype status OBX-5 SHALL contain 312948004^ Karyotype determination	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||70156005^Anomaly of chromosome pair 21 (disorder)^SNM ||||||F OBX|27|CWE|73779-1^ Down syndrome karyotype status ^LN||^312948004^ Karyotype determination^SNM |||||F
GAST			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Gastroschisis	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 72951007^Gastroschisis	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||72951007^Gastroschisis^SNM ||||||F
HYPO			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Hypospadias	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 416010008^Hypospadias	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||416010008^Hypospadias^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
LIMB			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Limb reduction defect	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 67341007^Longitudinal deficiency of limb	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||67341007^Longitudinal deficiency of limb^SNM |||||F
MNSB			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Meningomyelocele/ Spina Bifida	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 67531005^Spina bifida	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||67531005^Spina bifida^SNM |||||F
OMPH			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: Omphalocele	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 18735004^Congenital omphalocele	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||17190001^18735004^Congenital omphalocele^SNM |||||F
NOA55			Y	Y	Y	Y	Y	Y		Congenital anomalies of the Newborn: None of the anomalies listed above	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73780-9^Congenital anomalies of the newborn OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|27|CWE|73780-9^Congenital anomalies of the Newborn ^LN||260413007^None (qualifier value)^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
YLLB			Y	Y	Y	Y	Y	Y		Date of last live birth:	OBX-2 SHALL contain DTM OBX-3 SHALL contain 68499-3^Date last live birth OBX-5 SHALL contain the date of birth of the last live-born infant (month and year) excluding this delivery. Includes live-born infants now living and now dead. If this was a multiple delivery, include all live born infants who preceded the live born infant in this delivery. If first born, do not include this infant. If second born, include the first born. (Month and year should be provided.)	OBX|14|DTM|68499-3^Date last live birth^LN||20090926
MLLB			Y	Y	Y	Y	Y	Y		Date of last live birth:	OBX-2 SHALL contain DTM OBX-3 SHALL contain 68499-3^Date last live birth OBX-5 SHALL contain the date of birth of the last live-born infant (month and year) excluding this delivery. Includes live-born infants now living and now dead. If this was a multiple delivery, include all live born infants who preceded the live born infant in this delivery. If first born, do not include this infant. If second born, include the first born. (Month and year should be provided.)	OBX|14|DTM|68499-3^Date last live birth^LN||20090926

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
DLMP_DY			Y	Y	Y	Y	Y	Y		Date last Normal Menses began:	OBX-2 SHALL contain DTM OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|DTM|8665-2^ Date last menstrual period ||20100418
DLMP_MO			Y	Y	Y	Y	Y	Y		Date last Normal Menses began:	OBX-2 SHALL contain DTM OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|DTM|8665-2^ Date last menstrual period ||20100418
DLMP_YR			Y	Y	Y	Y	Y	Y		Date last Normal Menses began:	OBX-2 SHALL contain DTM OBX-3 SHALL contain 8665-2^Date last menstrual period OBX-5 SHALL contain the date the mother's last normal menstrual period began. (month, day and year.)	OBX|16|DM|8665-2^ Date last menstrual period ||20100418
YOPO			Y	Y	Y	Y	Y	Y		Date of Last Other Pregnancy Outcome: Year	OBX-2 SHALL contain DTM OBX-3 SHALL contain 68500-8^Date last other pregnancy outcome OBX-5 SHALL contain the date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. (month and year)	OBX|16|DTM|68500-8^Date last other pregnancy outcome||20100418

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
MOPO			Y	Y	Y	Y	Y	Y		Date of Last Other Pregnancy Outcome: Month	OBX-2 SHALL contain DTM OBX-3 SHALL contain 68500-8^Date last other pregnancy outcome OBX-5 SHALL contain the date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestation age. (month and year)	OBX|16|DTM|68500-8^Date last other pregnancy outcome||20100418
ADDRESS_D			Y	Y	Y	Y	Y	Y		Facility Address	PID-11 where XAD_BR-7 Address Type is BDL (,Birth delivery location (address where birth occurred)) from PHVS_BirthReportingAddressType_NCHS	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F|||300 Main St^^Metropolis^Rhode Island^03443^BDL||||||||||N
FNAME			Y	Y	Y	Y	Y	Y		Facility Name (if Not institution, give street and number)	OBX-2 SHALL contain AD OBX-3 SHALL contain 62330-6 ^Birth Hospital Facility Name OBX-5 SHALL contain the name of the facility where the delivery occurred	OBX|16|AD| 62330-6^Birth Hospital Facility Name || Good Health Hospital
FNPI			Y	Y	Y	Y	Y	Y		Facility National Provider Identifier	OBX-2 SHALL contain AD OBX-3 SHALL contain 62329-8 ^Facility ID OBX-5 SHALL contain the national identifier of the facility where the delivery occurred	OBX|16|AD|62329-8 I^Facility ID || 12345

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CHAM			Y	Y	Y	Y	Y	Y		Infections present and treated during this pregnancy: Chlamydia	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 105629000^Chlamydial infection For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 105629000^Chlamydial infection	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||105629000^Chlamydial infection ^SNM|||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||105629000^Chlamydial infection ^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
GON			Y	Y	Y	Y	Y	Y		Infections present and treated during this pregnancy: Gonorrhea	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 15628003^Gonorrhea For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 15628003^Gonorrhea	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||15628003^Gonorrhea ^SNM|||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN|15628003^Gonorrhea^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
HEPB			Y	Y			Y			Infections present and treated during this pregnancy: Hepatitis B	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^ Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 66071002^ Type B viral hepatitis For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 66071002^ Type B viral hepatitis	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||66071002^ Type B viral hepatitis ^SNM|||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN|66071002^ Type B viral hepatitis ^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
HEPC			Y	Y			Y			Infections present and treated during this pregnancy: Hepatitis C	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 50711007^Viral hepatitis C For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 50711007^Viral hepatitis C	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||50711007^Viral hepatitis C^SNM||||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN|50711007^Viral hepatitis C^SNM ||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
SYPH			Y	Y	Y	Y	Y	Y		Infections present and treated during this pregnancy: Syphilis	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 76272004^Syphilis For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 76272004^Syphilis	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||76272004^Syphilis ^SNM|||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN|76272004^Syphilis^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
NOA02			Y	Y	Y	Y	Y	Y		Infections present and treated during this pregnancy: None of the above	For Live Birth: OBX-2 SHALL contain CWE OBX-3 SHALL contain 72519-2^Infections present &or treated during this pregnancy for live birth OBX-5 SHALL contain 76272004^Syphilis (disorder) For Fetal Death: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 260413007^None (qualifier value)	For Live Birth: OBX|20|CWE|72519-2^Infections present and treated during this pregnancy for live birth^LN||260413007^None (qualifier value)^SNM|||||F For Fetal Death: OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN|260413007^None (qualifier value)^SNM |||||F
AINT			Y	Y	Y	Y	Y	Y		Maternal Morbidity: - Admission to Intensive care [unit]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 309904001^Intensive care unit	OBX|23|CWE|73781-7^Maternal Morbidity ^LN||309904001^Intensive care unit^SNM|||||F
MTR			Y	Y	Y	Y	Y	Y		Maternal Morbidity: Maternal Transfusion	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 116859006^Transfusion of blood product (procedure)	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||116859006^Transfusion of blood product^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
PLAC			Y	Y	Y	Y	Y	Y		Maternal Morbidity: [Third or fourth degree] perineal laceration	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 398019008^Perineal laceration during delivery (disorder)	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||398019008^Perineal laceration during delivery (disorder)^SNM|||||F
RUT			Y	Y	Y	Y	Y	Y		Maternal Morbidity: Ruptured Uterus	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 34430009^Rupture of uterus (disorder)	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||34430009^Rupture of uterus (disorder)^SNM|||||F
UHYS			Y	Y	Y	Y	Y	Y		Maternal Morbidity: Unplanned hysterectomy	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 236987005^Emergency cesarean hysterectomy (procedure)	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||236987005^Emergency cesarean hysterectomy (procedure)^SNM|||||F
UOPR			Y	Y	Y	Y	Y	Y		Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 442261000124103^Emergency operation following delivery	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||442261000124103^ Emergency operation following delivery^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
NOA05			Y	Y	Y	Y	Y	Y		Maternal Morbidity:None of the above NOTE: NOA05 is also used for onset of labor	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73781-7^ Maternal morbidity OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|22|CWE|73781-7^Maternal Morbidity ^LN||260413007^None (qualifier value)^SNM|||||F
PRES			Y	Y	Y	Y	Y	Y		Method of Delivery: Fetal presentation [at birth]: Cephalic	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 70028003^Vertex presentation (finding)	OBX|24|CWE|73761-9^Fetal presentation at Birth^LN||70028003^Cephalic^SNM|||||F
PRES			Y	Y	Y	Y	Y	Y		Method of Delivery: Fetal presentation [at birth]: Breech	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 6096002^Breech Presentation	OBX|20|CWE|73761-9^Fetal presentation at Birth^LN||6096002^Breech Presentation^SNM|||||F
PRES			Y	Y	Y	Y	Y	Y		Method of Delivery: Fetal presentation [at birth]: Other Category	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73761-9^Fetal Presentation at Birth OBX-5 SHALL contain 394841004^Other category (qualifier value)	OBX|20|CWE|73761-9^Fetal presentation at Birth^LN||394841004^ Other category^SNM|||||F
ROUT			Y	Y	Y	Y	Y	Y		Method of Delivery: [Final]Route and method of delivery: Vaginal/spontaneous	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73762-7^Final Route and Method of Delivery OBX-5 SHALL contain 48782003^Delivery normal	OBX|20|CWE|73762-7^Final Route and Method of Delivery^LN||48782003 ^ Delivery normal ^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
ROUT			Y	Y	Y	Y	Y	Y		Method of Delivery: [Final]Route and method of delivery: Vaginal/forceps	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73762-7^ Final Route and Method of Delivery OBX-5 SHALL contain 302383004^Forceps delivery	OBX|20|CWE|73762-7^Final Route and Method of Delivery^LN|| 302383004^ Forceps delivery^SNM||||||F
ROUT			Y	Y	Y	Y	Y	Y		Method of Delivery: [Final]Route and method of delivery: Vaginal/vacuum	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73762-7^ Final Route and Method of Delivery OBX-5 SHALL contain 61586001^ Delivery by vacuum extraction	OBX|20|CWE|73762-7^Final Route and Method of Delivery^LN|| 61586001^ Delivery by vacuum extraction^SNM||||||F
ROUT			Y	Y	Y	Y	Y	Y		Method of Delivery: [Final]Route and method of delivery: Cesarean	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73762-7^Final Route and Method of Delivery OBX-5 SHALL contain 11466000^ Cesarean section	OBX|20|CWE|73762-7^Final Route and Method of Delivery^LN||11466000^Cesarean section^SNM||||||F
TLAB			Y	Y	Y	Y	Y	Y		Method of Delivery: Trial of labor attempted	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73760-1^If cesarean, a trial of labor was attempted OBX-5 SHALL contain boolean indication using PHVS_YesNoUnknown_CDC Yes No Unknown (YNU)	OBX|24|CWE|73761-9^Fetal presentation at Birth^LN|| N^No^ PHVS_YesNoUnknown_CDC ||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
HFT	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Height: Feet	OBX-2 SHALL contain NM OBX-3 SHALL contain 83846-6^ Mother's body height OBX-5 SHALL contain the Mother's Height in Inches OBX-6 SHALL indicate feet using UCUM units: SHALL contain ft	OBX|9|NM|83846-6^ Mother's body height ^LN||6|ft
HIN	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Height: Inches	OBX-2 SHALL contain NM OBX-3 SHALL contain 83846-6^ Mother's body height OBX-5 SHALL contain the Mother's Height in Inches OBX-6 SHALL indicate inches using UCUM units: SHALL contain in	OBX|9|NM|83846-6^ Mother's body height ^LN||58|in
MRECNUM	Y	Y	Y	Y	Y	Y				Mother's medical record number	NK1-33 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|1830 Sunshine Drive^^Beautiful City^HerState^86534-1111^^H||||||||||||||||||||||||9876546688^^^^MRN
PWGT	Y	Y	Y	Y	Y	Y	Y	Y		Mother's pre-pregnancy weight	OBX-2 SHALL contain NM OBX-3 SHALL contain 56077-1^Body weight ^ pre current pregnancy OBX-5 SHALL contain the mother's weight before becoming pregnant OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb	OBX|10|NM|56077_1^Body weight-pre current pregnancy^LN||94lb

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
NFACL			Y	Y	Y	Y	Y	Y		Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	PV1-6	PV1||I||^^^^^^^^Simple Birth Clinic||||||||||||PI
TRAN			Y	Y	Y	Y	Y	Y		Mother transferred for maternal medical or fetal indications for delivery?	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73763-5^ Mother was transferred for maternal medical or fetal indications for delivery OBX-5 SHALL contain boolean indication of whether a trial of labor was attempted using PHVS_YesNoUnknown_CDC Yes No Unknown (YNU)	OBX|4|CWE|73763-5^Mother transferred for maternal medical or fetal indications for delivery?^LN||N^No^ PHVS_YesNoUnknown_CDC ||||||F
DWGT			Y	Y	Y	Y	Y	Y		Mother's weight at delivery	OBX-2 SHALL contain NM OBX-3 SHALL contain 69461-2^ Body weight at delivery OBX-5 SHALL contain the mother's weight at the time of delivery OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb	OBX|10|NM|69461-2^ Body weight at delivery^LN||124lb

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
POPO			Y	Y	Y	Y	Y	Y		Number of other pregnancy outcomes	OBX-2 SHALL contain NM OBX-3 SHALL contain 69043-8^Other pregnancy outcomes OBX-5 SHALL contain the total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. For multiple deliveries include all previous pregnancy losses before this infant in this pregnancy and in previous pregnancies.	OBX|15|NM|69043-8^Other pregnancy outcomes||1
PLBD			Y	Y	Y	Y	Y	Y		Number of previous live births now dead (do not include this child)	OBX-2 SHALL contain NM OBX-3 SHALL contain 68496-9^Live births.now dead OBX-5 SHALL contain the total number of previous live-born infants now dead. For multiple deliveries include all live-born infants before this infant in the pregnancy who are now dead. If the first born, do not include this infant	OBX|15|NM|68496-9^Live births.now dead||1
PLBL			Y	Y	Y	Y	Y	Y		Number of previous live births now living (do not include this child)	OBX-2 SHALL contain NM OBX-3 SHALL contain 11638-4^Births.still living OBX-5 SHALL contain the total number of previous live-born infants now living. For multiple deliveries include all live-born infants before this infant in the pregnancy. If the first born, do not include this infant.	OBX|12|NM|11638-4^Births.still living^LN||2

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
OWGEST			Y	Y	Y	Y	Y	Y		Obstetric Estimate of Gestation	OBX-2 SHALL contain NM OBX-3 SHALL contain 11884-4^Obstetric estimate of gestation OBX-5 SHALL contain the best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred. Do not complete solely based on the infant's date of birth and the mothers date of last menstrual period.	OBX|25|NM|11884-4^Obstetric estimate of gestation^LN||39|wk
CERV			Y	Y			Y			Obstetric procedures: Cervical cerclage	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 265636007^Cerclage of cervix (procedure)	OBX|21|CWE|73814-6^Obstetric procedures^LN||265636007^Cerclage of cervix (procedure)^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
ECVF			Y	Y			Y			Obstetric procedures: Failed External cephalic Version	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 240278000^External cephalic version (procedure) AND OBX-2 SHALL contain CWE OBX-3 SHALL contain 73820-3^Successful external cephalic version OBX-5 SHALL contain boolean indication (No)	OBX|21|CWE|73814-6^Obstetric procedures^LN||240278000^ External cephalic version (procedure)^SNM|||||F OBX|21|CWE|73820-3^Successful external cephalic version ^LN|| N^No^HL70532|||||F
ECVS			Y	Y			Y			Obstetric procedures: Successful External cephalic version	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 240278000^External cephalic version (procedure) AND OBX-2 SHALL contain CWE OBX-3 SHALL contain 73820-3^Successful external cephalic version OBX-5 SHALL contain boolean indication (Yes)	OBX|21|CWE|73814-6^Obstetric procedures^LN||240278000^ External cephalic version (procedure)^SNM|||||F OBX|21|CWE|73820-3^Successful external cephalic version ^LN|| Y^Yes^HL70532|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
TOC			Y	Y			Y			Obstetric procedures: Tocolysis	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 103747003^Tocolysis (procedure)	OBX|21|CWE|73814-6^Obstetric procedures^LN||103747003^Tocolysis (procedure)^SNM|||||F
NOA03			Y	Y			Y			Obstetric procedures: None of the above	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73814-6^Obstetric procedures performed OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|21|CWE|73814-6^Obstetric procedures^LN||260413007^None (qualifier value)^SNM|||||F
PROM			Y	Y			Y			Onset of labor: Premature Rupture	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 44223004^Premature Rupture of membranes (disorder)	OBX|22|CWE|73774-2^Onset of labor||44223004^Premature Rupture of membranes (disorder)^SNM|||||F
PRIC			Y	Y			Y			Onset of labor: Precipitous Labor	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 51920004^Precipitate labor (disorder)	OBX|22|CWE|73774-2^Onset of labor||51920004^Precipitate labor (disorder)^SNM|||||F
PROL			Y	Y			Y			Onset of labor: Prolonged Labor	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 53443007^Prolonged labor (disorder)	OBX|22|CWE|73774-2^Onset of labor||53443007^Prolonged labor (disorder)^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
NOA05			Y	Y			Y			Onset of labor: None of the above NOTE: NOA05 is also used for Maternal Morbidity	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73774-2^ Onset of labor OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|22|CWE|73774-2^Onset of labor||53443007^260413007^None (qualifier value)^SNM|||||F
SFN			Y	Y	Y	Y	Y	Y		Place where birth occurred: State Facility Number	OBX-2 SHALL contain AD OBX-3 SHALL contain 62329-8^ Birth Hospital Facility Id OBX-5 SHALL contain the address of the facility where the delivery occurred	OBX|16|AD| 62329-8^ Birth Hospital Facility Id ||300 Main St^^Metropolis^Rhode Island^03443^
FLOC			Y	Y	Y	Y	Y	Y		Place where birth occurred: Facility City/Town	OBX-2 SHALL contain AD OBX-3 SHALL contain 62331-4 ^Birth Hospital Facility Address OBX-5 SHALL contain the address of the facility where the delivery occurred	OBX|16|AD| 62331-4 ^Birth Hospital Facility Address ||300 Main St^^Metropolis^Rhode Island^03443^
CNAME			Y	Y	Y	Y	Y	Y		Place where birth occurred: County Name	OBX-2 SHALL contain AD OBX-3 SHALL contain 62331-4 ^Birth Hospital Facility Address OBX-5 SHALL contain the address of the facility where the delivery occurred	OBX|16|AD| 62331-4 ^Birth Hospital Facility Address ||300 Main St^^Metropolis^Rhode Island^03443^
CNTYO			Y	Y	Y	Y	Y	Y		Place where birth occurred: County Code	OBX-2 SHALL contain AD OBX-3 SHALL contain 62331-4 ^Birth Hospital Facility Address OBX-5 SHALL contain the address of the facility where the delivery occurred	OBX|16|AD| 62331-4 ^Birth Hospital Facility Address ||300 Main St^^Metropolis^Rhode Island^03443^

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Hospital	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 22232009^Hospital	OBX|1|CWE|73766-8^Birth/delivery location type^LN||22232009^Hospital^SNM||||||F
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Clinic/Doctor's Office	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 67190003^Free-standing clinic	OBX|1|CWE|73766-8^Birth/delivery location type^LN||67190003^Free-standing clinic ^SNM|||||F
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Freestanding Birth Center	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain 91154008^Free-standing birthing center	OBX|1|CWE|73766-8^Birth/delivery location type^LN||91154008^Free-standing birthing center ^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Home Birth	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain one of: 408839006^Planned Home Birth, SNM 408838003^Unplanned Home Birth, SNM PHC1297^Unknown if Planned Home Birth, PHINVS	OBX|1|CWE|73766-8^Birth/delivery location type^LN||408838003^Unplanned Home Birth^SNM||||||F
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Other category	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain OTH^Other, NullFlavor	OBX|1|CWE|73766-8^Birth/delivery location type^LN||OTH^Other^NullFlavor||||||F
BPLACE			Y	Y	Y	Y	Y	Y		Place where birth occurred: Birth Place: Unknown	PID-11 (for address if not in facility); If in Facility: OBX-2 SHALL contain CWE OBX-3 SHALL contain 73766-8^Place where birth occurred OBX-5 SHALL contain UNK^Unknown, NullFlavor	OBX|1|CWE|73766-8^Birth/delivery location type^LN||UNK^Unknown^NullFlavor||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
PLUR			Y	Y	Y	Y	Y	Y		Plurality	OBX-2 SHALL contain NM OBX-3 SHALL contain 57722-1^Birth plurality OBX-5 SHALL contain the number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy	OBX|30|NM|57722-1^Birth plurality^LN||1
DOFP_MO			Y	Y	Y	Y	Y	Y		Prenatal care visits: Date of first prenatal care visit: Month	OBX-2 SHALL contain DTM OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|DTM|69044-6^Date first prenatal visit^LN||20100528||||||F
DOFP_DY			Y	Y	Y	Y	Y	Y		Date of first prenatal care visit: Day	OBX-2 SHALL contain DTM OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|DTM|69044-6^Date first prenatal visit^LN||20100528||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
DOFP_YR			Y	Y	Y	Y	Y	Y		Date of first prenatal care visit: Year	OBX-2 SHALL contain DTM OBX-3 SHALL contain 69044-6^Date first prenatal visit OBX-5 SHALL contain the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	OBX|5|DTM|69044-6^Date first prenatal visit^LN||20100528||||||F
NPREV			Y	Y	Y	Y	Y	Y		Prenatal care visits: Total number of prenatal visits for this pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 68493-6^ Prenatal visits for this pregnancy OBX-5 SHALL contain the total number of visits recorded in the record.	OBX|8|NM|68493-6^Prenatal visits for this pregnancy^LN||10
PAY			Y	Y			Y			Principal source of payment for this delivery	PV1-20 SHALL contain PAY using the PHVS_BirthAndFetalDeathFinancialClass_NCHS	PV1||N||||^^^^^^^^Simple Birth Clinic|||||||||||2^MEDICAID^PHVS_BirthAndFetalDeathFinancialClass_NCHS|
PDIAB			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Prepregnancy Diabetes	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 73211009^Diabetes mellitus (disorder)	OBX|17|CWE|73775-9^Risk factors in this pregnancy^LN||73211009^Diabetes mellitus (disorder)^SNM|||||F
GDIAB			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Gestational Diabetes	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 11687002^Gestational diabetes mellitus (disorder)	OBX|17|CWE|11687002^Gestational diabetes mellitus (disorder)^LN||73211009^Diabetes mellitus (disorder)^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
PHYPE			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Prepregnancy Hypertension	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 38341003^Hypertensive disorder, systemic arterial (disorder)	OBX|17|CWE|11687002^Gestational diabetes mellitus (disorder)^LN||38341003^Hypertensive disorder, systemic arterial (disorder)^SNM|||||F
GHYPE			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Gestational Hypertension	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 48194001^Pregnancy-induced hypertension (disorder)	OBX|17|CWE|73775-9^Risk factors in this pregnancy^LN||48194001^ Pregnancy-induced hypertension (disorder)^SNM|||||F
EHYPE			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Eclampsia	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 15938005^Eclampsia (disorder)	OBX|17|CWE|73775-9^Risk factors in this pregnancy^LN||15938005^Eclampsia (disorder)^SNM|||||F
PPB			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Previous preterm births	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 161765003^History of - premature delivery (situation)	OBX|17|CWE|73775-9^Risk factors in this pregnancy^LN||161765003^History of - premature delivery (situation)^SNM|||||F
INFT			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Infertility treatment	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 58533008^ Artificial insemination (procedure)	OBX|18|CWE|73775-9^Risk factors in this pregnancy^LN||5853300865046005^ Artificial insemination (procedure)^SDM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
INFT_DRG			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Infertility: Fertility Enhancing Drugs, AI	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 445151000124101^ Fertility enhancing drug therapy	OBX|19|CWE|73775-9^Risk factors in this pregnancy^LN|| 445151000124101^ Fertility enhancing drug therapy^SNM|||||F
INFT_ART			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 63487001^Assisted fertilization (procedure)	OBX|19|CWE|73775-9^Risk factors in this pregnancy^LN||63487001^Assisted fertilization (procedure)^SNM|||||F
PCES			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Previous cesarean	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 200144004^Deliveries by cesarean (finding)	OBX|19|CWE|73775-9^Risk factors in this pregnancy^LN||200144004^Deliveries by cesarean (finding)^SNM|||||F
NPCES			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: Number of previous cesareans	OBX-2 SHALL contain NM OBX-3 SHALL contain 68497-7^Previous cesarean deliveries OBX-5 SHALL contain The number of previous cesarean deliveries	OBX|8|NM|68497-7^Previous cesarean deliveries^LN||1
NOA01			Y	Y	Y	Y	Y	Y		Risk factors in this pregnancy: None of the above	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73775-9^Risk Factors in this Pregnancy OBX-5 SHALL contain 260413007^None (qualifier value)	OBX|19|CWE|73775-9^Risk factors in this pregnancy^LN||260413007^None (qualifier value)^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
SORD			Y	Y	Y	Y	Y	Y		Set Order	PID-25	PID|1||987645432^^^^MRN||~^^^^^^U||20110530 2349|M||||||||||||N||2
FSEX					Y	Y		Y		Child: (fetus) Sex -	PID-8	PID|1||123456688^^^^MRN||Johnson^Baby||20110313|F||||||||||||N
FDOD_YR					Y	Y		Y			PID-29	PID|1||123456688^^^^MRN||Johnson^Baby|||20170408120700|F||||||||||||||||||||201704081207 00|
FDOD_MO					Y	Y		Y			PID-29	PID|1||123456688^^^^MRN||Johnson^Baby|||20170408120700|F||||||||||||||||||||201704081207 00|
FDOD_DY					Y	Y		Y			PID-29	PID|1||123456688^^^^MRN||Johnson^Baby|||20170408120700|F||||||||||||||||||||201704081207 00|
ETIME					Y	Y		Y		Estimated Time of Fetal Death	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73811-2^Estimated time of fetal death OBX-5 SHALL contain a value selected from value the set Fetal Death Time Points (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7112	OBX|19|CWE|73811-2^Estimated time of fetal death ^LN||634751000124116 ^ Dead at time of first assessment, no labor ongoing (observable entity)^SNM|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
LIVEB			Y	Y	Y	Y	Y	Y		Not single birth - specify number of infants in this delivery born alive.	OBX-2 SHALL contain NM OBX-3 SHALL contain 73773-4^Number of infants in this delivery born alive OBX-5 SHALL specify the number of live born in this delivery	OBX|8|NM|73773-4^Number of infants in this delivery born alive ^LN||1
FDTH					Y	Y		Y		Number of fetal deaths	OBX-2 SHALL contain NM OBX-3 SHALL contain 73772-6^ Number of fetal deaths delivered OBX-5 SHALL specify the number of fetal deaths in this delivery	OBX|8|NM|73772-6^ Number of fetal deaths delivered^LN||1
HYST										Method of Delivery: Hysterotomy/Hysterectomy?	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73759-3^ Hysterotomy or hysterectomy was performed at delivery OBX-5 SHALL contain boolean indication (Yes/No/Unknown/Not Applicable) of whether a hysterotomy or hysterectomy was performed using HL7 0532 Expanded yes/no indicator (NCHS)	OBX|21|CWE|73759-3^ Hysterotomy or hysterectomy was performed at delivery^LN||N^No^HL70532|||||F
TD										Time of delivery	PID-7	PID|1||123456688^^^^MRN||Johnson^Baby|||20170408120700|F||||||||||||||||||201704081207 00|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
AUTOP					Y	Y		Y		Was an autopsy performed?	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73768-4^Autopsy was performed OBX-5 SHALL contain a value selected from value the set Autopsy Examination (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7137	OBX|19|CWE|73768-4^Autopsy was performed ^LN||44551000009109^ Autopsy not performed ^SNM|||||F
FWO					Y	Y		Y		Weight of Fetus (in ounces)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams converted from Ounces OBX-6 SHALL indicate ounces using UCUM units: SHALL contain oz NOTE: it is preferred to send in grams (see FWG)	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|oz
FWG					Y	Y		Y		Weight of Fetus (grams preferred, specify unit)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams OBX-6 SHALL indicate grams using UCUM units: SHALL contain gm	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|gm

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
FWP					Y	Y		Y		Weight of Fetus (in pounds)	OBX-2 SHALL contain NM OBX-3 SHALL contain 8339-4 ^Weight at delivery OBX-5 SHALL contain the birthweight in Grams converted from Pounds OBX-6 SHALL indicate pounds using UCUM units: SHALL contain lb NOTE: it is preferred to send in grams (see FWG)	OBX|24|NM|8339-4 ^ Body weight at birth ^LN||1200|lb
LM					Y	Y		Y		Infections present and treated during this pregnancy: Listeria	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 4241002^ Listeriosis (disorder)	OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||4241002^ Listeriosis (disorder)^SNM ||||||F
GBS					Y	Y		Y		Infections present and treated during this pregnancy: Group B Streptococcus	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 426933007^Streptococcus agalactiae infection (disorder)	OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||426933007^Streptococcus agalactiae infection (disorder)^SNM ||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CMV					Y	Y		Y		Infections present and treated during this pregnancy: Cytomeglovirus	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 28944009^Cytomegalovirus infection (disorder)	OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||28944009^Cytomegalovirus infection (disorder)^SNM |||||F
B19					Y	Y		Y		Infections present and treated during this pregnancy: Parvovirus	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 186748004^Parvovirus	OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||186748004^Parvovirus^SNM |||||F
HISTOP					Y	Y		Y		Was a Histological Placental Examination performed?	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73767-6^Histological placental examination was performed OBX-5 SHALL contain a value selected from value the set Histological Placental Examination (NCHS) https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7138	OBX|19|CWE|73767-6^Histological placental examination was performed ^LN||262008008^ Not Performed^SNM|||||F
TOXO					Y	Y		Y		Infections present and treated during this pregnancy: Toxoplasmosis	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73769-2^ Infections present and treated during the pregnancy for fetal death OBX-5 SHALL contain 187192000^ Toxoplasmosis (disorder)	OBX|19|CWE|73769-2^Infections present treated during the pregnancy for fetal death^LN||187192000^ Toxoplasmosis (disorder)^SNM |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
PNC			Y	Y	Y	Y	Y	Y		An indication that a physician or other healthcare professional has not examined an/or counselled the pregnant woman for the pregnancy	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73776-7^No Prenatal Care Indicator OBX-5 SHALL contain a value selected from value the set from PHVS_YesNo_HL7_2x	OBX|32|CWE|73776-7^ No prenatal care indicator ^LN||N^No^ PHVS_YesNo_HL7_2x |||||F
MFNAME	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Current Legal Name: First Name	NK1-2 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MMNAME	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Current Legal Name: Middle Name	NK1-2 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MLNAME	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Current Legal Name: Last Name	NK1-2 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
MSUFF	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Current Legal Name: suffix	NK1-2 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
UNUM	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Apartment or Unit Number	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
CITY	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: City, Town or Location	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
CITYC	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Code for City, Town or Location	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
COUNTY	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: County*	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H^^ 09001||||||||||F|20871205||||||||||||||123343897^^ ^^MRN

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
LIMITS	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Inside City Limits	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
STATE	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: State	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
STNAME	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Street Name	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
STNUM	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Street Number	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
ZIP	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Residence: Zip Code	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M||||||||||F|20871205||||||||||||||12334389 7^^^^MRN

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
MSTNAME	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address*: Name	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MAPT	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address: Apartment	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MCITY	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address: City	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MSTATE	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address: State	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
MZIP	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address: Zip	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205||||||||||||||12334389 7^^^^MRN

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
MCOUNTRY	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Mailing Address: Country	NK1-4 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^M|||||||||||F|20871205|||||||||||||||12334389 7^^^^MRN
MDOB_YR	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Date of Birth* Year	NK1-16 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H|||||||||||F|19871205|||||||||||||||12334389 7^^^^MRN
MDOB_MO	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Date of Birth* Month	NK1-16 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H|||||||||||F|19871205|||||||||||||||12334389 7^^^^MRN
MDOB_DY	Y	Y	Y	Y	Y	Y	Y	Y		Mother's Date of Birth* Day	NK1-16 where NK1-3 (Relationship) is MTH (Mother)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H|||||||||||F|19871205|||||||||||||||12334389 7^^^^MRN
BPLACEC_CNT*	Y	Y	Y			Y	Y	Y		Birthplace – Code for Mother's country of birth	NK1-4.6where NK1-3 (Relationship) is MTH (Mother) Where NK1.38^7 ="BDL"	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^ ^CT^US ^44134-1111^^H|||||||||||F|19871205|||||||||||||||12334389 7^^^^MRN||||| BDL|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BPLACE_ST *	Y	Y	Y			Y	Y	Y		Birthplace – Mother's state of birth	NK1-4.4where NK1-3 (Relationship) is MTH (Mother) Where NK1.38^7 ="BDL"	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^Connecticut^US ^44134- 1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||BDL |
BPLACE_TER*	Y	Y	Y			Y	Y	Y		Birthplace – Mother's territory of birth	NK1-4.4where NK1-3 (Relationship) is MTH (Mother) Where NK1.38^7 ="BDL"	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^Puerto Rico^US^44134- 1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||| BDL|
BPLACEC_ST_TER *	Y	Y	Y			Y	Y	Y		Birthplace – Code for Mother's state or territory of birth	NK1-4.4 where NK1-3 (Relationship) is MTH (Mother) Where NK1.38^7 =”BDL”	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^ PR^US ^44134- 1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||| BDL|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
METHNIC1 - METHNIC5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Mother of Hispanic Origin? Mexican/ Mexican American/ Chicana Puerto Rican Cuban Other Spanish/Hispanic/Latina Other Literal Entry	NK1-28 where NK1-3 (Relationship) is MTH (Mother) And NK1.28^1 is drawn from "2148-5" (CDCREC)	NK1|1|Johnson^Susanna^J^III^^^^^^^^^^MD|MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN|||||Puerto Rico^US|

MRACE1 - MRACE22	Y	Y	Y	Y	Y	Y	Y	Y	Y	Mother's Race: White Black or African American American Indian or Alaska Native Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Race First American Indian or Alaska Native Second American Indian or Alaska Native First Other Asian Second Other Asian First Other Pacific Islander Second Other Pacific Islander First Other Race Second Other Race	NK1-35 where NK1-3 (Relationship) is MTH (Mother) And NK1.35^1 is drawn from NK1.35^1 = "2106-3" (CDCREC)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN||2106-3^White^CDCREC|||Puerto Rico^US|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CMHR	Y	Y	Y			Y	Y	Y		Mother: Did the mother get WIC food for herself during this pregnancy	OBX-2 SHALL contain CWE OBX-3 SHALL contain 87303-4^ Mother Receive WIC food OBX-5 SHALL contain a value selected from value the set from PHVS_YesNoUnknown_CDC	OBX|19|CWE| 87303-4^ Mother Receive WIC food ^LN|| N^ No ^ PHVS_YesNoUnknown_CDC ||||||F
CIGPN	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of cigarettes smoked prior to pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 64794-1^ Number of Packs of Cigarettes Smoked in 3 months prior to Pregnancy OBX-5 specify the Number of cigarettes smoked prior to pregnancy	OBX|19|NM| 64794-1^ Number of Packs of Cigarettes Smoked in 3 months prior to Pregnancy ^LN||20|||||F
CIGPP										Cigarette Smoking before and during pregnancy :Number of packs of cigarettes smoked prior to pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 64794-1^ Number of Packs of Cigarettes Smoked in 3 months prior to Pregnancy OBX-5 specify the Number of packs of cigarettes smoked prior to pregnancy	OBX|19|NM| 64794-1^ Number of Packs of Cigarettes Smoked in 3 months prior to Pregnancy ^LN||1|||||F
CIGFN	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of cigarettes smoked in 1st three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 87298-6^ Number of cigarettes smoked in 1st three months of pregnancy OBX-5 specify the Number of cigarettes smoked prior to pregnancy	OBX|19|NM|87298-6^ Number of cigarettes smoked in 1st three months of pregnancy ^LN||0|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CIGFP	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the first three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain LOINC XX1 ^ Number of packs of cigarettes smoked in the first three months of pregnancy OBX-5 specify the Number of packs of cigarettes smoked in the first three months of pregnancy	OBX|19|NM| LOINC XX1 ^ Number of packs of cigarettes smoked in the first three months of pregnancy ^LN||0|||||F
CIGSN	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of cigarettes smoked in the 2nd three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 87299-4^ Number of cigarettes smoked in the 2nd three months of pregnancy OBX-5 specify the Number of cigarettes smoked in the 2nd three months of pregnancy	OBX|19|NM|87299-4^ Number of cigarettes smoked in the 2nd three months of pregnancy ^LN||0|||||F
CIGSP	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the 2nd three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain LOINC XX2 ^ Number of packs of cigarettes smoked in the 2nd three months of pregnancy OBX-5 specify the Number of packs of cigarettes smoked in the 2nd three months of pregnancy	OBX|19|NM| LOINC XX2 ^ Number of packs of cigarettes smoked in the 2nd three months of pregnancy ^LN||0|||||F
CIGLN	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number cigarettes smoked in 3rd three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain 64795-8^ Number of Cigarettes Smoked in third or last trimester OBX-5 specify the Number cigarettes smoked in 3rd three months of pregnancy	OBX|19|NM|64795-8^ Number of Cigarettes Smoked in third or last trimester^LN||0|||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CIGLP	Y	Y	Y			Y	Y	Y		Cigarette Smoking before and during pregnancy: Number of packs of cigarettes smoked in the 3rd three months of pregnancy	OBX-2 SHALL contain NM OBX-3 SHALL contain LOINC XX3 ^ Number of packs of cigarettes smoked in the 3rd three months of pregnancy OBX-5 specify the Number of packs of cigarettes smoked in the 3rd three months of pregnancy	OBX|19|NM| LOINC XX3 ^ Number of packs of cigarettes smoked in the 3rd three months of pregnancy ^LN||0||||||F
FBPLACE_ST_TER_L	Y	Y	Y			Y	Y	Y		Father's Birthplace (State or Territory)	NK1-38 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||Connecticut^US|
FBPLACE_ST_L	Y	Y	Y			Y	Y	Y		Father's Birthplace (Code for Father's State of Birth)	NK1-38 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||CT^US|
FBPLACE_ST_TER_C	Y	Y	Y			Y	Y	Y		Father's Birthplace (Code for Father's State or Territory of Birth)	NK1-38 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||CT^US|
FBPLACE_CNT_C	Y	Y	Y			Y	Y	Y		Father's Birthplace (Code for Father's Country of Birth)	NK1-38 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||||||12334389 7^^^^MRN||||CT^US|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
FFNAME	Y	Y	Y			Y	Y	Y		Father's Current Legal Name*: First Name	NK1-2 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD | FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
FMNAME	Y	Y	Y			Y	Y	Y		Father's Current Legal Name*: Middle Name	NK1-2 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD | FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
FLNAME	Y	Y	Y			Y	Y	Y		Father's Current Legal Name*: Last Name	NK1-2 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD | FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
FSUFF	Y	Y	Y			Y	Y	Y		Father's Current Legal Name*: Suffix	NK1-2 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD | FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|20871205||||||||||||||12334389 7^^^^MRN
FNREF	Y	Y	Y			Y	Y	Y		Father's Current Legal Name*: Refused	NK1-2 where NK1-3 (Relationship) is FTH (Father)	NK1|1|| FTH^Father ^ HL70063| ||||||||||F|20871205||||||||||||||123343897^^^^MR N
FDOB_YR	Y	Y	Y			Y	Y	Y		Father's Date of Birth*: Year	NK1-16 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD |FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19850922||||||||||||||12334389 7^^^^MRN

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
FDOB_MO	Y	Y	Y			Y	Y	Y		Father's Date of Birth*: Month	NK1-16 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19850922||||||||||||||12334389 7^^^^MRN
FDOB_DY	Y	Y	Y			Y	Y	Y		Father's Date of Birth*: Day	NK1-16 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father ^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19850922||||||||||||||12334389 7^^^^MRN
FEDUC	Y		Y				Y			Father's Education*	OBX-2 SHALL contain CWE OBX-3 SHALL contain 87300-0^ Father's education OBX-5 SHALL contain a value selected from value the set from PHVS_DecedentEducationLevel_NCHS	OBX|19|CWE| 87300-0^ Father's education ^LN|| PHC1451^ Some college credit, but no degree ^PHINVS |||||F
FETHNIC1 - FETHNIC5	YY		Y				Y			Father of Hispanic Origin? Mexican, Mexican American or Chicano Puerto Rican Cuban Other Other literal entry	NK1-38 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD|FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN|||||Puerto Rico^US|

FRACE1 - FRACE23			Y				Y			Father's Race: White Black or African American American Indian or Alaska Native Asian Indian Chinese Filipino Japanese Korean Father's Race: Vietnamese Other Asian Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other Race First American Indian or Alaska Native Second American Indian or Alaska Native First Other Asian Second Other Asian First Other Pacific Islander Second Other Pacific Islander First Other Race Second Other Race	NK1-35 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD |FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN||2106-3^White^CDCREC|||Puerto Rico^US|

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
MSSN	Y		Y				Y			Mother's Jurisdiction Identifier (e.g., Security Number)	NK1-37 where NK1-3 (Relationship) is MTH (Mother)	NK1|1| Johnson^Susanna^J^III^^^^^^^^^^MD |MTH^Mother^ HL70063|23 Front St^^River Town^HerState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN||2106-3^White^CDCREC||123456789^SS|Puerto Rico^US|
FSSN	Y		Y				Y			Father's Jurisdiction Identifier (e.g., Security Number)	NK1-37 where NK1-3 (Relationship) is FTH (Father)	NK1|1| Johnson^Peter^J^III^^^^^^^^^^MD |FTH^Father^ HL70063|23 Front St^^River Town^HisState^44134-1111^^H||||||||||F|19871205||||||||||2180-8^Puerto Rican^CDCREC|||||123343897^^^^MRN||2106-3^White^CDCREC||123456789^SS|Puerto Rico^US|
ACKN	Y		Y				Y			Acknowledgment of paternity signed	OBX-2 SHALL contain CWE OBX-3 SHALL contain 87302-6^ Acknowledgment of paternity signed OBX-5 SHALL contain a value selected from value the set from PHVS_YesNoUnknown_CDC	OBX|19|CWE|87302-6^ Acknowledgment of paternity signed ^LN|| Y^ Yes ^ PHVS_YesNoUnknown_CDC |||||F
MHT	Y	Y	Y	Y	Y	Y	Y			Mother's body height	OBX-2 SHALL contain NM OBX-3 SHALL contain 83846-6^ Mother's body height OBX-6 SHALL indicate contain the Mother's Height using UCUM units:	OBX|19|NM|83846-6^ Mother's body height ^LN|| 58|in |||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
BREGDATE							Y			Date of birth registration	OBX-2 SHALL contain DTM OBX-3 SHALL contain 87302-6^ Date of birth registration OBX-5 SHALL contain the date of birth registration	OBX|5|DTM|87302-6^ Date of birth registration ^LN||20171028||||||F
FAGE	Y	Y	Y			Y	Y	Y		Father's reported age in years	OBX-2 SHALL contain NM OBX-3 SHALL contain 87296-0^ Father's reported age in years OBX-6 SHALL indicate age in years units using UCUM units:	OBX|19|NM| 87296-0^ Father's reported age in years ^LN|| 28|yr ||||||F
HDELPLAN	Y	Y	Y	Y	Y	Y	Y	Y		73765-0 Planned to deliver at home	OBX-2 SHALL contain CWE OBX-3 SHALL contain 73765-0^ Planned to deliver at home OBX-5 SHALL contain a value selected from value the set from PHVS_YesNoUnknown_CDC	OBX|19|CWE|73765-0^ Planned to deliver at home ^LN|| Y^ Yes ^ PHVS_YesNoUnknown_CDC ||||||F
MAGE	Y	Y	Y	Y	Y	Y	Y	Y		Mother's reported age in years	OBX-2 SHALL contain NM OBX-3 SHALL contain 85724-3^ Mother's reported age in years OBX-6 SHALL indicate age in years units using UCUM units:	OBX|19|NM|85724-3^ Mother's reported age in years ^LN|| 28|yr ||||||F
NOINAME	Y									Baby name not yet chosen	OBX-2 SHALL contain CWE OBX-3 SHALL contain v ^ Baby name not yet chosen OBX-5 SHALL contain a value selected from value the set from PHVS_YesNoUnknown_CDC	OBX|19|CWE|85724-3^ Baby name not yet chosen ^LN|| Y^ Yes ^ PHVS_YesNoUnknown_CDC ||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
CERTDATE			Y	Y	Y	Y				Date birth certified	OBX-2 SHALL contain DTM OBX-3 SHALL contain 87288-7^ Date birth certified OBX-5 SHALL contain Date birth certified	OBX|5|DTM|87288-7^ Date birth certified ^LN||20171028||||||F
FDREGDATE								Y		Date of fetal death registration	OBX-2 SHALL contain DTM OBX-3 SHALL contain 87289-5^ Date of fetal death registration OBX-5 SHALL contain Date of fetal death registration	OBX|5|DTM|87289-5^ Date of fetal death registration ^LN||20171028||||||F
FDELDATE					Y			Y		LOINC 17 Date of fetal delivery	OBX-2 SHALL contain DTM OBX-3 SHALL contain LOINC 17^ Date of fetal delivery OBX-5 SHALL contain the Date of fetal delivery	OBX|5|DTM|LOINC 17^ Date of fetal delivery ^LN||20171028||||||F
FETNAME		Y		Y		Y				LOINC 22 Name of fetus	OBX-2 SHALL contain XPN OBX-3 SHALL contain LOINC 22^ Name of fetus OBX-5 SHALL contain the Name of fetus	OBX|5|XPN|LOINC 22^ Name of fetus ^LN||Jones^Pricilla||||||F
INFOSRC	Y		Y							LOINC 23 Person providing information for mother's live birth information	OBX-2 SHALL contain XPN OBX-3 SHALL contain LOINC 23^ Person providing information for mother's worksheet mother's live birth information OBX-5 SHALL contain the Name of the person providing the information for the mother's worksheet	OBX|5|XPN|LOINC 23^ Person providing information for mother's worksheet mother's live birth information ^LN||Jones^Pricilla||||||F

Form Data Element < V1 X.7>	Usage									Form Data Element Name	Segment and Location within the Segment	Example
	PSMLBI	PSMFDI	PSLBI	PSFLBI	PSFFDI	PSFDI	JLBI	JFDI	CCOFDI			
RELINFOSRC	Y									Relationship of person providing information for mother's live birth information	OBX-2 SHALL contain CWE OBX-3 SHALL contain 87289-5^ Relationship of person providing information for mother's worksheet mother's live birth information OBX-5 SHALL contain a value selected from value the set from PHVS_InformantRelationshiptoMother_NCHS	OBX|19|CWE|87289-5^ Relationship of person providing information for mother's worksheet mother's live birth information ^LN|| PHC1496 ^ Father of baby ^ PHVS_InformantRelationshiptoMother_NCHS ||||||F
DISPMET					Y	Y				Fetal remains disposition method	OBX-2 SHALL contain CWE OBX-3 SHALL contain LOINC 28 ^ Fetal remains disposition method OBX-5 SHALL contain a value selected from value the set from PHVS_FetalRemainsDispositionMethod_NCHS	OBX|19|CWE| 87289-5^ Fetal remains disposition method ^LN|| 449971000124106 ^ Burial ^ PHVS_FetalRemainsDispositionMethod_NCHS ||||||F
OTHCOD									Y	76061-1 Death cause other significant conditions	OBX-2 SHALL contain CWE OBX-3 SHALL contain 76061-1 ^ Death cause other significant conditions OBX-5 SHALL contain a value selected from value the set from PHVS_CauseOfDeath_ICD-10_CDC	OBX|19|CWE| 76061-1 ^ Death cause other significant conditions ^LN|| I71.3 ^ Abdominal aortic aneurysm, ruptured ^ PHVS_CauseOfDeath_ICD-10_CDC |||||F
INITCOD									Y	76060-3 Initiating cause of death or condition	OBX-2 SHALL contain CWE OBX-3 SHALL contain 76060-3 ^ Initiating cause of death or condition OBX-5 SHALL contain a value selected from value the set from PHVS_CauseOfDeath_ICD-10_CDC	OBX|19|CWE| 76060-3 ^ Initiating cause of death or condition ^LN|| I71.3 ^ Abdominal aortic aneurysm, ruptured ^ PHVS_CauseOfDeath_ICD-10_CDC |||||F

6.6.4 Discrete Data Import Element Mappings From APS to LDS-VR Content Document

This section identifies the form data elements that may be available from the Antepartum Summary Record (APS), and the associated mapping for discrete data import of these data elements from the APS. Form Fillers that support the Antepartum Import Option SHALL support import of these attributes where available for incorporation into the LDS or LDS-VR pre-population document.

Table 6.6.4-1: Discrete Data Import Elements Data Mapped to LDS-VR Content Document Modules for Birth

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
DOFP_MO DOFP_DY DOFP_Y	Date of first prenatal care visit	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133 Documenting ../effectiveTime using date timestamp associated with the event
NPREV	Total number of prenatal care visits for this pregnancy	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Number Prenatal Care Visits (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135 Documenting ../value using INT

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
OWGEST	Obstetric Estimate of Gestation	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Estimate of Gestation (templateId: 2.16.840.1.113883.10.20.26.21) Documenting ../value using INT NOTE: The preferred source for the Obstetric Estimate of Gestation is the OB History and Physical. The primary source would be the OB admission H&P. This information may also be available in the prenatal care record (e.g., APS), but this should be used as a secondary source if the OB admission H&P does not contain this information.
DLMP_DY DLMP_MO DLMP_YR	Date last normal menses began	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Last Menstrual Period Date (templateId: 2.16.840.1.113883.10.20.26.33) Documenting ../effectiveTime using date timestamp associated with the event

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
PLBL	Number of previous live births now living	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123 Documenting ../value using INT
PLBD	Number of previous live births now dead	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122 Documenting ../value using INT
YLLB MLLB	Date of last live birth	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67 Documenting ../effectiveTime using date timestamp associated with the event
POPO	Number of other pregnancy outcomes	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Previous Other Pregnancy Outcomes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121 Documenting ../value using INT

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
YOPO MOPO	Date of last other pregnancy outcome	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70 Documenting ../effectiveTime using date timestamp associated with the event
PDIAB	Risk factors in this pregnancy: Pre-Pregnancy Diabetes	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Prepregnancy Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
GDIAB	Risk factors in this pregnancy: Gestational Diabetes	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Gestational Diabetes (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
PHYPE	Risk factors in this pregnancy: pre-pregnancy hypertension	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Prepregnancy Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
GHYPE	Risk factors in this pregnancy: gestational hypertension	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Gestational Hypertension (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
EHYPE	Risk factors in this pregnancy: gestational eclampsia	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Eclampsia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
PPB	Previous Preterm Births	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Preterm Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141 Documenting ../value using INT
INFT	Pregnancy resulted from infertility treatment	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Infertility Treatment (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
INFT_DRG	Fertility-enhancing drugs, artificial insemination, or intrauterine insemination	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Artificial or Intrauterine Insemination (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
INFT_ART	Assisted reproductive technology (e g , in-vitro fertilization [IVF] gamete intrafallopian transfer [GIFT])	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Assistive Reproductive Technology (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
PCES	Previous Cesarean	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/value Using valueset Previous Cesarean (NCHS) 2.16.840.1.114222.4.11.7165 Documenting PregnancyObservation/code/@code=73775-9 Risk Factors in this Pregnancy
NPCES	Number of previous cesareans	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	Pregnancy Observation 1.3.6.1.4.1.19376.1.5.3.1.4.13.5	/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4']] /entry/observation/code Using valueset Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148 Documenting ../value using INT

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
GON	Infections present and/or treated during this pregnancy: Gonorrhea	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Gonorrhea (NCHS)2.16.840.1.114222.4.11.6071 Documenting ../code = 'finding', '404684003'
SYPH	Infections present and/or treated during this pregnancy: Syphilis	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Syphilis (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98 Documenting ../code = 'finding', '404684003'
CHAM	Infections present and/or treated during this pregnancy: Chlamydia	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Chlamydia (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93 Documenting ../code = 'finding', '404684003'

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
HEPB	Infections present and/or treated during this pregnancy: Hepatitis B (HBV, serum hepatitis)	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Hepatitis B (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96 Documenting ../code = 'finding', '404684003'
HEPC	Infections present and/or treated during this pregnancy: Hepatitis C (non A or non B hepatitis [HCV])	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Hepatitis C (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97 Documenting ../code = 'finding', '404684003'
LM	Infections present and/or treated during this pregnancy: Listeria	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Listeria (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147 Documenting ../code = 'finding', '404684003'

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
GBS	Infections present and/or treated during this pregnancy: Group B Streptococcus	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Group B Streptococcus (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166 Documenting ../code = 'finding', '404684003'
CMV	Infections present and/or treated during this pregnancy: Cytomegalovirus	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Cytomegalovirus (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167 Documenting ../code = 'finding', '404684003'
B19	Infections present and/or treated during this pregnancy: Parvovirus	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Parvovirus (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168 Documenting ../code = 'finding', '404684003'

Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element	APS Section Level Map (if specific)	APS Entry Level Map	LDS Mapping
TOXO	Infections present and/or treated during this pregnancy: Toxoplasmosis	Antepartum Summary Specification 1.3.6.1.4.1.19376.1.5.3.1.1.11.2 Code History of Infection 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem Concern Entry 1.3.6.1.4.1.19376.1.5.3.1.4.5.2	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 Using valueset Toxoplasmosis (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169 Documenting ../code = 'finding', '404684003'

7095

6.6.5 QRPH Data Mapping to FHIR Resources

6.6.5.1 FHIR Resource Bundle Content

FHIR Resource	Cardinality	Structured Definition
Composition	1..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.Composition
MedicationAdministration	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherMedicationAdministration
MedicationAdministration	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornMedicationAdministration
Procedure	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherProcedure
Procedure	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherProcedure

FHIR Resource	Cardinality	Structured Definition
Observation	0..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservations which is a composite of: • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPLUR • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLIVEB • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsFDTH • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLLB • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsLMP • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsOPO • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsDOFP • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPLBD • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPLBL • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPPB • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsOWGEST • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsNPCES • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsNPREV • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPOPO • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsPNC • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsHT • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MaternalObservationsWT
Observation	0..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservations which is a composite of: • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsAPGAR5 • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsAPGAR10 • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsBW • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsFW • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsBPLACE • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornObservationsKaryotype
Observation	0..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservations which is a composite of: • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsFW • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsETIME • http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusObservationsHISTOP
Condition	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherCondition

FHIR Resource	Cardinality	Structured Definition
Condition	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornCondition
Condition	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusCondition
Encounter	1..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherBirthEncounter
Encounter	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornBirthEncounter
Encounter	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusDeliveryEncounter
Patient	1..1	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.MotherPatient
Patient	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.NewbornPatient
Patient	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.FetusPatient
Coverage	0..*	http://ihe.net/fhir/StructureDefinition/IHE.BFDRE.Coverage

6.6.5.2 FHIR Resource Data Specifications

7100

The following table shows the mapping of the FHIR Resources supporting the content for each of the BFDR Data Elements/Attributes. Data Responders SHALL support the Resources identified by this table. Data Consumers SHALL be able to retrieve birth and fetal death reporting related health information from the specified resource for one or more attributes.

Table 6.6.5.2-1: Required Mappings – Birth and Fetal Death Reporting Attribute to FHIR Resource

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
Attributes related to mother as the primary patient. The newborn or fetus will be referenced by partOf.Encounter.Resource of the mother.				
MedicationAdministration.Resource	medication[x].medicationCodableConcept	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: 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	ANTI AUGL ESAN	Abnormal conditions of the newborn: • Antibiotics [received by the newborn for suspected neonatal sepsis] Characteristics of labor and delivery: • Augmentation of labor • [Epidural or spinal] Anesthesia [during labor]

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
MedicationAdministration.Resource	dosage.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	ANTI ANTB	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis] Antibiotics received by the mother during labor. Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxine, and Ceftriaxone. Information about the course of labor and delivery.
MedicationAdministration.Resource	reasonReference	Neonatal Sepsis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6	ANTI	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]
MedicationAdministration.Resource	medication[x].medicationCodableConcept	Fertility Enhancing Drugs Medications (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144	INFT_DRG	Fertility-enhancing drugs, artificial insemination, or intrauterine insemination

Procedure.Resource	Code	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 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 Unplanned Hysterectomy (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103 Transfusion Whole Blood or Packed Red Bld (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99 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 Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138 Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14	AUGL ESAN INDL STER UOPR UHYS MTR CERV ECVF ECVS TOC HYST HISTOP ANTB AINT	Characteristics of labor and delivery: • Augmentation of labor • [Epidural or spinal]Anesthesia[during labor] • Induction of labor • Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery Maternal Morbidity: • Unplanned operat[ing]ion [room procedure following delivery] • Unplanned hysterectomy • Maternal Transfusion Obstetric procedures: • Cervical cerclage • Failed External cephalic Version • Successful External cephalic version • Tocolysis Method of Delivery: • Hysterotomy/Hysterectomy

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
		For External Cephalic Version, the procedure should be documented whether it is performed during prenatal care record or during labor and delivery.		Was a Histological Placental Examination performed? Abnormal conditions of the newborn: • Antibiotics [received by the newborn for suspected neonatal sepsis] Maternal Morbidity: - Admission to Intensive care [unit]
	Performed[x].period	SHALL be included for all procedures performed if known		
	Outcome	For Failed External Cephalic Version outcome= 385671000 unsuccessful, SNOMED-CT	ECVF	Obstetric procedures: • Failed External cephalic
	performer.actor Refernce (Practitioner.identifier)	SHALL also indicate the NPI 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	NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.
	Performer.role	SHALL also indicate the provider role 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 Using the following value sets unless otherwise constrained by jurisdiction: Physician (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15 Doctor of Osteopathic Medicine (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16 Certified Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17 /Midwife (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18	ATTEND	The title of the person (attendant) responsible for delivering the child. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery. Titles include: M.D. (doctor of medicine); D.O. (doctor of osteopathy); CNM/CM (certified nurse midwife/certified midwife); Other midwife (midwife other than a CNM/CM); and Other (specify)

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
	performer.actor Refernce (Practitioner.name)	SHALL also indicate the provider name 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	ATTENDN	The name of the attendant (the person responsible for delivering the child), their title, and their National Provider Identification (NPI) Number.
	Methodp (HL7 extension: procedure-method)	Route and Method of Delivery SHALL be documented using the following value sets unless further extended by national extension: Route and Method of Delivery - Spontaneous (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111 Route and Method of Delivery - Forceps (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112 Route and Method of Delivery - Vacuum (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113 Route 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	ROUT	Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head; Vaginal/vacuum Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head; or Cesarean: Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

Condition.Resource	code	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 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 Gonorrhea (NCHS) 2.16.840.1.114222.4.11.6071 Hepatitis B (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96 Hepatitis C (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97 Syphilis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98 Listeria (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147 Group B Streptococcus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166 Cytomegalovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167 Parvovirus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168 Toxoplasmosis (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169 Prepregnancy Diabetes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136	INDL ROUT TLAB TRAN GON SYPH CHAM HEPB HEPC LM GBS CMV B19 TOXO PDIAB GDIAB PHYPE GHYPE EHYPE PPB INFT INFT_DRG INFT_ART INFT_DRG PCES PLAC RUT PRES PRIC PROL PROM	Characteristics of labor and delivery: Induction of labor Method of Delivery: [Final]Route and method of delivery: Vaginal/spontaneous Vaginal/forceps Vaginal/vacuum Cesarean Method of Delivery: Trial of labor attempted Mother transferred for maternal medical or fetal indications for delivery? Infections present and/or treated during this pregnancy: • Gonorrhea • Syphilis • Chlamydia • Hepatitis B (HBV, serum hepatitis) • Hepatitis C (non A or non B hepatitis [HCV]) • Listeria • Group B Streptococcus • Cytomegalovirus • Parvovirus • Toxoplasmosis Risk factors in this pregnancy: • Prepregnancy Diabetes • Gestational Diabetes

		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 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 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 Third Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100 Fourth Degree Perineal Laceration (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101 Ruptured Uterus (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102 Fetal Presentation at Birth- Breech (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108 Fetal Presentation at Birth- Cephalic (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109 Fetal Presentation at Birth- Other (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110 Precipitous Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130 Prolonged Labor (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131		• Prepregnancy Hypertension • Gestational Hypertension • Eclampsia • Previous preterm births • Infertility treatment • Infertility: Fertility Enhancing Drugs, AI • Infertility: Asst. Rep. Technology • Previous cesarean Maternal Morbidity: [Third or fourth degree] perineal laceration Ruptured Uterus Method of Delivery: Fetal presentation [at birth]: Cephalic Onset of labor: Precipitous Labor Prolonged Labor Premature Rupture

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
		Premature Rupture (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129		
	code	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	CHOR	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]
Observation.Resource	Code	Birth Plurality of Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132	PLUR	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.)
	valueQuantity	Integer		
Observation.Resource	Code	Number of Live Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68	LIVEB	Not single birth - specify number of infants in this delivery born alive.
	valueQuantity	integer		
Observation.Resource	Code	Number of Fetal Deaths This Delivery (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164	FDTH	Number of fetal deaths
	valueQuantity	Integer		
Observation.Resource	Code	Date of Last Live Birth (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67	YLLB	Date of last live birth

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
	ValueDateTime	timestamp	MLLB	
Observation.Resource	Code	Date of Last Menses (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69	DLMP_DY DLMP_MO DLMP_YR	Date last normal menses began
	ValueDateTime	timestamp		
Observation.Resource	Code	Date of Last Other Pregnancy Outcome (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70 (e.g., spontaneous or induced losses or ectopic pregnancy)	YOPO MOPO	Date of last other pregnancy outcome
	ValueDateTime	timestamp		
Observation.Resource	code	First Prenatal Care Visit (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133	DOFP_MO DOFP_DY DOFP_Y	Date of first prenatal care visit
	valueDateTime	timestamp 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: 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		
Observation.Resource	code	Number of Previous Live Births Now Dead (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122	PLBD	Number of previous live births now dead (do not include this child)
	valueQuantity	integer		
Observation.Resource	code	Number of Previous Live Births Now Living (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123	PLBL	Number of previous live births now living (do not include this child)
	valueQuantity	integer		

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
Observation.Resource	code	Number of Preterm Births (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.187	PPB	Risk factors in this pregnancy: Previous preterm births
	valueQuantity	Integer		
Observation.Resource	code	Obstetric Estimate of Gestation (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	OWGEST	Obstetric Estimate of Gestation
	valueQuantity	Integer		
Observation.Resource	code	Number of Previous Cesareans (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148	NPCES	Risk factors in this pregnancy: Number of previous cesareans
	valueQuantity	Integer		
Observation.Resource	code	Number Prenatal Care Visits (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135	NPREV	Prenatal care visits: Total number of prenatal visits for this pregnancy
	valueQuantity	integer For the Number of Prenatal Care Visits, the following guidance should be noted: 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.		
Observation.Resource	code	Previous Other Pregnancy Outcomes (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121	POPO	Number of other pregnancy outcomes
	valueQuantity	Integer		

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
Observation.Resource	code	code=73776-7 No-prenatal care indicator, LOINC	PNC	An indication that a physician or other healthcare professional has not examined an/or counselled the pregnant woman for the pregnancy
	valueBoolean	boolean		
Observation.Resource	Code	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	HFT HIN	Mother's Height: Feet Mother's Height: Inches
	valueQuantity	The height SHALL be expressed using UCUM for units with the preference to express in feet and inches.		
Observation.Resource	Code	Mother's Weight SHALL be included, using the value set: Body Weight (NCHS) 2.16.840.1.114222.4.11.7421	PWGT DWGT	Mother's pre-pregnancy weight Mother's weight at delivery
	method	using the following value set unless further extended by national extension: 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		
	valueQuantiy	the weight SHALL be expressed using UCUM for units with the preference to express in pounds unless further extended by national extension		
Encounter.Resource	part of	Type Refernce(Encounter) Where reference encounter is the child		
	hospitalization.admitSource		NFACL	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.
	hospitalization.origin(location.name)			

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
Patient.resource	Name	SHALL be populated with Mother's Current Legal Name	MFNAME MMNAME MLNAME MSUFF	Mother's Current Legal Name
Attributes related to newborn or fetus, such that partOf.Encounter.Resource reflects the newborn or fetus				
Patient.resource	multipleBirth[x].multipleBirthInteger	SHALL be present if known	SORD	The order born in the delivery, live-born or fetal death.
	birthDate	SHALL be present	AVEN1 IDOB_YR IDOB_MO IDOB_DY ITRAN FTRAN TB	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery] Child: Date of Birth: • Year • Month • Day Child: Infant transferred within 24 hours of delivery/name the facility, FTRAN Child: Time of Birth
	Name	SHALL be present if available.	KIDFNAME KIDMNAME KIDLNAME KIDSUFFX	The name of the newborn or fetus
	gender	SHALL be present	ISEX	The sex of the infant.

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
	deceased[x].deceasedBoolean	SHALL be present if infant has died	ILIV	Child: Infant living at time of report?
	deceased[x].deceasedDateTime			
	identifier	Infant's Medical Record Number SHALL be present to indicate the number assigned by the organization	IRECNUM	Child: Newborn Medical Record Number
Observation.Resource	code	Body Weight (NCHS) 2.16.840.1.114222.4.11.7421	BWG BWO BWP FWO FWG FWP	Birth weight (Infant's) in • Grams • Ounces • Pounds Weight of Fetus in • Ounces • Grams • Pounds
	method	Birth Weight (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20		
	valueQuantity	The weight SHALL be expressed using UCUM for units with the preference to express in grams		
Observation.Resource	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 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	APGAR5 APGAR10	Apgar Score: • 5 Minute • 10 Minute
	Value	where the value is INT<=10		

Condition.Resource	Code	Breastfed Infant (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41 Neonatal Death (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149 Seizure or Serious Neurologic Dysfunction (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10 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 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 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 Karyotype Confirmed (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56 Congenital Diaphragmatic Hernia (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55 Assisted Ventilation for >6 hours Finding (NCHS) 2.16.840.1.114222.4.11.7534	BFED ILIV SIEZ MNSB ANEN CL CP CCHD GAST LIMB OMPH HYPO BINJ CDIS CDIC CDIP DOWN DOWC DOWP CDH AVEN6 AVEN1 TRANS	Infant being breastfed? Infant living at time of report? Congenital anomalies of the Newborn: • Seizure or serious neurologic dysfunction • Meningomyelocele/Spina Bifida • Anencephaly • Cleft Lip with or without Cleft Palate • Cleft Palate alone • Cyanotic congenital heart disease • Gastroschisis • Limb reduction defect • Omphalocele • Hypospadias • Significant birth injury • Suspected chromosomal Disorder • Suspected chromosomal disorder karyotype confirmed • Suspected chromosomal disorder karyotype pending • Down Syndrome • Down Karyotype Confirmed • Down Karyotype Pending

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
		Assisted Ventilation Finding (NCHS) 2.16.840.1.114222.4.11.7533 Transfer to (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190		• Congenital diaphragmatic hernia Assisted ventilation for 6 or more hours Assisted ventilation [required immediately following delivery]
	onset[x].onsetDateTime	Problem Date and Time SHALL be included for all problems if known		
Procedure.Resource	Code	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 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 Transfer to facility (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	ANTI AVEN1 AVEN6 AUTOP DOWC DOWP CDC CDP ITRAN FTRAN	Assisted ventilation [required immediately following delivery] Assisted ventilation for 6 or more hours Congenital anomalies of the Newborn: • Suspected chromosomal disorder karyotype confirmed • Suspected chromosomal disorder karyotype pending • Down Karyotype Confirmed • Down Karyotype Pending Was an autopsy performed? Child: Infant transferred within 24 hours of delivery/name the facility
	Performed[x].period	Procedure Date and Time SHALL be included for all procedures performed if known		
	Value	Procedure value SHALL contain the name of the receiving facility where procedure.code contains: Transfer to facility (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.190	FTRAN	Child: Infant transferred within 24 hours of delivery/name the facility

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
MedicationAdministration.Resource	medication[x].medicationCodableConcept	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	SURF ANTI	Abnormal conditions of the newborn: • Surfactant replacement therapy • Antibiotics [received by the newborn for suspected neonatal sepsis]
	dosage.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	ANTI	Abnormal conditions of the newborn: • Antibiotics [received by the newborn for suspected neonatal sepsis]
	reasonReference	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		
Observation.Resource	Code	Birthplace Setting (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184	BPLACE	Place where birth occurred: Birth Place

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
	value	Birthplace Hospital (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.192 Birth Place Home Intended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.193 Birth Place Home Unintended (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.194 Birth Place Home Unknown Intention (NCHS)1.3.6.1.4.1.19376.1.7.3.1.1.13.8.195 Birthplace Clinic Office (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.197 Birth Place Freestanding Birthing Center (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.196		
Observation.Resource	Code	Histological Placental Examination Performed (NCHS) 2.16.840.1.114222.4.11.7430	HISTOP	Was a Histological Placental Examination performed?
	Value	Histological Placental Examination (NCHS) 2.16.840.1.114222.4.11.7138		
Observation.Resource	Code	Estimated Time Of Fetal Death (NCHS) 2.16.840.1.114222.4.11.7426	ETIME	Estimated Time of Fetal Death
	Value	Fetal Death Time Point (NCHS) 2.16.840.1.114222.4.11.7112		
Encounter.Resource	location.location.type	NICU Care (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.198	NICU	Abnormal conditions of the newborn: Admission to NICU
	location.period	In support of some jurisdictional needs, the date and time that the patient was transferred out MAY be documented		
	Location.status	Where EncounterLocationStatus = planned	TRANS	Infant transferred within 24 hours of delivery
	Location.name	Where EncounterLocationStatus = planned	FTRAN	Infant transferred within 24 hours of delivery/name the facility

FHIR Resource Location	FHIR Source Element Name	Notes	Attribute Name <QRPH TF-1: Appx B>	Birth and Fetal Death Report Data Element
	serviceProvider(organization.name)		ADDRESS_D FLOC	The name of the city, town, township, village, or other location where the birth occurred.
	serviceProvider(organization.identifier)		SFN	Place where birth occurred: State Facility Number
Observation.resource	Code	Karyotype Result (NCHS) 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59	CDIC CDIP DOWC DOWP	Abnormal conditions of the newborn: • Suspected chromosomal disorder karyotype confirmed • Suspected chromosomal disorder karyotype pending • Down Karyotype Confirmed • Down Karyotype Pending
	Value	The 'value' element not constrained		
Coverage.resource	Type	Potential vocabularies to use include HL7 ActCoverageType X12 Data Element 1336	PAY	Principal source of payment for this delivery

7105

Appendices

Appendix A – BFDR Birth CDA Document Quick Reference

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

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

Birth/FD Use	Section Reference #	BFDR	TemplateId	LOINC	Type
Birth		Document	2.16.840.1.113883.10.20.26.1	68998-4	
FD		Document	2.16.840.1.113883.10.20.26.1	68998-4	Document
			Note: this document does not use the General Header Template for C-CDA		
		Header			
Both		recordTarget	2.16.840.1.113883.10.20.26.1	n/a	
Both		Author	2.16.840.1.113883.10.20.26.1	n/a	
Both		Custodian	2.16.840.1.113883.10.20.26.1	n/a	
		Section and sub-section Specification			
Both	1	Prenatal Testing and Surveillance Section	2.16.840.1.113883.10.20.26.3	57078-8	
Both		*Prenatal Care*	2.16.840.1.113883.10.20.26.42	73776-7	*Entry*
Both	2	Prior Pregnancy History Section	2.16.840.1.113883.10.20.26.12	57073-9	
Both		*Date of Last Live Birth*	2.16.840.1.113883.10.20.26.20	68499-3	*Entry*
Both		*Last Menstrual Period Date*	2.16.840.1.113883.10.20.26.33	8665-2	*Entry*
Both		*Number of Births Now Living*	2.16.840.1.113883.10.20.26.36	11638-4	*Entry*

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

Birth/FD Use	Section Reference #	BFDR		TemplateId	LOINC	Type
Birth	5	Newborn Delivery Section		2.16.840.1.113883.10.20.26.10	57075-4	Section
Birth			Plurality	2.16.840.1.113883.10.20.26.41	57722-1	*Entry*
Birth			Birth Order	2.16.840.1.113883.10.20.26.16	73771-8	*Entry*
Birth			Number of Infants Born Alive	2.16.840.1.113883.10.20.26.37	73773-4	*Entry*
Birth			Abnormal Conditions of the Newborn	2.16.840.1.113883.10.20.26.13	73812-0	*Entry*
Birth			Congenital Anomaly	2.16.840.1.113883.10.20.26.19	73780-9	*Entry*
Birth			Infant Transfer	2.16.840.1.113883.10.20.26.29	73758-5	*Entry*
Birth			Infant Living	2.16.840.1.113883.10.20.26.28	73757-7	*Entry*
Birth			Infant Breastfed	2.16.840.1.113883.10.20.26.27	73756-9	*Entry*
Birth	5.1		Newborns Vital Signs Section	2.16.840.1.113883.10.20.26.11	8716-3	Sub-Section
Birth	5.2		Assessments Section	2.16.840.1.113883.10.20.26.9	51848-0	Sub-Section
FD	5	Fetal Delivery Section		2.16.840.1.113883.10.20.26.4	MISSING LOINC	Section
FD			*Plurality*	2.16.840.1.113883.10.20.26.41	57722-1	*Entry*
FD			*Birth Order*	2.16.840.1.113883.10.20.26.16	73771-8	*Entry*
FD			*Number of Infants Born Alive*	2.16.840.1.113883.10.20.26.37	73773-4	*Entry*
FD			*Autopsy Performance*	2.16.840.1.113883.10.20.26.15	73768-4	*Entry*
FD			*Fetal Death Occurrence*	2.16.840.1.113883.10.20.26.22	73811-2	*Entry*
FD			*Congenital Anomaly*	2.16.840.1.113883.10.20.26.19	73780-9	*Entry*
FD			*Fetal Delivery Time*	2.16.840.1.113883.10.20.26.23	11778-8	*Entry*

Appendix B – LDS-VR Document Quick Reference

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

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
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
2	Admission Medication History	1.3.6.1.4.1.19376.1.5.3.1.3.20	42346-7	Section
	Medications			Entry
3	Chief Complaint	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	10154-3	Section
	No entries defined			*Entry*
4	Transport Mode	1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2	11459-5	Section
	Transport (act)	*1.3.6.1.4.1.19376.1.5.3.1.1.10.4.1*		*Entry*
5	Assessment and Plan	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	51847-2	Section
	No Entries Defined			*Entry*
6	Pain Assessment Panel	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4	38212-7	Section
	No entries defined			*Entry*

Section Reference #	LDS-VR	TemplateId	LOINC	Type
7	Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	30954-2	Section
	Procedure Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
	References Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.4*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
8	Coded Antenatal Testing and Surveillance	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	57078-8	Section
	Antenatal Testing and Surveillance Battery	*1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10*		*Entry*
9	Coded History of Infection	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	56838-6	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
10	Pregnancy History	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	10162-6	Section
	Pregnancy History Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5.1*		*Entry*
	Pregnancy Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5*		*Entry*
11	History of Present Illness	1.3.6.1.4.1.19376.1.5.3.1.3.4	10164-2	Section
	No Entries Defined			*Entry*
12	History of Past Illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	11348-0	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.5*		*Entry*
13	Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	11450-4	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
14	Advance Directives	1.3.6.1.4.1.19376.1.5.3.1.3.34	42348-3	Section
	No entries defined			*Entry*
15	Birth Plan	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	57079-6	Section
	No entries defined			*Entry*
16	Allergies and Other Adverse Reactions	1.3.6.1.4.1.19376.1.5.3.1.3.13	48765-2	Section

Section Reference #	LDS-VR	TemplateId	LOINC	Type
	Allergy Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.3*		*Entry*
	Allergy Intolerances Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.6*		*Entry*
17	Detailed Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	29545-1	Section
	No Entries Defined			*Entry*
17.1	Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	8716-3	Section
	Vital Signs Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.1*		*Entry*
	Vital Signs Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.2*		*Entry*
18	Estimated Delivery Dates	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	57060-6	Section
	Estimated Delivery Date Observation (a simple observation)	*1.3.6.1.4.1.19376.1.5.3.1.1.11.2.3.1*		*Entry*
19	Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	18610-6	Section
	Medications	*1.3.6.1.4.1.19376.1.5.3.1.4.7*		*Entry*
20	Intravenous Fluids Administered	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	57072-1	Section
	Intravenous Fluids (substanceAdministration)	*1.3.6.1.4.1.19376.1.5.3.1.1.13.3.2*		*Entry*
21	Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	XX-IntakeAndOutput	Section
	No entries defined			*Entry*
22	Estimated Blood Loss	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	8717-1	Section
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
23	History of Blood Transfusions	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	56836-0	Section
	No Entries Defined			*Entry*
24	History of Surgical Procedures	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	10167-5	Section
	No Entries Defined			*Entry*
25	Labor and Delivery Events	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	57074-7	Section

Section Reference #	LDS-VR	TemplateId	LOINC	Type
	No Entries Defined			*Entry*
25.1	Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	10167-5	Section
	Procedures	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
25.2	Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	42545-4	Section
	Patient Transfer (act)	*1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26	Newborn Delivery Information	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	57075-4	Section
	No Entries Defined			*Entry*
26.1	Detailed Physical Examination	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	29545-1	Section
	No Entries Defined			*Entry*
26.1.1	Coded Vital Signs	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	8716-3	Section
	Vital Signs Organizer	*1.3.6.1.4.1.19376.1.5.3.1.4.13.1*		*Entry*
	Vital Signs Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13.2*		*Entry*
26.1.2	General Appearance	1.3.6.1.4.1.19376.1.5.3.1.1.9.16	10210-3	Section
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
26.2	Active Problems	1.3.6.1.4.1.19376.1.5.3.1.3.6	11450-4	Section
	Problem Concern	*1.3.6.1.4.1.19376.1.5.3.1.4.5.2*		*Entry*
	Problem Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.5*		*Entry*
26.3	Procedures and Interventions	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	10167-5	Section
	Procedure	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
26.4	Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	18610-6	Section
	Medications	*1.3.6.1.4.1.19376.1.5.3.1.4.7*		*Entry*
26.5	Event Outcomes	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	42545-4	Section
	No entries defined.			*Entry*
26.6	Coded Event Outcomes	1.3.6.1.4.1.19376.1.7.3.1.1.13.7	42545-4	Section

Section Reference #	LDS-VR	TemplateId	LOINC	Type
	Patient Transfer	*1.3.6.1.4.1.19376.1.5.3.1.1.25.1.4.1*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26.7	Coded Results	1.3.6.1.4.1.19376.1.5.3.1.3.28	30954-2	Section
	Procedure Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.19*		*Entry*
	References Entry	*1.3.6.1.4.1.19376.1.5.3.1.4.4*		*Entry*
	Simple Observation	*1.3.6.1.4.1.19376.1.5.3.1.4.13*		*Entry*
26.8	Intake and Output	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	XX-IntakeAndOutput	Section
	No entries defined			*Entry*
27	Payers	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	48768-6	Section
	Coverage Entity	*1.3.6.1.4.1.19376.1.5.3.1.4.17*		*Entry*

Volume 3 Namespace Additions

Add the following terms to the IHE Namespace:

Add to section 5 Namespaces and Vocabularies

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

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

Add to section 5.1.1 IHE Format Codes

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

Add to section 5.1.2 IHE ActCode Vocabulary

No new ActCode Vocabulary

Add to section 5.1.3 IHE RoleCode Vocabulary

No new RoleCode Vocabulary

Volume 4 – National Extensions

Add appropriate Country section

4 National Extensions

4.I National Extensions for IHE USA

4.I.1 Comment Submission

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

http://www.ihe.net/QRPH_Public_Comments

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

4.I.2.1 BFDR US Volume 1 Constraints

4.I.2.1.1 BFDR Actors and Options US Constraints

The US National Extension constrains the actors and options defined in QRPH TF-1: Table X.2-1: BFDR - Actors and Options. Birth and Fetal Death reporting in the US requires that State Jurisdictions support the following Profile Options for message transactions that will be conducted with NCHS and Provider information sources. Information is also provided for prospective Infrastructure/HIE communications that may serve to facilitate some of these communications.

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

The hospital is responsible for completing the Record of Live Birth in the jurisdiction's Electronic Birth Registration System (EBRS). Information collected from the mother on the mother’s live birth information must be data entered into the 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. Select birth data may be transmitted later to public health authorities as allowed by individual state statute and other vital records stakeholders

4.I.2.2 BFDR US Volume 2 Constraints

The following table shows the optionality for the PID segment that differ for the US National Extension.

Table 3.37.4.1.2.4-1: IHE Profile - PID segment

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
1	4	SI	O	O	O		00104	Set ID - Patient ID	Literal Value: '1'.
2	20	CX	O	O	O		00105	Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.
3	250	CX	R	R	R		00106	Patient Identifier List	Field used to convey all types of patient/person identifiers. Use of the Medical Record Number is expected if the birth (for the baby) or fetal death (for the mother) takes place in a hospital, or the baby is admitted to one.
4	20	CX	O	O	O		00107	Alternate Patient ID	Deprecated as of HL7 Version 2.3.1. See PID-3.
5	250	XPN	R	R	R		00108	Patient Name	New born name. In the case of fetal death reporting, the name is for the mother.
6	**250**	**XPN**	**O+**	**O**	**O+**		**00109**	**Mother's Maiden Name**	**Optional in IG, but Optional in PIX** **Additional constraint included for international support**
7	26	TS	RE	RE	RE		00110	Date/Time of Birth	Newborn's date and time of birth, or (for fetal death reporting) the mother's. Format: YYYY[MM[DD[HH[MM[SS[.S[S[S[S]]]]]]]]][+/-ZZZZ]
8	1	IS	RE	RE	RE	0001	00111	Administrative Sex	Sex of the newborn or of the fetus.
9	250	XPN	O	O	O		00112	Patient Alias	Deprecated as of HL7 Version 2.4. See PID-5 Patient Name.
10	250	RCE	O	RE	O	0005	00113	Race	

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
11	250	XAD	RE	RE	O		00114	Patient Address	Address type code = Birth Address. Only use the field, if the birth or fetal delivery does not take place in a healthcare facility. When used, the field captures the place of birth, or the place of fetal delivery. Street address, city, state and zip code are expected. If descriptive information is provided instead of an address, the Other Geographic Designation component of the XAD data type is used. Note, either PID.11 or ROL.11 may be used to record the place of birth or delivery depending on circumstances.
12	4	IS	O	O	O	0289	00115	County Code	Deprecated as of HL7 Version 2.3. See PID-11 - Patient Address, component 9 County/Parish Code.
13	250	XTN	O	O	O		00116	Phone Number – Home	
14	250	XTN	O	O	O		00117	Phone Number - Business	
15	250	CE	O	O	O	0296	00118	Primary Language	
16	250	CE	O	O	O	0002	00119	Marital Status	
17	250	CE	O	O	O	0006	00120	Religion	
18	250	CX	O	O	O		00121	Patient Account Number	
19	16	ST	O	O	O		00122	SSN Number – Patient	Deprecated as of HL7 Version 2.3.1. See PID-3 Patient Identifier List.
20	25	DLN	O	O	O		00123	Driver's License Number - Patient	Deprecated as of HL7 Version 2.5. See PID-3 Patient Identifier List.
21	250	CX	O	O	O		00124	Mother's Identifier	
22	250	CE	O	RE	O	0189	00125	Ethnic Group	
23	250	ST	O	O	O		00126	Birth Place	
24	1	ID	RE	O	O	0136	00127	Multiple Birth Indicator	Indicates whether the baby or fetus was part of a multiple birth.

SEQ	LEN	DT	OPT			TBL #	ITEM #	ELEMENT NAME	Description/ Comments
			LB	FD	ID				
25	2	N M	RE	O	O		00128	Birth Order	Indicate the order delivered in the pregnancy of the baby or fetus, aka "Set Number". Leave the field empty for singleton births or deliveries.
26	250	CE	O	O	O	0171	00129	Citizenship	
27	250	CE	O	O	O	0172	00130	Veterans Military Status	
28	**250**	**CE**	**O+**	**O+**	**O+**	**0212**	**00739**	**Nationality**	**Constrained for international use.**
29	26	TS	O	O	O		00740	Patient Death Date and Time	
30	1	ID	O	O	O	0136	00741	Patient Death Indicator	
31			O	O	O			Identity Unknown Indicator	
32			O	O	O			Identity Reliability Code	
33			O	O	O			Last Update Date/Time	
34			O	O	O			Last Update Facility	
35			O	O	O			Species Code	
36			O	O	O			Breed Code	
37			O	O	O			Strain	
38			O	O	O			Production Class Code	
39			O	O	O			Tribal Citizenship	

Adapted from the HL7 standard, Version 2.6

4.I.2.3 BFDR US Volume 3 Constraints

4.I.2.3.1 BFDR US Forms Pre-population

The U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death SHALL use derived elements to populate the processing variables as indicated in Table 6.6.1-1: Form Data Elements Data Mapped to Input Content Document Modules and as specified in the Birth Edit Specifications and the Fetal Death Edit Specifications for the 2003 Revisions of the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death.

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

The U.S. currently limits the data that may be pre-populated from an EMR for birth and fetal death events to a subset of vital records' medical/health data requirements, that is, primarily those items included in the U.S. Standard Facility Worksheet for the Live Birth Certificate and the U.S. Standard Facility Worksheet for the Report of Fetal Death. The initial goal will be to monitor and assess the quality of the data that will be exchanged between electronic health record and vital records systems and the quality of the process of information exchange.

4.I.2.3.2 BFDR-E Data Element Index

A relevant data set for birth and fetal death record content reporting includes those elements identified within the US efforts under the CDC/National Center for Health Statistics (NCHS) that can be computed from data elements in the electronic health record. The BFDR-E Summary CDA mapping rules described below overlays these data elements typically presented to the birth registrar. This Derived Data Element Index specifies which sections are intended to cover which domains, the value sets to be used to interpret the Summary CDA®Document content, and rules for examining Summary CDA content to determine whether or not the data element is satisfied. These rules may specify examination of one or more Summary CDA Document locations to make a determination of the data element result. The list includes derived data elements that compose knowledge concepts not currently represented in standards, most of which are optional. Where such standards do not exist, the Form Manager will enhance with non-standard fields. Any Summary CDA document may be used to populate the form.

4.I.2.3.3 BFDR-E Form Manager Pre-population Data Element Mapping Specification

Table 4.I.2.1.2-1 describes the US domain mapping to the BFDR-e data elements and the form for the U.S. Standard Facility Worksheet for the Live Birth Certificate. It also indicates attributes that are permissible in the US for pre-population and those that require data entry. Further edit specifications are in the Birth Edit Specifications for the 2003 Revision of the U.S. Standard

Certificate of Live Birth (4/2004; 3/2005; Updated 7/2012). Mapping to these attributes is also provided below. For the US, all of the data elements are required. Form Managers SHALL support direct data entry to offer the opportunity to modify all pre-populated information before it is submitted to VR systems

NOTE: The following attributes are no longer part of the National requirements, but may continue to be used by the jurisdictions:

- CERV
- BINJ
- TOC
- PROM
- PRIC
- PROL
- HIST
- LM
- GBS
- CMV
- B19
- TOXO

Table 4.I.2.1.2-1: Form Element Mapping Specification for Birth

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Facility name: Include the name of Facility where birth occurred	The name of the facility where the delivery took place. If not an institution, give street and number.	1	Pre-populate	FNAME
Facility I.D. (National Provider Identifier)	Facility National Provider Identifier	2	Pre-populate	FNPI
Facility: City, Town or Location of birth	The name of the city, town, township, village, or other location where the birth occurred.	3	Pre-populate	ADDRESS_DFLOC

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Facility: County of birth	The name of the county where the birth occurred.	4	Pre-populate	CNAME CNTYO
Type of Place of birth	The type of place where the birth occurred.	5	Pre-populate	BPLACE
Date of first prenatal care visit	The date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	6	Pre-populate	DOFP_YR, DOFP_MO, DOFP_DY
No Prenatal Care	There was no prenatal care.	6	Pre-populate	PNC
Total number of prenatal care visits for this pregnancy	The total number of prenatal visits recorded in the record.	7	Pre-populate	NPREV
Date last normal menses began	The date the mother's last normal menstrual period began. This item is used to compute the gestational age of the infant.	8	Pre-populate	DLMP_YR, DLMP_MO, DLMP_DY
<!-- #9. Number of previous live births now living -->	The total number of previous live-born infants now living.	9	Pre-populate	PLBL
Number of previous live births now dead	The total number of previous live-born infants now dead..	10	Pre-populate	PLBD
Date of last live birth	The date of birth of the last live-born infant.	11	Pre-populate	YLLB, MLLB
Total number of other pregnancy outcomes	The total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	12	Pre-populate	POPO
Date of last other pregnancy outcome	The date of the last pregnancy that did not result in a live birth ended. Includes pregnancy losses of any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	13	Pre-populate	YOPO, MOPO
Risk factors in this pregnancy	Risk factors of the mother during this pregnancy.	14	Pre-populate	GDIAB, PHYPE, GHYPE, PPB, VB, INFT, PCES, NPCES

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Infections present and/or treated during this pregnancy	Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	15	Pre-populate	GON, SYPH, CHAM, HEPB, HEPC
Obstetric procedures	Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	16	Pre-populate	CERV, TOC, ECVS, ECVF
Onset of Labor	Serious complications experienced by the mother associated with labor and delivery.	17	Pre-populate	PROM, PRIC, PROL
Date of birth	The infant's date of birth	18	Pre-populate	IDOB_YR, IDOB_MO, IDOB_DY
Time of birth	The infant's time of birth	19	Pre-populate	TB
Certifier's name and title: OMIT	The individual who certified to the fact that the birth occurred.	20	Direct Data Entry	No Attribute conveyed
Date certified:	The date that the birth was certified.	21	Direct Data Entry	No Attribute conveyed
Principal source of payment for this delivery	The principal source of payment at the time of delivery.	22	Pre-populate	PAY
Infant's medical record number	The medical record number assigned to the newborn.	23	Pre-populate	IRECNUM
Was the mother transferred to this facility for maternal medical or fetal indications for delivery?	Information about the transfer status of the mother prior to delivery. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	24	Pre-populate	TRAN
Attendant's name	The name of the person responsible for delivering the child.	25A	Pre-populate	ATTENDN
Attendants title	The title of the person responsible for delivering the child. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.	25B	Pre-populate	ATTEND

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Attendant's N.P.I	The National Provider Identification Number of the person responsible for delivering the child. The attendant at birth is defined as the individual physically present at the delivery who is responsible for the delivery.	25C	Pre-populate	NPI
Mother's weight at delivery	The mother's weight at the time of delivery. The preferred unit of measure is in pounds.	26	Pre-populate	DWGT
Characteristics of labor and delivery	Information about the course of labor and delivery.	27	Pre-populate	INDL, AUGL, STER, ANTB, CHOR, ESAN
Method of Delivery	The physical process by which the complete delivery of the fetus was affected.	28	Pre-populate	ROUT, PRES, TLAB
Maternal morbidity	Serious complications experienced by the mother associated with labor and delivery.	29	Pre-populate	MTR, PLAC, RUT, UHYS, AINT, UOPR
Birthweight	The weight of the infant at birth. The preferred unit of measure is in grams.	30	Pre-populate	BWG
Obstetric estimate of gestation at delivery	The best obstetric estimate to the infants gestation in completed weeks based on birth attendant's final estimate of gestation. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam.	31	Pre-populate	OWGEST
Sex (Male, Female, or Not yet determined)	Sex of the infant.	32	Pre-populate	ISEX
APGAR Score at 5 minutes	A systematic measure for evaluating the physical condition of the infant at 5 minutes following birth.	33A	Pre-populate	APGAR5
APGAR Score at 10 minutes-	A systematic measure for evaluating the physical condition of the infant at 10 minutes following birth. The APGAR score at 10 minutes is documented if the score at 5 minutes is less than 6.	33B	Pre-populate	APGAR10

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Plurality	The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy.	34	Pre-populate	PLUR
If not single birth (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): Not Applicable	The order born in the delivery, live-born or fetal death.	35	Pre-populate	SORD
If not single birth, specify number of infants in this delivery born alive	The number of infants in this delivery born alive at any point in the pregnancy.	36	Pre-populate	LIVEB
Abnormal conditions of the newborn	Disorders or significant morbidity experienced by the newborn.	37	Pre-populate	AVEN1, AVEN6, NICU, SURF, ANTI, SEIZ, BINJ
Congenital anomalies of the newborn	Malformations of the newborn diagnosed prenatally or after delivery.	38	Pre-populate	ANEN, MNSB, CCHD, CDH, OMPH, GAST, LIMB, CL, CP, DOWN, DOWC, DOWP, CDIS, CDIC, CDIP, HYPO
Was infant transferred within 24 hours of delivery	Transfer status of the infant within 24 hours after delivery.	39	Pre-populate	ITRAN
Is infant living at time of report	Information on the infant's survival.	40	Pre-populate	ILIV

US Birth Registration Form Question	Description	Mapping to US Birth Registration Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Is infant being breastfed at discharge	Information on whether the infant is being breast-fed before discharge from the hospital.	41	Pre-populate	BFED
Maternal height	The mother's height The preferred unit of measure is in feet and inches.	42	Pre-populate	HFT, HIN
Maternal weight immediately before this pregnancy	The mother's pre-pregnancy weight The preferred unit of measure is in pounds.	43	Pre-populate	PWGT

7230 **Table 4.I.2.1.2-2: Form Element Mapping Specification for Fetal Death**

US Fetal Death Report Form Question	Description	Mapping to US Fetal Death Report Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Facility name: Include the name of Facility where birth occurred-	The name of the facility where the delivery took place. If not an institution, give street and number.	1	Pre-populate	FNAME
Facility I.D. (National Provider Identifier)	Facility National Provider Identifier	2	Pre-populate	FNPI
Facility: City, Town or Location of delivery	The name of the city, town, township, village, or other location where the birth occurred.	3	Pre-populate	FLOC
Facility: County of delivery	The name of the county where the delivery occurred.	4	Pre-populate	CNAME CNTYO
Type of Place of delivery	The type of place where the delivery occurred.	5	Pre-populate	BPLACE
Date of first prenatal care visit	The date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	6	Pre-populate	DOFP_YR, DOFP_MO, DOFP_DY
No Prenatal Care	There was no prenatal care.	6	Pre-populate	PNC

US Fetal Death Report Form Question	Description	Mapping to US Fetal Death Report Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Total number of prenatal care visits for this pregnancy	The total number of prenatal visits recorded in the record.	7	Pre-populate	NPREV
Date last normal menses began	The date the mother/patient's last normal menstrual period began. This item is used to compute the gestational age of the fetus.	8	Pre-populate	DLMP_YR, DLMP_MO, DLMP_DY
Number of previous live births now living	The total number of previous live-born infants now living.	9	Pre-populate	PLBL
Number of previous live births now dead	The total number of previous live-born infants now dead.	10	Pre-populate	PLBD
Date of last live birth	The date of birth of the last live-born infant.	11	Pre-populate	YLLB, MLLB
Total number of other pregnancy outcomes	The total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	12	Pre-populate	POPO
Date of last other pregnancy outcome	The date of the last pregnancy that did not result in a live birth ended. Includes pregnancy losses of any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	13	Pre-populate	YOPO, MOPO
Risk factors in this pregnancy	Risk factors of the mother during this pregnancy.	14	Pre-populate	GDIAB, PHYPE, GHYPE, PPB, PPO, VB, INFT, PCES, NPCES
Infections present and/or treated during this pregnancy	Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	15	Pre-populate	GON, SYPH, CHAM, LM, GBS, CMV, B19, TOXO

US Fetal Death Report Form Question	Description	Mapping to US Fetal Death Report Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Date of Delivery	The fetus' date of delivery	16	Pre-populate	FDOD_YR , FDOD_MO , FDOD_DY ,
Time of Delivery	The fetus' date of delivery	17	Pre-populate	TD
Name and title of person completing report:	The individual who certified to the fact that the delivery occurred.	18	Direct Data Entry	No Attribute conveyed
Date Report Completed	The date that the delivery was certified.	19	Direct Data Entry	No Attribute conveyed
Was the mother transferred to this facility for maternal medical or fetal indications for delivery?	Information about the transfer status of the mother prior to delivery. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	20	Pre-populate	TRAN
Attendant's name	The name of the person responsible for delivering the fetus.	21A	Pre-populate	ATTENDN
Attendants title	The title of the person responsible for delivering the fetus. The attendant is defined as the individual physically present at the delivery who is responsible for the delivery.	21B	Pre-populate	ATTEND
Attendant's N.P.I.	The National Provider Identification Number of the person responsible for delivering the fetus. The attendant is defined as the individual physically present at the delivery who is responsible for the delivery.	21C	Pre-populate	NPI
Mother/patient's weight at delivery	The mother/patient's weight at the time of delivery. The preferred unit of measure is in pounds.	22	Pre-populate	DWGT
Method of Delivery:	Information about the course of labor and delivery.	23	Pre-populate	ROUT, PRES, TLAB, HYST
Maternal morbidity	Serious complications experienced by the mother/patient associated with labor and delivery.	24	Pre-populate	MTR, PLAC, RUT, UHYS, AINT, UOPR
Weight of Fetus:	The weight of the fetus at delivery. The preferred unit of measure is in grams.	25	Pre-populate	FWG

US Fetal Death Report Form Question	Description	Mapping to US Fetal Death Report Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Obstetric estimate of gestation at delivery	The best obstetric estimate to the fetus gestation in completed weeks based on birth attendant's final estimate of gestation. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam.	26	Pre-populate	OWGEST
Sex (Male, Female, or Unknown):	Sex of the fetus.	27	Pre-populate	FSEX
Plurality	The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy.	28	Pre-populate	PLUR
If not single delivery (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): Not Applicable-	The order this fetus was delivered in the set. Include all live-births and fetal death.	29	Pre-populate	SORD
If not single birth, specify number of infants in this delivery born alive	The number of infants in this delivery born alive at any point in the pregnancy.	30	Pre-populate	LIVEB
Malformations of the fetus diagnosed prenatally or after delivery	Malformations of the fetus diagnosed prenatally or after delivery.	31	Pre-populate	ANEN, MNSB, CCHD, CDH, OMPH, GAST, LIMB, CL, CP, DOWC, DOWN, DOWP, CDIC, CDIS, CDIP, HYPO
Method of Disposition OMIT	Method of final disposition of the dead fetus.	32	Direct Data Entry	No Attribute conveyed

US Fetal Death Report Form Question	Description	Mapping to US Fetal Death Report Form Number	US Requirements for Direct Data Entry or Pre-populate	BFDR-E Data Element
Initiating Cause/Condition OMIT	The initiating cause/condition is for reporting a single condition that most likely began the sequence of events resulting in the death of the fetus.	33	Direct Data Entry	No Attribute conveyed
Other Significant Causes or Conditions OMIT	Other significant causes or conditions include all other conditions contributing to death. These conditions may be conditions that are triggered by the initiating cause or causes that are not among the sequence of events triggered by the initiating cause.	34	Direct Data Entry	No Attribute conveyed
Was an autopsy performed?	Information on whether or not an autopsy was performed.	35	Pre-populate	AUTOP
Was a histological placental examination performed?	Information on whether or not a histological placental examination was performed.	36	Pre-populate	HISTOP
Were autopsy or histological placental examination results used in determining the cause of fetal death? OMIT	Information on whether the findings of the autopsy or histological placental examination, if performed, were used in completing the medical portion of the fetal death report.	37	Direct Data Entry	No Attribute conveyed
Estimated time of fetal death	Item to indicate when the fetus died with respect to labor and assessment.	38	Pre-populate	ETIME

