Integrating the Healthcare Enterprise

IHE Quality, Research and Public Health (QRPH)

Technical Framework Supplement

Maternal Child Health - Birth and Fetal Death Reporting (MCH-BFDrpt)

Trial Implementation

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Author: Lori Reed-Fourquet, Michelle Williamson

Email: qrph@ihe.net

Foreword

This is a supplement to the IHE Quality, Research and Public Health (QRPH) Trial Implementation 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 submitted for Trial Implementation as of September 2, 2011 and will be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the QRPH Final Text Technical Framework. Comments are invited and can be submitted at http://www.ihe.net/qrph/qrphcomments.cfm or by email to qrph@ihe.net.

This supplement describes changes to the existing technical framework documents and where indicated amends text by addition (**bold underline**) or removal (~~**bold strikethrough**~~), as well as addition of large new sections introduced by editor's instructions to "add new text" or similar, which for readability are not bolded or underlined.

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

Replace Section X.X by the following:

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CONTENTS

INTRODUCTION **12**

PROFILE ABSTRACT 13
OPEN ISSUES AND QUESTIONS 13
CLOSED ISSUES 13

VOLUME 1 – PROFILES **14**

1.7 HISTORY OF ANNUAL CHANGES 14
1.N COPYRIGHT PERMISSION 14
2.1 DEPENDENCIES AMONG PROFILES 14
2.2.X Maternal Child Health- Birth and Fetal Death Reporting (MCH-BFDrpt) Profile *14*

X MATERNAL CHILD HEALTH- BIRTH AND FETAL DEATH REPORTING (MCH-BFDRPT) PROFILE **15**

X.1 MCH-BFDRPT ACTORS/TRANSACTIONS 15
X.1.1 Actor Descriptions and Requirements *16*
X.2 MCH-BFDRPT OPTIONS 17
X.3 MCH-BFDRPT ACTOR GROUPINGS AND PROFILE INTERACTIONS 17
X.4 MCH-BFDRPT PROCESS FLOW 17
X.4.1 Use Cases *17*
X.4.2 Process Flow *18*
X.5 MCH-BFDRPT SECURITY CONSIDERATIONS 19

APPENDIX A ACTOR SUMMARY DEFINITIONS **21**

APPENDIX B TRANSACTION SUMMARY DEFINITIONS **21**

APPENDIX X SPECIFICATION OF PRE-POPULATION DATA FOR MCH-BFDRPT PROFILE **21**

5 NAMESPACES AND VOCABULARIES **23**

5.1.1 IHE FORMAT CODES 23

6 QRPH CONTENT MODULES **24**

6.2 FOLDER CONTENT MODULES 24
6.3 HL7 VERSION 3.0 CONTENT MODULES 24
6.3.1 CDA Document Content Modules *24*

<APPENDIX Z> SPECIFICATION OF VALUE SETS USED IN THE MCH-BFDRPT PROFILE **47**

APPENDIX A MCH FILTER VALUE SETS **47**

A.1 MCH HBS FACILITY LOCATION NICU CODES 47
A.1.1 Metadata *47*
A.1.2 Facility Location NICU Value Set Table *48*
A.2 MCH HBS FACILITY LOCATION ICU CODES 48
A.2.1 Metadata *48*
A.2.2 Facility Location ICU Value Set Table *49*
A.3 MCH HBS FACILITY LOCATION OR CODES 49
A.3.1 Metadata *49*
A.3.2 Facility Location OR Value Set Table *50*

A.4 MCH HBS ANTIBIOTICS CODES 50
A.4.1 Metadata *50*
A.4.2 MCH HBS Antibiotics Value Set Table *51*
A.5 MCH HBS IV MEDICATION ADMINISTRATION CODES 56
A.5.1 Metadata *56*
A.5.2 MCH HBS IV Medication Administration Route Value Set *57*
A.6 MCH HBS INTRAMUSCULAR MEDICATION ADMINISTRATION ROUTE CODES 57
A.6.1 Metadata *57*
A.6.2 MCH HBS Intramuscular Administration Route Value Set *58*
A.7 MCH HBS NEONATAL SEPSIS CODES 58
A.7.1 Metadata *58*
A.7.2 MCH HBS Neonatal Sepsis Value Set *59*
A.8 QRPH MCH HBS ASSISTED VENTILATION IMMEDIATELY FOLLOWING DELIVERY CODES 60
A.8.1 Metadata *60*
A.8.2 MCH HBS Assisted Ventilation Immediately Following Delivery Value Set *61*
A.9 MCH HBS ASSISTED VENTILATION FOR 6 OR MORE HOURS CODES 61
A.9.1 Metadata *61*
A.9.2 MCH HBS Assisted Ventilation for 6 or More Hours Value Set *62*
A.10 QRPH MCH HBS SIGNIFICANT BIRTH INJURY CODES 62
A.10.1 Metadata *62*
A.10.2 MCH HBS Significant Birth Injury Value Set *63*
A.11 QRPH MCH HBS SEIZURE OR SERIOUS NEUROLOGIC DYSFUNCTION CODES 65
A.11.1 Metadata *65*
A.11.2 MCH HBS Seizure or Serious Neurologic Dysfunction Value Set *66*
A.12 QRPH MCH HBS NEWBORN RECEIVING SURFACTANT REPLACEMENT THERAPY CODES 68
A.12.1 Metadata *68*
A.12.2 MCH HBS Newborn Receiving Surfactant Replacement Therapy Value Set *68*
A.13 QRPH MCH HBS NEONATAL DEATH CODES 69
A.13.1 Metadata *69*
A.13.2 MCH HBS Neonatal Death Value Set *70*
A.14 QRPH MCH HBS 5 MIN APGAR SCORE CODES 70
A.14.1 Metadata *70*
A.14.2 MCH HBS 5 Min Apgar Score Value Set *71*
A.15 QRPH MCH HBS 10 MIN APGAR SCORE CODES 71
A.15.1 Metadata *71*
A.15.2 MCH HBS 10 Min Apgar Score Value Set *72*
A.16 QRPH MCH HBS DELIVERY CODES 72
A.16.1 Metadata *72*
A.16.2 MCH HBS Delivery Value Set *73*
A.17 QRPH MCH HBS PHYSICIAN CODES 77
A.17.1 Metadata *77*
A.17.2 MCH HBS Physician Value Set *78*
A.18 QRPH MCH HBS DOCTOR OF OSTEOPATHIC MEDICINE CODES 78
A.18.1 Metadata *78*
A.18.2 MCH Doctor of Osteopathic Medicine Value Set *79*
A.19 QRPH MCH HBS CERTIFIED MIDWIFE MEDICINE CODES 79
A.19.1 Metadata *79*
A.19.2 MCH HBS Certified Midwife Value Set *80*
A.20 QRPH MCH HBS MIDWIFE MEDICINE CODES 80
A.20.1 Metadata *80*
A.20.2 MCH HBS Midwife Value Set *81*
A.21 QRPH MCH HBS U.S. TERRITORIES CODES 82

A.21.1 Metadata *82*
A.21.2 MCH HBS U.S. Territories Value Set *83*
A.22 QRPH MCH HBS BIRTH WEIGHT CODE 83
A.22.1 Metadata *83*
A.22.2 MCH HBS Birth Weight Value Set *84*
A.23 QRPH MCH HBS MEASURED HEIGHT CODES 84
A.23.1 Metadata *84*
A.23.2 MCH HBS Measured Height Value Set *85*
A.24 QRPH MCH HBS PRE-PREGNANCY WEIGHT CODES 85
A.24.1 Metadata *85*
A.24.2 MCH HBS Pre-Pregnancy Weight Value Set *86*
A.25 QRPH MCH HBS MOTHER'S DELIVERY WEIGHT CODES 86
A.25.1 Metadata *86*
A.25.2 MCH HBS Mother's Delivery Weight Value Set *87*
A.26 QRPH MCH HBS PREVIOUS OTHER PREGNANCY OUTCOMES CODES 87
A.26.1 Metadata *87*
A.26.2 MCH HBS Previous Other Pregnancy Outcomes Value Set *88*
A.27 QRPH MCH HBS NUMBER OF PREVIOUS LIVE BIRTHS NOW DEAD CODES 88
A.27.1 Metadata *88*
A.27.2 MCH HBS Number of Previous Live Births Now Dead Value Set *89*
A.28 QRPH MCH HBS NUMBER OF PREVIOUS LIVE BIRTHS NOW LIVING CODES 89
A.28.1 Metadata *90*
A.28.2 MCH HBS Number of Previous Live Births Now Living Value Set *90*
A.29 QRPH MCH HBS OBSTETRIC ESTIMATE OF GESTATION CODES 91
A.29.1 Metadata *91*
A.29.2 MCH HBS Obstetric Estimate of Gestation Value Set *91*
A.30 QRPH MCH HBS BIRTH PLURALITY OF DELIVERY CODES 92
A.30.1 Metadata *92*
A.30.2 A.32.2 MCH HBS Birth Plurality of Delivery Value Set *92*
A.31 QRPH MCH HBS FIRST PRENATAL CARE VISIT CODES 93
A.31.1 Metadata *93*
A.31.2 MCH HBS First Prenatal Care Visit Value Set *93*
A.32 QRPH MCH HBS LAST PRENATAL CARE VISIT CODES 94
A.32.1 Metadata *94*
A.32.2 MCH HBS Last Prenatal Care Visit Value Set *94*
A.33 QRPH MCH HBS NUMBER PRENATAL CARE VISITS CODES 95
A.33.1 Metadata *95*
A.33.2 MCH HBS Number Prenatal Care Visits Value Set *95*
A.34 QRPH MCH HBS AUGMENTATION OF LABOR – PROCEDURE CODES 96
A.34.1 Metadata *96*
A.34.2 MCH HBS Augmentation of Labor - Procedure Value Set *96*
A.35 QRPH MCH HBS AUGMENTATION OF LABOR – MEDICATION CODES 97
A.35.1 Metadata *97*
A.35.2 MCH HBS Augmentation of Labor - Medication Value Set *97*
A.36 QRPH MCH HBS CHORIOAMNIONITIS DURING LABOR CODES 98
A.36.1 Metadata *98*
A.36.2 MCH HBS Chorioamnionitis During Labor Value Set *98*
A.37 QRPH MCH HBS FEVER GREATER THAN 100.4 CODES 99
A.37.1 Metadata *99*
A.37.2 MCH HBS Fever Greater Than 100.4 Value Set *100*
A.38 QRPH MCH HBS EPIDURAL ANESTHESIA – MEDICATION CODES 100
A.38.1 Metadata *100*

A.38.2 MCH HBS Epidural Anesthesia - Medication Value Set *101*
A.39 QRPH MCH HBS EPIDURAL ANESTHESIA - PROCEDURE CODES 103
A.39.1 Metadata *103*
A.39.2 MCH HBS Epidural Anesthesia - Procedure Value Set *103*
A.40 QRPH MCH HBS SPINAL ANESTHESIA – MEDICATION CODES 104
A.40.1 Metadata *104*
A.40.2 MCH HBS Spinal Anesthesia - Medication Value Set *105*
A.41 QRPH MCH HBS SPINAL ANESTHESIA - PROCEDURE LABOR CODES 107
A.41.1 Metadata *107*
A.41.2 MHC HBS Spinal Anesthesia - Procedure Value Set *108*
A.42 QRPH MCH HBS FETAL INTOLERANCE OF LABOR CODES 109
A.42.1 Metadata *109*
A.42.2 MCH HBS Fetal Intolerance of Labor Value Set *110*
A.43 QRPH MCH HBS IN-UTERO RESUSCITATION CODES 111
A.43.1 Metadata *111*
A.43.2 MCH HBS In-utero Resuscitation Value Set *112*
A.44 QRPH MCH HBS FURTHER FETAL ASSESSMENT CODES 112
A.44.1 Metadata *112*
A.44.2 MCH HBS Further Fetal Assessment Value Set *113*
A.45 QRPH MCH HBS OPERATIVE DELIVERY ASSESSMENT CODES 113
A.45.1 Metadata *113*
A.45.2 MCH HBS Operative Delivery Value Set *114*
A.46 QRPH MCH HBS INDUCTION OF LABOR CODES 117
A.46.1 Metadata *117*
A.46.2 MCH HBS Induction of Labor Value Set *118*
A.47 QRPH MCH HBS SPONTANEOUS ONSET OF LABOR CODES 119
A.47.1 Metadata *119*
A.47.2 MCH HBS Spontaneous Onset of Labor Value Set *120*
A.48 QRPH MCH HBS MECONIUM STAINING CODES 120
A.48.1 Metadata *120*
A.48.2 MCH HBS Meconium Staining Value Set *121*
A.49 QRPH MCH HBS NON-VERTEX PRESENTATION IN ACTIVE PHASE OF LABOR AND DELIVERY CODES 121
A.49.1 Metadata *121*
A.49.2 MCH HBS Non-vertex presentation in active phase of labor and delivery Value Set *122*
A.50 QRPH MCH HBS GLUCOCORTICO STEROIDS CODES 123
A.50.1 Metadata *123*
A.50.2 MCH HBS Glucocortico Steroids Value Set *124*
A.51 QRPH MCH HBS BREASTFED INFANT CODES 124
A.51.1 Metadata *124*
A.51.2 MCH HBS Breastfed Infant Value Set *125*
A.52 QRPH MCH HBS MALE GENDER CODES 126
A.52.1 Metadata *126*
A.52.2 MCH HBS Male Gender Value Set *126*
A.53 QRPH MCH HBS FEMALE GENDER CODES 127
A.53.1 Metadata *127*
A.53.2 MCH HBS Female Gender Value Set *127*
A.54 QRPH MCH HBS DISCHARGE TRANSFER CODES 128
A.54.1 Metadata *128*
A.54.2 MCH HBS Discharge Transfer Value Set *128*
A.55 QRPH MCH HBS ANENCEPHALY OF THE NEWBORN CODES 129
A.55.1 Metadata *129*
A.55.2 MCH HBS Anencephaly of the Newborn Value Set *129*

A.56 QRPH MCH HBS CYANOTIC CONGENITAL HEART DISEASE CODES 130
A.56.1 Metadata *130*
A.56.2 MCH HBS Cyanotic Congenital Heart Disease Value Set *131*
A.57 QRPH MCH HBS CONGENITAL DIAPHRAGMATIC HERNIA CODES 135
A.57.1 Metadata *135*
A.57.2 MCH HSB Congenital Diaphragmatic Hernia Value Set *135*
A.58 QRPH MCH HBS KARYOTYPE CONFIRMED CODES 136
A.58.1 Metadata *136*
A.58.2 MCH HBS Karyotype Confirmed Value Set *137*
A.59 QRPH MCH HBS SUSPECTED CHROMOSOMAL DISORDER CODES 137
A.59.1 Metadata *137*
A.59.2 MCH HBS Suspected Chromosomal Disorder Value Set *138*
A.60 QRPH MCH HBS CLEFT LIP WITH/WITHOUT CLEFT PALATE CODES 141
A.60.1 Metadata *141*
A.60.2 MCH HBS Cleft Lip with/without Cleft Palate Value Set *142*
A.61 QRPH MCH HBS KARYOTYPE RESULT CODES 143
A.61.1 Metadata *143*
A.61.2 MCH HBS Karyotype Result Value Set *143*
A.62 QRPH MCH HBS CLEFT LIP WITHOUT CLEFT PALATE CODES 144
A.62.1 Metadata *144*
A.62.2 MCH HSB Cleft Lip without Cleft Palate Value Set *145*
A.63 QRPH MCH HBS DOWNS SYNDROME CODES 145
A.63.1 Metadata *145*
A.63.2 MCH HSB Downs Syndrome Value Set *146*
A.64 QRPH MCH HBS GASTROSCHISIS OF THE NEWBORN CODES 147
A.64.1 Metadata *147*
A.64.2 MCH HBS Gastroschisis of the Newborn Value Set *147*
A.65 QRPH MCH HBS HYPOSPADIAS CODES 148
A.65.1 Metadata *148*
A.65.2 MCH HBS Hypospadias Value Set *148*
A.66 QRPH MCH HBS LIMB REDUCTION DEFECT CODES 149
A.66.1 Metadata *149*
A.66.2 MCH HSB Limb Reduction Defect Value Set *150*
A.67 QRPH MCH HBS MENINGOMYELOCELE/SPINA BIFIDA OF THE NEWBORN CODES 151
A.67.1 Metadata *151*
A.67.2 MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set *152*
A.68 QRPH MCH HBS OMPHALOCELE OF THE NEWBORN CODES 154
A.68.1 Metadata *154*
A.68.2 MCH HBS Omphalocele of the Newborn Value Set *155*
A.69 QRPH MCH HBS DATE OF LAST LIVE BIRTH CODES 155
A.69.1 Metadata *155*
A.69.2 MCH HSB Date of Last Live Birth Value Set *156*
A.70 QRPH MCH HBS NUMBER OF LIVE BIRTHS CODES 156
A.70.1 Metadata *156*
A.70.2 MCH HBS Number of Live Births Value Set *157*
A.71 QRPH MCH HBS DATE OF LAST MENSES CODES 158
A.71.1 Metadata *158*
A.71.2 MCH HBS Date of Last Menses Value Set *158*
A.72 QRPH MCH HBS DATE OF LAST OTHER PREGNANCY OUTCOME CODES 159
A.72.1 Metadata *159*
A.72.2 MCH HBS Date of Last Other Pregnancy Outcome Value Set *159*
A.73 QRPH MCH HBS NUMBER OF PRIOR PREGNANCIES CODES 160

A.73.1 Metadata *160*
A.73.2 MCH Number of Prior Pregnancies Value Set *160*
A.74 MCH HBS PROBLEM STATUS ACTIVE CODES 161
A.74.1 Metadata *161*
A.74.2 MCH HBS Problem Status Active Value Set *161*
A.75 QRPH MCH HBS CHLAMYDIA CODES 162
A.75.1 Metadata *162*
A.75.2 MCH HBS Clamydia Value Set *162*
A.76 QRPH MCH HBS GONORRHEA CODES 164
A.76.1 Metadata *164*
A.76.2 MCH HBS Gonorrhea Value Set *165*
A.77 QRPH MCH HBS HEPATITIS B CODES 169
A.77.1 Metadata *169*
A.77.2 MCH HBS Hepatitis B Value Set *170*
A.78 QRPH MCH HBS HEPATITIS C CODES 170
A.78.1 Metadata *170*
A.78.2 MCH HBS Hepatitis C Value Set *171*
A.79 QRPH MCH HBS SYPHILIS CODES 172
A.79.1 Metadata *172*
A.79.2 MCH HBS Syphilis Value Set *173*
A.80 QRPH MCH HBS CONCEPTION DATE CODES 179
A.80.1 Metadata *179*
A.80.2 MCH HBS Conception Date Value Set *180*
A.81 QRPH MCH HBS TRANSFUSION WHOLE BLOOD OR PACKED RED BLOOD CODES 180
A.81.1 Metadata *180*
A.81.2 MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set *181*
A.82 QRPH MCH HBS THIRD DEGREE PERINEAL LACERATION CODES 182
A.82.1 Metadata *182*
A.82.2 MCH HBS Third Degree Perineal Laceration Value Set *182*
A.83 QRPH MCH HBS FOURTH DEGREE PERINEAL LACERATION CODES 183
A.83.1 Metadata *183*
A.83.2 MCH HBS Fourth Degree Perineal Laceration Value Set *184*
A.84 QRPH MCH HBS RUPTURED UTERUS CODES 184
A.84.1 Metadata *184*
A.84.2 MCH HBS Ruptured Uterus Value Set *185*
A.85 QRPH MCH HBS UNPLANNED HYSTERECTOMY CODES 185
A.85.1 Metadata *185*
A.85.2 MCH HBS Unplanned Hysterectomy Value Set *186*
A.86 QRPH MCH HBS UNPLANNED OPERATION CODES 186
A.86.1 Metadata *186*
A.86.2 MCH HBS Unplanned Operation Value Set *187*
A.87 QRPH MCH HBS FETAL PRESENTATION AT BIRTH- BREECH CODES 189
A.87.1 Metadata *189*
A.87.2 MCH HBS Fetal Presentation at Birth- Breech Value Set *189*
A.88 QRPH MCH HBS FETAL PRESENTATION AT BIRTH- CEPHALIC CODES 191
A.88.1 Metadata *191*
A.88.2 MCH HBS Fetal Presentation at Birth- Cephalic Value Set *191*
A.89 QRPH MCH HBS FETAL PRESENTATION AT BIRTH- OTHER CODES 192
A.89.1 Metadata *192*
A.89.2 MCH HBS Fetal Presentation at Birth- Other Value Set *193*
A.90 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY - SPONTANEOUS DELIVERY CODES 194
A.90.1 Metadata *194*

A.90.2 MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set *194*
A.91 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY - FORCEPS DELIVERY CODES 195
A.91.1 Metadata *195*
A.91.2 MCH HBS Route and Method of Delivery - Forceps Delivery Value Set *196*
A.92 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY - VACUUM DELIVERY CODES 197
A.92.1 Metadata *197*
A.92.2 MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set *198*
A.93 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY - CESAREAN DELIVERY CODES 198
A.93.1 Metadata *198*
A.93.2 MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set *199*
A.94 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY – TRIAL OF LABOR CODES 200
A.94.1 Metadata *200*
A.94.2 MCH HBS Route and Method of Delivery - Trial of Labor Value Set *201*
A.95 QRPH MCH HBS ROUTE AND METHOD OF DELIVERY - SCHEDULED CESAREAN CODES 201
A.95.1 Metadata *201*
A.95.2 MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set *202*
A.96 QRPH MCH HBS CERVICAL CERCLAGE CODES 202
A.96.1 Metadata *202*
A.96.2 MCH HBS Cervical Cerclage Value Set *203*
A.97 QRPH MCH HBS STATED HEIGHT CODES 204
A.97.1 Metadata *204*
A.97.2 MCH HBS Stated Height Value Set *204*
A.98 QRPH MCH HBS EXTERNAL CEPHALIC VERSION CODE 205
A.98.1 Metadata *205*
A.98.2 MCH HBS External Cephalic VersionValue Set *205*
A.99 QRPH MCH HBS TOCOLYSIS CODES 206
A.99.1 Metadata *206*
A.99.2 MCH HBS Tocolysis Value Set *206*
A.100 QRPH MCH HBS PREMATURE RUPTURE CODES 207
A.100.1 Metadata *207*
A.100.2 MCH HBS Premature Rupture Value Set *208*
A.101 QRPH MCH HBS PRECIPITOUS LABOR CODES 208
A.101.1 Metadata *208*
A.101.2 MCH HBS Precipitous Labor Value Set *209*
A.102 QRPH MCH HBS PROLONGED LABOR CODES 210
A.102.1 Metadata *210*
A.102.2 MCH HBS Prolonged Labor Value Set *210*
A.103 QRPH MCH HBS PREPREGNANCY DIABETES CODES 211
A.103.1 Metadata *211*
A.103.2 MCH HBS Prepregnancy Diabetes Value Set *212*
A.104 QRPH MCH HBS GESTATIONAL DIABETES CODES 218
A.104.1 Metadata *218*
A.104.2 MCH HBS Gestational Diabetes Value Set *219*
A.105 QRPH MCH HBS PREPREGNANCY HYPERTENSION CODES 220
A.105.1 Metadata *220*
A.105.2 MCH HBS Prepregnancy Hypertension Value Set *220*
A.106 QRPH MCH HBS GESTATIONAL HYPERTENSION CODES 224
A.106.1 Metadata *224*
A.106.2 MCH HBS Gestational Hypertension Value Set *225*
A.107 QRPH MCH HBS ECLAMPSIA CODES 226
A.107.1 Metadata *226*
A.107.2 MCH HBS Eclampsia Value Set *227*

A.108 QRPH MCH HBS PRETERM BIRTH CODES 227
A.108.1 Metadata *227*
A.108.2 MCH HBS Preterm Birth Value Set *228*
A.109 QRPH MCH HBS POOR PREGNANCY OUTCOME – HISTORY CODES 229
A.109.1 Metadata *229*
A.109.2 MCH HBS Poor Pregnancy Outcome – History Value Set *229*
A.110 QRPH MCH HBS INFERTILITY TREATMENT CODES 230
A.110.1 Metadata *230*
A.110.2 MCH HBS Infertility Treatment Value Set *231*
A.111 QRPH MCH HBS FERTILITY ENHANCING DRUGS MEDICATIONS CODES 232
A.111.1 Metadata *232*
A.111.2 MCH HBS Fertility Enhancing Drugs Value Set *233*
A.112 QRPH MCH HBS ARTIFICIAL OR INTRAUTERINE INSEMINATION CODES 237
A.112.1 Metadata *237*
A.112.2 MCH HBS Artificial or Intrauterine Value Set *238*
A.113 QRPH MCH HBS ASSISTIVE REPRODUCTIVE TECHNOLOGY CODES 239
A.113.1 Metadata *239*
A.113.2 MCH HBS Assistive Reproductive Technology Value Set *240*
A.114 QRPH MCH HBS PREVIOUS CESAREAN CODES 240
A.114.1 Metadata *241*
A.114.2 MCH HBS Previous Cesarean Value Set *241*
A.115 QRPH MCH HBS NUMBER OF PREVIOUS CESAREANS CODES 242
A.115.1 Metadata *242*
A.115.2 MCH Number of Previous Cesareans Value Set *243*
A.116 QRPH MCH HBS TIME OF DEATH CODES 243
A.116.1 Metadata *243*
A.116.2 MCH Time of Death Value Set *244*
A.117 QRPH MCH HBS HYSTEROTOMY/ HYSTERECTOMY CODES 244
A.117.1 Metadata *244*
A.117.2 MCH HBS Hysterotomy/Hysterectomy Value Set *245*
A.118 QRPH MCH HBS FETUS WEIGHT CODES 246
A.118.1 Metadata *246*
A.118.2 MCH Fetus Weight Value Set *247*
A.119 QRPH MCH HBS HISTOLOGICAL PLACENTAL EXAMINATION CODES 247
A.119.1 Metadata *247*
A.119.2 MCH Histological Placental Examination Value Set *248*
A.120 QRPH MCH HBS FETAL AUTOPSY CODES 248
A.120.1 Metadata *248*
A.120.2 MCH Fetal Autopsy Value Set *249*
A.121 QRPH MCH HBS KARYOTYPE DETERMINATION CODES 250
A.121.1 Metadata *250*
A.121.2 MCH Karyotype Determination Value Set *251*
A.122 QRPH MCH HBS NUMBER OF FETAL DEATHS THIS DELIVERY CODES 251
A.122.1 Metadata *251*
A.122.2 MCH HBS Number of Fetal Deaths This Delivery Value Set *252*
A.123 QRPH MCH HBS LISTERIA CODES 252
A.123.1 Metadata *252*
A.123.2 MCH HBS Listeria Value Set *253*
A.124 QRPH MCH HBS GROUP B STREPTOCOCCUS CODES 254
A.124.1 Metadata *254*
A.124.2 MCH HBS Group B Streptococcus Value Set *255*
A.125 QRPH MCH HBS CYTOMEGALOVIRUS CODES 255

A.125.1 Metadata *255*
A.125.2 MCH HBS Cytomegalovirus Value Set *256*
A.126 QRPH MCH HBS PARVOVIRUS CODES 257
A.126.1 Metadata *257*
A.126.2 MCH HBS Parvovirus Value Set *258*
A.127 QRPH MCH HBS TOXOPLASMOSIS CODES 258
A.127.1 Metadata *258*
A.127.2 MCH HBS Toxoplasmosis Value Set *259*
A.128 QRPH MCH HBS STATE CODES 260
A.128.1 Metadata *260*
A.128.2 MCH HBS State Value Set *261*
A.129 QRPH MCH HBS MCH HBS TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY CODES 261
A.129.1 Metadata *261*
A.129.2 MCH HBS MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set 262
A.130 QRPH MCH HBS TRANSFER IN CODES 262
A.130.1 Metadata *262*
A.130.2 MCH HBS Transfer In Value Set *263*
A.131 QRPH MCH HBS MCH HBS ANTIBIOTIC ADMINISTRATION PROCEDURE CODES 264
A.131.1 Metadata *264*
A.131.2 MCH HBS Antibiotic Administration Procedure Value Set *264*
A.132 QRPH MCH HBS GENDER OBSERVATION VALUE SET CODES 265
A.132.1 Metadata *265*
A.132.2 MCH HBS Gender Observation Value Set *265*
A.133 QRPH MCH HBS BIRTHPLACE VALUE SET CODES 266
A.133.1 Metadata *266*
A.133.2 MCH HBS Birthplace Value Set *266*

GLOSSARY **268**

VOLUME 2 – TRANSACTIONS **275**

VOLUME 3 – CONTENT MODULES **276**

6.3.1 CDA Document Content Modules *276*
6.3.2 CDA Header Content Modules *276*
6.3.3 CDA Section Content Modules *276*
6.3.4 CDA Entry Content Modules *276*

VOLUME 4 – NATIONAL EXTENSIONS FOR IHE UNITED STATES **277**

5.0 NATIONAL EXTENSIONS FOR IHE UNITED STATES **277**

5.X PRE-POPULATION SPECIFICATION FOR US STANDARDS CERTIFICATE OF LIVE BIRTH AND US STANDARD REPORT OF FETAL DEATH 277
5.x.1 Data Element Index *277*
5.x.2 Form Manager Pre-population Data Element Mapping Specification *278*

Introduction

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

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

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

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

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

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

Profile Abstract

Specific vital statistics data as well as medical data is collected by social services and public health organizations within the early years of the child's life in order to administer preventative/prophylactic measures, and perform epidemiological studies.

The general physician, pediatrician, obstetrician, labor and delivery nurse and other hospital staff provide information for the certificates.[3] Completion of the form(s) is required by law in some countries because they are used as key-indicators of the child's health.

The Maternal Child Health- Birth and Fetal Death Reporting (MCH-BFDrpt) Profile describes the content and format to be used within the pre-population data part of the Retrieve Form Request transaction from the RFD Integration Profile. It is expected that the Form Filler and Form Manager will implement the RFD transaction as specified in the RFD, and this profile does not include any additional constraints or extensions on the RFD transactions.

This profile describes the content to be used in automating the data captured for vital records purposes such as for the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death[4].

Open Issues and Questions

1. A common, standardized vocabulary and datasets is needed so that the data aggregation can be achieved.
2. When forms are partially filled, the data source actor should have the possibility to store this form and complete it later.
3. Not all the information might be present, depending on the existence of an antepartum summary (APS) and a labor and delivery summary (LDS). Informative appendix with preliminary recommendations for LDS content requirements included, but not fully specified as Volume 3 content

Closed Issues

[3] The birth certificate and the health certificates contain the same type of information. The difference is due to national extensions practices.

[4] These can also be early childhood health certificates in other countries such as France.

Volume 1 – Profiles

1.7 History of Annual Changes

Add the following bullet to the end of the bullet list in section 1.7

- Added the MCH-BFDrpt Profile which specifies pre-population of selected medical/health birth certificate and fetal death information forms from the PCC Labor and Delivery Summary document.

1.n Copyright Permission

<Add information on any standards referenced in the profile that are not already addressed in the permission section.>

Add the following to sections 1.n:

2.1 Dependencies among Profiles

Add the following to Table 2-1

MCH-BFDrpt	Labor and Delivery Summary (LDS)	Content profile	This profile provides some of the content needed to pre-populate the forms needed in MCH content profile.

Add the following section to section 2.2.X

2.2.X Maternal Child Health- Birth and Fetal Death Reporting (MCH-BFDrpt) Profile

Add Section X

X Maternal Child Health- Birth and Fetal Death Reporting (MCH-BFDrpt) Profile

The MCH-BFDrpt Profile is based on the ITI RFD profile. The reader is referred to ITI TF 1:X for a description of the ITI RFD profile. This MCH-BFDrpt Profile defines the content that is used to pre-populate the form retrieved from the Form Manager, and the specification of the pre-population rules to be executed by the Form Manager. This profile does not further constrain the Form Receiver or Form Archiver actors. The prepop data is defined by the IHE PCC LDS Profile. See QRPH 1: Appendix X for the specification of the desired prepop data constraints to PCC LDS that optimize the Birth and fetal death report data pre-population.

X.1 MCH-BFDrpt Actors/Transactions

The MCH-BFDrpt for Public Health Profile defines no new actors or transactions. It uses actors and transactions from the ITI RFD Profile (IHE ITI Technical Framework Supplement: Retrieve Form for Data Capture).

Figure X.1-1 shows the actors directly involved in the Maternal Child Health - Birth and Fetal Death Forms for Public Health Integration Profile and the relevant transactions between them. Actors that may be indirectly involved due to their participation in other profiles are not shown.

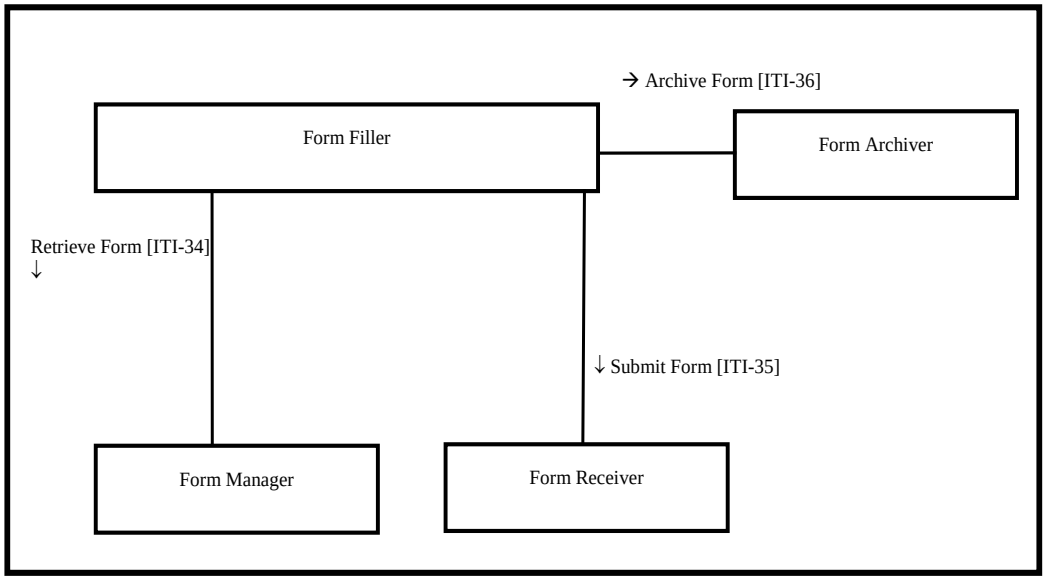


Figure X.1-1. Retrieve Form for Data Capture Actor Diagram

Table X.1-1 lists the transactions for each actor directly involved in the MCH-BFDrpt Profile. In order to claim support of this Profile, an implementation must perform the required transactions (labeled “R”). Transactions labeled “O” are optional. A complete list of options defined by this Profile and that implementations may choose to support is listed in Volume 1, Section X.2.

Table X.1-1. MCH-BFDrpt Profile - Actors and Transactions

Actors	Transactions	Optionality	Section in Vol. 2
Form Filler	Retrieve Form [ITI-34]	R	ITI TF-2b: 3.34
	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
	Archive Form [ITI-36]	O	ITI TF-2b: 3.36
Form Manager	Retrieve Form [ITI-34]	R	ITI TF-2b: 3.34
Form Receiver	Submit Form [ITI-35]	R	ITI TF-2b: 3.35
Form Archiver	Archive Form [ITI-36]	R	ITI TF-2b: 3.36

X.1.1 Actor Descriptions and Requirements

X.1.1.1 Form Filler

The Form Filler is defined in the ITI RFD Profile. In the MCH-BFDrpt Profile, the Form Filler supports the XHMTL format of the Retrieve Form transaction (RFD Trial Implementation Profile, section 2b: 3.34.4.2.3.2).

The Form Filler's support for the LDS pre pop option determines how pre-population data is handled when the Form Filler retrieves the form using ITI-34:

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

If the Form Filler supports the Archive Form option, it shall support the Archive Form transaction ITI-36.

X.1.1.2 Form Manager

The Form Manager is defined in the ITI RFD Profile. In the MCH-BFDrpt Profile, the Form Manger supports the XHMTL format of the Retrieve Form transaction (RFD Trial Implementation Profile, section 2b: 3.34.4.2.3.2).

Within the US, the system fulfilling this roll in the MCH-BFDrpt Profile SHALL accept prepop data in the form of content defined by the IHE PCC LDS Profile and return a form that has been appropriately pre-populated based on the US National Extension (QRPH 4: 5.x Pre-Population Specification for US Standards Certificate of Live Birth and US Standard Report of Fetal Death) for the guidance with respect to the IHE LDS prepop data.

X.1.1.3 Form Receiver

The Form Receiver is defined in the ITI RFD Profile. In the MCH-BFDrpt Profile, the Form Receiver shall receive the populated form from the Form Filler when the form is submitted. No further requirements are placed on the Form Receiver within the scope of this profile. It is however envisioned that in the future the Form Receiver would create a CDA document from the form data and transmit that document to a jurisdictions. These future possibilities are out of scope for the current MCH profile.

X.1.1.4 Form Archiver

The actions of the Form Archiver are defined in the ITI RFD Profile. In the MCH-BFDrpt Profile, the Form Archiver MAY be leveraged to support traceability of the submitted documents that will be a source to the legal record of birth. No further refinements of that document are stated by this profile.

X.2 MCH-BFDrpt Options

Options that may be selected for this Profile are listed in the table X.2-1 along with the Actors to which they apply. Dependencies between options when applicable are specified in notes.

Table X.2-1. MCH-BFDrpt - Actors and Options

Actor	Options	Volume & Section
Form Filler	LDS pre-pop	QRPH TF-1: X.1.1.1
	Archive Form	QRPH TF-1: X.1.1.1
Form Manager	US BFDForm Option	QRPH4:5.x
Form Receiver	No options defined	- -
Form Archiver	No options defined	- -

X.3 MCH-BFDrpt Actor Groupings and Profile Interactions

Each actor in the MCH-BFDrpt Profile directly implements ITI transactions used by the RFD profile. There are no groupings with actors.

X.4 MCH-BFDrpt Process Flow

X.4.1 Use Cases

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

Birth and Fetal Death Edit Specifications for the 2003 Revision of the U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death.

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

The hospital is responsible for completing the Record of Live Birth in the jurisdiction's Electronic Birth Registration System (EBRS). Information collected from the mother on the Mother's Worksheet must be data entered into the EBRS. Facility Worksheet data transmitted electronically into the EBRS from the EHR must be reviewed for completeness and accuracy. The birth records specialist plays an essential role in gathering the information and ensuring that all information is complete before transmission to the vital registration system at the states/jurisdictional vital record offices. Select birth data may be transmitted later to public health authorities as allowed by individual state statute and other vital records stakeholders.

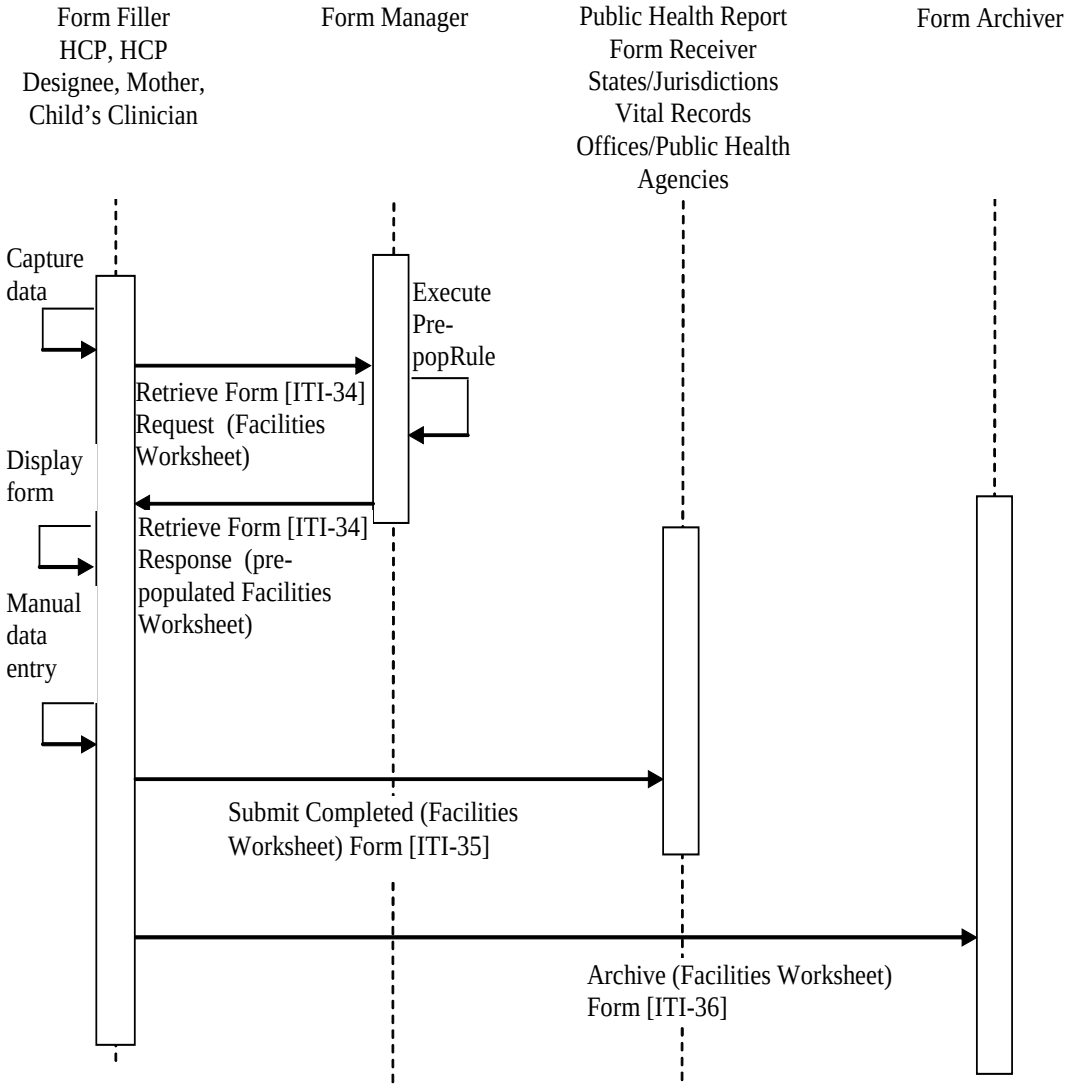
Example Forms:

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

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

X.4.2 Process Flow

The process flow of this profile is defined by the ITI RFD profile. Please refer to ITI TF 1:X 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 MCH-BFDrpt is described below.



680

Figure X.4.2-3 Process Flows

X.5 MCH-BFDrpt Security Considerations

685 MCH-BFDrpt includes clinical content related to the child and the child's mother. As such, it is expected that the transfers of Personal Health Information (PHI) will be protected using ATNA and Consistent Time. The content of the form also results in a legal document, and the Form Manager MAY include a digital signature to assure that the form content submitted cannot be changed.

690 In addition to the usual considerations when sharing PHI, the MCH profile introduces a unique situation since the record is about two patients – the mother and the newborn child. This introduces a risk for data integrity of the mother's and child's record. The mitigation for this risk is achieved through unambiguous documentation of data for the mother and child in sections as defined by IHE PCC LDS and by mapping of data as described by this profile.

695 The IHE ITI ATNA Integration Profile is required 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.

This infrastructure support Security and privacy through the use of the Consistent Time (CT) and Audit Trail and Node Authentication (ATNA) profiles

700

Appendix A Actor Summary Definitions

This supplement does not define any new actors.

Appendix B Transaction Summary Definitions

This supplement does not define any new transactions.

Appendix X Specification of pre-Population Data for MCH-BFDrpt Profile

This is where you need to define the pre-pop data. If you want to argue that it belongs in Volume 2 or elsewhere, I would understand that argument and welcome a discussion. I believe it does not belong inline in section X of Volume 1, but I am not convinced it goes in a Volume 1 appendix.

The following specification is provided to inform PCC LDS Content Creators that will create LDS documents used for MCH-BFDrpt pre-population data. Specifications for the LDS content document are found in the Labor and Delivery Profiles PCC Technical Framework Supplement in section 6.3.1.B and the TemplateId of an LDS content document is 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2. Sections from IHE PCC LDS SHOULD be provided where information is known using the indicated vocabulary:

X.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 MCH Template Identifiers	This is the root OID for all the IHE MCH 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

codeSystem	codeSystemName	Description
2.16.840.1.113883	ServiceDeliveryLocation	See the HL7 ServiceDeliveryLocation Vocabulary
2.16.840.1.113883.12.1	AdministrativeGender	See the HL7 AdministrativeGender Vocabulary
2.16.840.1.113883.5.111	Role	See the HL7 Role Vocabulary
2.16.840.1.113883.5.1077	EducationLevel	See the HL7 EducationLevel Vocabulary
2.16.840.1.113883.6.1	LOINC	Logical Observation Identifier Names and Codes
2.16.840.1.113883.6.96	SNOMED-CT	SNOMED Clinical Terms
2.16.840.1.113883.6.103	ICD-9CM (diagnosis codes)	International Classification of Diseases, Clinical Modifiers, Version 9
2.16.840.1.113883.6.104	ICD-9CM (procedure codes)	International Classification of Diseases, Clinical Modifiers, Version 9
2.16.840.1.113883.6.3	ICD10	International Classification of Diseases revision 10 (ICD 10) Note this does NOT have the CM changes, and is specifically for international use.
2.16.840.1.113883.6.4	ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
2.16.840.1.113883.6.90	ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
2.16.840.1.113883.6.26	MEDCIN	A classification system from MEDICOMP Systems.
2.16.840.1.113883.6.88	RxNorm	RxNorm
2.16.840.1.113883.6.63	FDDC	First DataBank Drug Codes
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)

5 Namespaces and Vocabularies

Add the following rows to the QRPH TF-2:5.0 Namespaces and Vocabularies

5.1.1 IHE Format Codes

Add the following rows to the QRPH TF-2:5.1.1 IHE Format Codes

Profile	Format Code	Media Type	Template ID
2011 Profiles			
MCH-BFDrpt	urn:ihe:qrph:BFDF:2011	Text/XML	1.3.6.1.4.1.19376.1.7.3.1.1.19.1.1

6 QRPH Content Modules

6.2 Folder Content Modules

No new folder content modules added with this supplement.

6.3 HL7 Version 3.0 Content Modules

6.3.1 CDA Document Content Modules

Add section 6.3.1.A

6.3.1.A Labor and Delivery Summary for Vital Records (LDS-VR) Specification (included here as an Informative Annex)

The Labor and Delivery Summary for Vital Records (LDS-VR) constrains the PCC Labor and Delivery Summary (LDS) to maximize the pre-population ability for feeds to the Vital Records System using this profile. This includes requirements for the following sections:

Child's Metadata

- Birthplace
- Date of Birth
- Person Name
- Child's Medical Record Number
- Child's Gender
- Child's Facility Address
- Child's Facility Name
- Child's Facility NPI ID
- Child's Birthplace
- Child's Gender

Mother's Metadata Entry

- Mother's facility location
- Mother's facility location
- effectiveTime
- Marital Status
- Mother's Name

- Mother's Person ID

Mother's Encounter

- Referring Facility Name
- Admission Source

Payers

- Coverage Entry

Newborn Delivery Information

- Medications Administered:
  - Indication
  - Coded Product Name
  - Route
- Active Problems:
  - Problem Code
- Disposition
- Procedures and Interventions:
  - Procedure ID
  - Procedure Date/Time
- Coded Results:
  - Result Type
  - Result Value

Child's Encounter

- dischargeDispositionCode
- effectiveTime
- Referred To Facility

Child's Coded Events Outcome

- Result Type
- Result Value

Labor and Delivery

- Procedures and Interventions
  - Provider Name
  - Procedure ID
  - Provider Type
  - Provider ID (NPI)
  - Procedure Date/Time
- Medications Administered
  - Coded Product Name
  - Medications Administered
  - Route
- Active Problems
  - Problem Code
- Coded Results
  - Result Type
  - Result Value
- Multiple Birth Indication
  - Event Outcome
  - Birth Order

Pregnancy History

- Coded Results
  - Result Type
  - Result Value
- Active Problems
  - Problem Code

Coded History of Infection Section

- Active Problems
  - Problem Code

Prenatal Events

- Active Problems
  - Problem Code
  - Problem Status
- Coded Results
  - Result Type
  - Result Value
  - Result Value Units
- Procedures and Interventions
  - Procedure ID
  - Procedure Date/Time
- Medications Administered
  - Coded Product Name

6.3.1.A.1 LOINC Code

The LOINC code for this document is **57057-2** Labor and delivery summary

6.3.1.A.2 Parent Template

This document is an instance of the Labor and Delivery Summary template.

6.3.1.A.3 Standards

CCD	ASTM/HL7 Continuity of Care Document
CDAR2	HL7 CDA Release 2.0
ACOG AR	American College of Obstetricians and Gynecologists (ACOG), Antepartum Record
LOINC	Logical Observation Identifiers, Names and Codes
SNOMED	Systemized Nomenclature for Medicine
CDTHP	CDA for Common Document Types History and Physical Notes (DSTU)

6.3.1.A.4 Specification

This section references content modules using Template ID as the key identifier. Definitions of the modules are found in either:

- IHE Patient Care Coordination Volume 2: Final Text
- IHE PCC Content Modules 2010-2011 Supplement

The Record Target of this CDA document shall reference the mother. All sections listed in Table 6.3.1.A.4-1 shall refer to the mother. All sections listed in Table 6.3.1.A.4-2 shall refer to the newborn and shall include the subject at the section level. Multiple newborns shall be

represented with each newborn having his/her own section. The IHE PCC LDS is further constrained as described below.

The following table describes content within the LDS that will result in a more fully pre-populated form for the form filler. The way that this differs from the current LDS is:

The following optional sections of LDS are defined as Required, or Required if known here:

No new optionality: all LDS specified sections are listed as R and R2

These sections not currently in LDS are included here:

- Mother's Encounter
- Payers
- Pregnancy History
- Coded History of Infection
- Labor and Delivery Events: Medications Subsection
- Labor and Delivery Events: Active Problems Subsection
- Newborn Delivery Information: Procedures and Interventions Subsection
- Newborn's Encounter
- Newborn's Disposition

All of the IHE PCC LDS constraints apply. The QRPH LDS-VR further constrains the IHE PCC LDS as follows:

Table 6.3.1.A.4-1 LDS-VR Document Section Specification

Template Name	Opt	Section Template Id	Value Set Template Id
Mother's Encounter	R2	2.16.840.1.113883.10.20.1.21	Admission Source ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/participant[@typeCode='ORG']/code MCH HBS Transfer In Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177
Payers	R2	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	Payer ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7]]/code

Template Name	Opt	Section Template Id	Value Set Template Id
Pregnancy History	R	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	NOTE: this is not a currently defined section within the LDS document Pregnancy observation code and associated value 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 SHALL include the following observations if known: MCH HSB Date of Last Live Birth Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67 [NOTE: Code Pending] MCH HBS Number of Live Births Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68 MCH HBS Date of Last Menses Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69 MCH HBS Date of Last Other Pregnancy Outcome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70 [NOTE: Code Pending] MCH HBS Number of Previous Live Births Now Dead Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122 [NOTE: Code Pending] MCH HBS Number of Previous Live Births Now Living Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123 MCH HBS Obstetric Estimate of Gestation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124 MCH Number of Previous Cesareans Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148 [NOTE: Code Pending]

Template Name	Opt	Section Template Id	Value Set Template Id
Coded History of Infection Section	R2	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1	Problem code, 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/code SHALL include the following problems and status (e.g. active) if known: MCH HBS Chlamydia Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93 MCH HBS Gonorrhea Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94 MCH HBS Hepatitis B Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96 MCH HBS Hepatitis C Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97 MCH HBS Syphilis Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98 MCH HBS Listeria Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.165 MCH HBS Group B Streptococcus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166 MCH HBS Cytomegalovirus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167 MCH HBS Parvovirus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168 MCH HBS Toxoplasmosis Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169 MCH HBS Other Pregnancy Infection Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Hospital Admission Diagnosis This section shall indicate the reasons for admitting the mother to the birthing facility (e.g. premature labor, ruptured membrane).	R	1.3.6.1.4.1.19376.1.5.3.1.3.3	N/A
Admission Medication History	R2	1.3.6.1.4.1.19376.1.5.3.1.3.20	Medication Coded Product, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.20]]/ substanceAdministration/code SHALL include the following substance administration history if known and associated administration dates/times: MCH HBS Fertility Enhancing Drugs 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144

Template Name	Opt	Section Template Id	Value Set Template Id
Coded Results This section shall contain any lab draws during the delivery time interval including: Cord Blood Gas(es); Cord Blood for Type/Cross, Rh and Coomb's Test. The Antepartum Laboratory Value Set may be used to represent the results.	R	1.3.6.1.4.1.19376.1.5.3.1.3.28	Coded results code, ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']]/entry/act/entryRelationship/observation/code SHALL include the following observations, associated values, and units if known: MCH HBS Pre-Pregnancy Weight Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118 MCH HBS Last Prenatal Care Visit Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134 [NOTE: Code Pending] MCH HBS Number Prenatal Care Visits Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135 [NOTE: Code Pending]
Coded Antenatal Testing and Surveillance	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1	1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10
History of Present Illness	R	1.3.6.1.4.1.19376.1.5.3.1.3.4	N/A

Template Name	Opt	Section Template Id	Value Set Template Id
History of Past Illness This section shall include clinically relevant information to the labor and delivery. This section should use the codes as specified in the Antepartum History and Physical History of Past Illness Value Set.	R	1.3.6.1.4.1.19376.1.5.3.1.3.8	Problem code, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.8]]/entry/act/entryRelationship/observation/code SHALL include the following problems if known: MCH HBS Previous Cesarean Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147 MCH Number of Previous Cesareans Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148 MCH HBS Prepregnancy Diabetes Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136 MCH HBS Gestational Diabetes Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137 MCH HBS Prepregnancy Hypertension Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138 MCH HBS Gestational Hypertension Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139 MCH HBS Eclampsia Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140 MCH HBS Preterm BirthValue Set (History of), 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141 MCH HBS Poor Pregnancy Outcome – History Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142

Template Name	Opt	Section Template Id	Value Set Template Id
Problems This section shall include the patient's current active problem list as well as any labor, delivery and/or operative complications the patient may have including significant fever > 100.4.	R	1.3.6.1.4.1.19376.1.5.3.1.3.6	Problem code, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.6]]/entry/act/entryRelationship/observation/code SHALL include the following problems if known: MCH HBS Previous Cesarean Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147 MCH HBS Chlamydia Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93 MCH HBS Gonorrhea Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94 MCH HBS Hepatitis B Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96 MCH HBS Hepatitis C Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97 MCH HBS Syphilis Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98 MCH HBS Listeria Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.165 MCH HBS Group B Streptococcus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166 MCH HBS Cytomegalovirus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167 MCH HBS Parvovirus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168 MCH HBS Toxoplasmosis Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169 MCH HBS Other Pregnancy Infection Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Coded Advance Directives	R2	1.3.6.1.4.1.19376.1.5.3.1.3.35	N/A
Birth Plan	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1	N/A

Template Name	Opt	Section Template Id	Value Set Template Id
Allergies and Other Adverse Reactions This section shall include one observation of Latex Allergy which may be negated through the negationInd attribute. Latex Allergy is particularly relevant for Obstetrics because of the frequency of vaginal exams that might involve the use of latex gloves. The observation value code for Latex Allergy is '300916003'. The codeSystem is '2.16.840.1.113883.6.96'. The codeSystemName is 'SNOMED CT'	R	1.3.6.1.4.1.19376.1.5.3.1.3.13	N/A

Template Name	Opt	Section Template Id	Value Set Template Id
Coded Physical Exam This section shall also include mother's weight at delivery.	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	Result type code, 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=1.3.6.1.4.1.19376.1.5.3.1.3.25]]/entry/act/entryRelationship/observation/code SHALL include the following observations, associated values, and units if known MCH HBS Mother's Delivery Weight Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120 MCH HBS Measured Height Value Set , 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.117 MCH HBS Stated Height Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.179
Estimated Delivery Date	R	1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1	N/A
Medications Administered This section shall include the following data elements including route, timing and indication: Anesthesia, Sedatives,Tocolytics,Oxytocin, Antihypertensives, Anticonvulsants/Antispasmodics, Opiates (IM or IV), Antibiotics, Other Medications	R	1.3.6.1.4.1.19376.1.5.3.1.3.21	Medication Coded Product, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/ substanceAdministration/code SHALL include the following substance administrations if known and associated route and administration dates/times: MCH HBS Antibiotics Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3 MCH HBS Augmentation of Labor - Medication Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23 MCH HBS Epidural Anesthesia - Medication Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26 MCH HBS Spinal Anesthesia - Medication Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28 MCH HBS Glucocortico Steroids Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38 Route SHALL be coded using HL7 Route of Administration (2.16.840.1.113883.12.162), specifically indicating the route where IV or IM administration route is used: ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/ substanceAdministration/routeCode MCH HBS IV Medication Administration Route Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4 MCH HBS Intramuscular Administration Route Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5

Template Name	Opt	Section Template Id	Value Set Template Id
Intravenous Fluids Administered This section shall include the types of IV fluids the mother received.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6	N/A
Intake and Output This section shall include any intake and output while the newborn is in the delivery suite (excluding estimated blood loss) such as: first urine/void; stool; gastric output; and if breast fed in the delivery room.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	N/A
Estimated Blood Loss	R2	1.3.6.1.4.1.19376.1.5.3.1.1.9.2	N/A
Transfusion History	R	1.3.6.1.4.1.19376.1.5.3.1.1.9.12	N/A
History of Surgical Procedures This section shall contain any procedure that occurred during the interval between the Labor & Delivery History and Physical and the Labor & Delivery summary time frames.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2	Procedure, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2]]/entry/procedure/code SHALL include the following procedure codes and associated date/timestamps if known: MCH HBS Infertility Treatment Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143 MCH HBS Artificial or Intrauterine Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145 MCH HBS Assistive Reproductive Technology Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146 MCH HBS First Prenatal Care Visit Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133

Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events	R	1.3.6.1.4.1.19376.1 .5.3.1.1.21.2.3	This section shall contain information pertinent to the labor and delivery process including: date/time of labor onset, type of labor, duration of active phase of labor, spontaneous rupture of membranes (date/time), description of amniotic fluid (color, character, odor, amount/quantity), presence of particulate meconium, delivery obstetric provider, delivery date/time, placenta delivery date/time, weeks gestation at time of delivery, presentation of fetus at delivery and fetal monitoring findings. The Labor and Delivery Events Section SHALL contain the following Subsections: The subsection Procedures and Interventions with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 shall contain procedures and interventions specific to labor and delivery events. These may include induction, the delivery type (e.g. vaginal, vaginal birth after cesarean section or cesarean section along with incision type), electronic fetal monitoring, etc. The subsection Event Outcomes with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 shall include event outcomes such as live birth or stillborn and also including maternal death with date/time. The subsection Medications with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include medications administered to the mother during labor and delivery The subsection Active Problems with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include problems occurring during labor and delivery

Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events Procedures and Interventions The subsection Procedures and Interventions with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 shall contain procedures and interventions specific to labor and delivery events. These may include induction, the delivery type (e.g. vaginal, vaginal birth after cesarean section or cesarean section along with incision type), electronic fetal monitoring, etc.	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3, 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	Procedure, Procedure Date and Time ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime SHALL include for the following procedure codes and associated date/timestamps if known: MCH HBS Augmentation of Labor - Procedure Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22 MCH HBS Epidural Anesthesia - Procedure Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27 MHC HBS Spinal Anesthesia - Procedure Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29 MCH HBS In-utero Resuscitation Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31 MCH HBS Operative Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33 MCH HBS Further Fetal Assessment Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32 MCH HBS Induction of Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34 MCH HBS Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14 MCH HBS Unplanned Operation Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105 MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111 MCH HBS Route and Method of Delivery - Forceps Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112 MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113 MCH HBS Route and Method of Delivery - Trial of Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115 MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116 MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114 MCH HBS Cervical Cerclage Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125 MCH HBS External Cephalic Version Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127 MCH HBS Tocolysis Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128

Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events The subsection Event Outcomes with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 shall include event outcomes such as live birth or stillborn and also including maternal death with date/time.	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3, 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	Event outcome, 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=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9]]/entry/act/entryRelationship/observation/code MCH HBS Birth Plurality of Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132 MCH HBS Number of Live Births Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68 MCH HBS Number of Fetal Deaths This Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16
Labor and Delivery Events Medications Sub-Section The subsection Medications with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include medications administered to the mother during labor and delivery	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3, 1.3.6.1.4.1.19376.1.5.3.1.3.21	Medication Coded Product, 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=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code SHALL include the following substance administrations if known and associated route and administration dates/times: MCH HBS Antibiotics Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3 MCH HBS Augmentation of Labor - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23 MCH HBS Epidural Anesthesia - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26 MCH HBS Spinal Anesthesia - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28 MCH HBS Glucocortico Steroids Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38 Route SHALL be coded using HL7 Route of Administration (2.16.840.1.113883.12.162), specifically indicating the route where IV or IM administration route is used: ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode

Template Name	Opt	Section Template Id	Value Set Template Id
Labor and Delivery Events Active Problems Sub-Section The subsection Active Problems with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include problems occurring during labor and delivery	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3, 1.3.6.1.4.1.19376.1.5.3.1.3.6	Problem code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/entry/act/entryRelationship/observation/code SHALL include the following problem codes and associated dates/times if known: MCH HBS Chorioamnionitis During Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24 MCH HBS Fever Greater Than 100.4 Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25 MCH HBS Fetal Intolerance of Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30 MCH HBS Meconium staining Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36 MCH HBS Third Degree Perineal Laceration Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100 MCH HBS Ruptured Uterus Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102 MCH HBS Unplanned Hysterectomy, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103 MCH HBS Fetal Presentation at Birth- Breech Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108 MCH HBS Fetal Presentation at Birth- Cephalic Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109 MCH HBS Fetal Presentation at Birth- Other Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110 MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176 [NOTE: Code pending] MCH HBS Precipitous Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130 MCH HBS Prolonged Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131 MCH HBS Premature Rupture Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129 MCH HBS Precipitous Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130 MCH HBS Prolonged Labor Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131 MCH HBS Hysterotomy/ Hysterectomy Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150 MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99

Template Name	Opt	Section Template Id	Value Set Template Id
Intake and Output	R2	1.3.6.1.4.1.19376.1 .5.3.1.1.20.2.3	N/A

870 **Table 6.3.1.B.4-2 Labor and Delivery Summary Specification (Newborn)**

Templat e Name	Opt	Section Template Id	Value Set Template Id
Coded Results This section shall contain any lab draws during the delivery time interval including: Cord Blood Gas(es); Cord Blood for Type/Cross, Rh and Coomb's Test. The Antepartum Laboratory Value Set may be used to represent the results.	R	1.3.6.1.4.1.19376.1 .5.3.1.3.28`	Coded results code, ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']]/entry/act/entryRelationship/observation/code SHALL include the following observations, associated values and units if known: MCH HBS Karyotype Result Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59 MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
Newborn Delivery Information	R	1.3.6.1.4.1.19376.1 .5.3.1.1.21.2.4	This section shall contain information pertaining to the newborns delivery including the birth date and time. This will be the same as the delivery date/time in the Labor and Delivery events section. The Newborn Delivery Information Section SHALL contain the following Subsections: The subsection Coded Physical Exam with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 shall include information about the newborn such as: gender/sex of the newborn; birth weight; length; head circumference; cord vessel count; gestational age assessment; size (AGA, SGA or LGA); Apgar score assessment ; vital signs, physical exam

Template Name	Opt	Section Template Id	Value Set Template Id
			findings The subsection Medications Administered with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include the medication that was administered to the newborn while in the birthing suite such as: Vitamin K (Aquamephyton) injection; erythromycin eye ointment; and resuscitation medications (if any) including date, time, and route of administration. The subsection Event Outcomes with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 shall include the outcomes of the procedures and interventions such as a resuscitation event. The subsection Procedures and Interventions with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 shall contain procedures and interventions specific to newborn events.
Newborn Delivery Information The subsection Coded Physical Exam with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 shall include information about the newborn such as: gender/sex of the newborn; birth weight; length; head circumference; cord vessel count; gestational age assessment; size (AGA,	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4, 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	Result type code, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/entry/act/entryRelationship/observation/code MCH HBS 5 Min Apgar Score Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12 MCH HBS 10 Min Apgar Score Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13 MCH HBS Birth Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20 MCH HBS Fetus Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68 MCH HBS Karyotype Result Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59 MCH HBS Gender Observation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.183 Result value, 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=1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1]]/entry/act/entryRelationship/observation/value For Gender Observation, Result value SHALL be drawn from MCH HBS Male Gender Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42 MCH HBS Female Gender Value Set

Template Name	Opt	Section Template Id	Value Set Template Id
SGA or LGA); Apgar score assessment; vital signs, physical exam findings			1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
Newborn Delivery Information The subsection Medications Administered with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.21 shall include the medication that was administered to the newborn while in the birthing suite such as: Vitamin K (Aquamephyton) injection; erythromycin eye ointment; and resuscitation medications (if any) including date, time, and route of administrat	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4, 1.3.6.1.4.1.19376.1.5.3.1.3.21	Medication Coded Product, ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/code MCH HBS Antibiotics Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3 Route SHALL be coded using HL7 Route of Administration (2.16.840.1.113883.12.162), specifically indicating the route where IV or IM administration route is used: 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=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/routeCode MCH HBS Intramuscular Administration Route Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5 MCH HBS IV Medication Administration Route Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4 Medication indication SHALL be coded using SNOMED-CTT where Antibiotics are administered for Neonatal Sepsis ClinicalDocument/component/structuredBody/component/section[[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/substanceAdministration/entryRelationship[@typeCode='RSON']/observation[cda:templateId/@root='2.16.840.1.113883.10.20.1.28'] MCH HBS Neonatal Sepsis Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6

Template Name	Opt	Section Template Id	Value Set Template Id
ion.			
Newborn Delivery Information The subsection Event Outcomes with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 shall include the outcomes of the procedures and interventions such as a resuscitation event.	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4, 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	disposition 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=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9]]/entry/act/entryRelationship/observation/code MCH HBS Facility Location NICU Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1 MCH HBS Time of Death Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Newborn Delivery Information Active Problems The subsection Problems with template ID 1.3.6.1.4.1.19376.1.5.3.1.3.6 shall describe problems that the newborn might have had during or immediately prior to	R2	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4, 1.3.6.1.4.1.19376.1.5.3.1.3.6	Problem Code 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=1.3.6.1.4.1.19376.1.5.3.1.3.21]]/entry/act/entryRelationship/observation/code SHALL be included for the following problem codes and associated date/timestamps if known: MCH HBS Significant Birth Injury Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9 MCH HBS Seizure or Serious Neurologic Dysfunction Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10 MCH HBS Anencephaly of the Newborn Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53 MCH HBS Cyanotic Congenital Heart Disease Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54 MCH HSB Congenital Diaphragmatic Hernia Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55 MCH HBS Karyotype Confirmed Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56 MCH HBS Suspected Chromosomal Disorder Value Set,

Template Name	Opt	Section Template Id	Value Set Template Id
delivery as well as delivery complications.			1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57 MCH HBS Suspected Chromosomal Disorder Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57 MCH HBS Suspected Chromosomal Disorder, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57 MCH HBS Cleft Lip with/without Cleft Palate Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58 MCH HSB Cleft Lip without Cleft Palate Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60 MCH HSB Downs Syndrome Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61 MCH HBS Gastroschisis of the Newborn Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62 MCH HBS Hypospadias Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63 MCH HSB Limb Reduction Defect Value Set, 6.1.4.1.19376.1.7.3.1.1.13.8.64 MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65 MCH HBS Omphalocele of the Newborn Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66 MCH HBS Fetal Autopsy Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153 MCH HBS Breastfed Infant Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41 MCH HBS Neonatal Death Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Intake and Output	R2	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3	N/A
Newborn Delivery Information Procedures and Interventions The subsection Procedures and Interventions with template ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 shall contain		1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4, 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	Procedure, Procedure Date and Time ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/code ClinicalDocument/component/structuredBody/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4]]/component/section[templateId[@root=1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11]]/entry/procedure/effectiveTime SHALL be included for the following procedure codes and associated date/timestamps if known: MCH HBS Antibiotic Administration Procedure Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178 MCH HBS Antibiotic Administration Procedure Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178 MCH Assisted Ventilation Immediately Following Delivery Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7 [NOTE: Code Pending] MCH Assisted Ventilation for 6 or More Hours Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.8 [NOTE: Code Pending] MCH HBS Newborn Receiving Surfactant Replacement Therapy Value

Template Name	Opt	Section Template Id	Value Set Template Id
procedures and interventions specific to newborn events.			Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11 MCH HBS Further Fetal Assessment Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32 MCH HBS Breastfed Infant Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41 MCH HBS Neonatal Death Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149 MCH HBS Karyotype Determination Value Set, 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
Encounter	R	2.16.840.1.113883.10.20.1.21	MCH HBS Discharge Transfer Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44
Coded Results This section shall contain any lab draws during the delivery time interval including: Cord Blood Gas(es); Cord Blood for Type/Cross, Rh and Coomb's Test. The Antepartum Laboratory Value Set may be used to represent the results.	R	1.3.6.1.4.1.19376.1.5.3.1.3.28`	Coded results code, ClinicalDocument/component/structuredBody/component/section[templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.3.28']]/entry/act/entryRelationship/observation/code SHALL include the following observations, associated values and units if known: MCH HBS Karyotype Result Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59 MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184

Please note that a sample Labor and Delivery Summary Document supporting optimal pre-population for MCH-BFDrpt is provide at
875 **ftp://ftp.ihe.net/TF_Implementation_Material/QRPH/MCH-BFDrpt/LDS%20Sample%20for%20MCH-BFDrpt.cda.xml**

<Appendix Z> Specification of Value Sets used in the MCH-BFDrpt Profile

Appendix A MCH Filter Value Sets

This appendix contains value sets to be used as filters against coded information described in content profiles. Each section corresponds to a particular content profile in the technical framework.

These value sets may be used by the form filler to determine the values of the pre-populated form based on specific rules.

A.1 MCH HBS Facility Location NICU codes

A.1.1 Metadata

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1
Name	This is the name of the value set	MCH HBS Facility Location NICU Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn was treated in the NICU reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7ServiceDeliveryLocation
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.1.2 Facility Location NICU Value Set Table

MCH Facility Location NICU uses the HL7ServiceDeliveryLocation code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1
Vocabulary:	2.16.840.1.113883
HL7ServiceDeliveryLocation Code	HL7ServiceDeliveryLocation Code description
1039-7	Neonatal critical care unit [Level II/III]
1040-5	Neonatal critical care unit [Level III]
1037-1	Neonatal unit Neonatal unit
1041-3	Step down neonatal ICU [Level II]

A.2 MCH HBS Facility Location ICU codes

A.2.1 Metadata

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2
Name	This is the name of the value set	MCH HBS Facility Location ICU Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the patient (mother) was treated in the ICU reflecting an maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7ServiceDeliveryLocation
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A

Metadata Element	Description	Mandatory
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.2.2 Facility Location ICU Value Set Table

MCH Facility Location ICU uses the HL7ServiceDeliveryLocation code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2
Vocabulary :	2.16.840.1.113883
HL7ServiceDelivery Code	HL7ServiceDeliveryLocation Code description
1027-2	Medical critical care unit
1029-8	Medical/Surgical critical care unit
1035-5	Neurology critical care and stroke unit
1031-4	Neurosurgical critical care unit
1032-2	Surgical cardiothoracic critical care unit
1030-6	Surgical critical care unit
1025-6	Trauma critical care unit

A.3 MCH HBS Facility Location OR codes

A.3.1 Metadata

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104
Name	This is the name of the value set	MCH Facility Location OR Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the patient (mother) was treated in the OR reflecting unplanned operation
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7ServiceDeliveryLocation
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.3.2 Facility Location OR Value Set Table

900 MCH Facility Location OR uses the HL7ServiceDeliveryLocation code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104
Vocabulary	2.16.840.1.113883
HL7ServiceDeliveryLocation Code	Code description
1096-7	Inpatient operating room/suite
1094-2	Operating and recovery rooms

A.4 MCH HBS Antibiotics codes

A.4.1 Metadata

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Name	This is the name of the value set	MCH HBS Antibiotics Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that antibiotics were administered
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

905

A.4.2 MCH HBS Antibiotics Value Set Table

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	**2.16.840.1.113883.6.88**
RxNORM Code	**RxNORM description**
1 ML penicillin G benzathine 300000 UNT/ML / penicillin G procaine 300000 UNT/ML Prefilled Syringe	731558
2 ML penicillin G benzathine 300000 UNT/ML / penicillin G procaine 300000 UNT/ML Prefilled Syringe	731538
4 ML penicillin G benzathine 300000 UNT/ML / penicillin G procaine 300000 UNT/ML Prefilled Syringe	731590
5000 MG Clindamycin 20 MG/ML Prefilled Applicator	890921
Acyclovir 25 MG/ML Injectable Solution	248108
Acyclovir 50 MG/ML Injectable Solution	313812
Acyclovir Injectable Solution	377143
Amphotericin B 5 MG/ML Injectable Solution	239240
Amphotericin B Injectable Solution	376660
Ampicillin (as ampicillin sodium) 100 MG/ML Injectable Solution	789980
Ampicillin (as ampicillin sodium) 250 MG/ML Injectable Solution	313819
Ampicillin / Floxacillin Injectable Solution	378107
Ampicillin / Sulbactam Injectable Solution	376673
Ampicillin 100 MG/ML / Sulbactam 50 MG/ML Injectable Solution	240984
Ampicillin 125 MG / floxacillin 125 MG per 5 ML Elixir	756252

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	**2.16.840.1.113883.6.88**
RxNORM Code	**RxNORM description**
Ampicillin 125 MG/ML Injectable Solution	308207
Ampicillin 167 MG/ML / Floxacillin 167 MG/ML Injectable Solution	105134
Ampicillin 20 MG/ML / Sulbactam 10 MG/ML Injectable Solution	993109
Ampicillin 250 MG/ML / Sulbactam 125 MG/ML Injectable Solution	308208
Ampicillin 30 MG/ML / Sulbactam 15 MG/ML Injectable Solution	308208
Ampicillin Injectable Solution	370584
Cefazolin 10 MG/ML Injectable Solution	309051
Cefazolin 100 MG/ML Injectable Solution	796301
Cefazolin 20 MG/ML Injectable Solution	309052
Cefazolin 200 MG/ML Injectable Solution	313920
Cefazolin 225 MG/ML Injectable Solution	309053
Cefazolin 250 MG/ML Injectable Solution	562062
Cefazolin 330 MG/ML Injectable Solution	313929
Cefazolin Injectable Solution	371324
Cefotaxime 20 MG/ML Injectable Solution	198396
Cefotaxime 200 MG/ML Injectable Solution	309065
Cefotaxime 230 MG/ML Injectable Solution	309068
Cefotaxime 300 MG/ML Injectable Solution	309066
Cefotaxime 330 MG/ML Injectable Solution	309067
Cefotaxime 40 MG/ML Injectable Solution	198395
Cefotaxime Injectable Solution	371331
Ceftazidime 10 MG/ML Injectable Solution	389025
Ceftazidime 170 MG/ML Injectable Solution	309083
Ceftazidime 20 MG/ML Injectable Solution	309082
Ceftazidime 200 MG/ML Injectable Solution	242800
Ceftazidime 210 MG/ML Injectable Solution	249926
Ceftazidime 250 MG/ML Injectable Solution	240447
Ceftazidime 280 MG/ML Injectable Solution	313890
Ceftazidime 40 MG/ML Injectable Solution	309084
Ceftazidime 60 MG/ML Injectable Solution	389026
Ceftazidime Injectable Solution	371337
Ceftriaxone 100 MG/ML Injectable Solution	309090
Ceftriaxone 20 MG/ML Injectable Solution	309091
Ceftriaxone 250 MG/ML Injectable Solution	309092
Ceftriaxone 350 MG/ML Injectable Solution	204871

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	**2.16.840.1.113883.6.88**
RxNORM Code	**RxNORM description**
Ceftriaxone 40 MG/ML Injectable Solution	309093
Clindamycin 12 MG/ML Injectable Solution	309335
Clindamycin 150 MG/ML	323888
Clindamycin 150 MG/ML Injectable Solution	205964
Clindamycin 18 MG/ML Injectable Solution	309336
Clindamycin 6 MG/ML Injectable Solution	309339
Clindamycin 900 MG per 50 ML Injectable Solution	309336
Clindamycin 900 MG per 6 ML Injectable Solution	205964
Clindamycin Injectable Solution	371557
Erythromycin 50 MG/ML Injectable Solution	310163
Erythromycin Gluceptate 1 MG/ML Injectable Solution	686354
Erythromycin Gluceptate 50 MG/ML Injectable Solution	686447
Erythromycin lactobionate 50 MG/ML Injectable Solution	597298
Fluconazole 2 MG/ML Injectable Solution	252432
Fluconazole 4 MG/ML Injectable Solution	861607
Fluconazole Injectable Solution	377071
Gentamicin Sulfate (USP) 0.4 MG/ML Injectable Solution	259047
Gentamicin Sulfate (USP) 0.6 MG/ML Injectable Solution	310472
Gentamicin Sulfate (USP) 0.7 MG/ML Injectable Solution	392406
Gentamicin Sulfate (USP) 0.8 MG/ML Injectable Solution	310473
Gentamicin Sulfate (USP) 0.9 MG/ML Injectable Solution	310474
Gentamicin Sulfate (USP) 1 MG/ML Injectable Solution	242816
Gentamicin Sulfate (USP) 1.2 MG/ML Injectable Solution	310475
Gentamicin Sulfate (USP) 1.4 MG/ML Injectable Solution	310476
Gentamicin Sulfate (USP) 1.6 MG/ML Injectable Solution	310477
Gentamicin Sulfate (USP) 10 MG/ML Injectable Solution	239204
Gentamicin Sulfate (USP) 2 MG/ML Injectable Solution	197736
Gentamicin Sulfate (USP) 2.4 MG/ML Injectable Solution	310478
Gentamicin Sulfate (USP) 3.6 MG/ML Injectable Solution	484047
Gentamicin Sulfate (USP) 40 MG/ML Injectable Solution	313996
Gentamicin Sulfate (USP) 5 MG/ML Injectable Solution	102770
Gentamicin Sulfate (USP) 50 MG/ML Injectable Solution	415059
Gentamicin Sulfate (USP) 60 MG/ML Injectable Solution	102769
Gentamicin Sulfate (USP) 80 MG/ML Injectable Solution	246296
Gentamicin Sulfate (USP) Injectable Solution	372302

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	2.16.840.1.113883.6.88
RxNORM Code	RxNORM description
Metronidazole 5 MG/ML Injectable Solution	311683
Metronidazole Injectable Solution	376657
Nafcillin 100 MG/ML Injectable Solution	239189
Nafcillin 20 MG/ML Injectable Solution	311895
Nafcillin 250 MG/ML Injectable Solution	239190
Nafcillin 40 MG/ML Injectable Solution	311896
Nafcillin Injectable Solution	372980
Oxacillin 100 MG/ML Injectable Solution	312127
Oxacillin 167 MG/ML Injectable Solution	312130
Oxacillin 20 MG/ML Injectable Solution	312128
Oxacillin 40 MG/ML Injectable Solution	240637
Oxacillin Injectable Solution	376698
Penicillin G 10000 UNT/ML Injectable Solution	617857
Penicillin G 100000 UNT/ML Injectable Solution	617881
Penicillin G 300000 UNT/ML Injectable Suspension	312270
Penicillin G 375 MG/ML Injectable Solution	105078
Penicillin G benzathine 1,200,000 UNT / penicillin G procaine 1,200,000 UNT per 2 ML Prefilled Syringe	824584
Penicillin G benzathine 1,200,000 UNT per 2 ML Prefilled Syringe	731567
Penicillin G benzathine 150000 UNT/ML / penicillin G procaine 150000 UNT/ML Injectable Solution	731560
Penicillin G benzathine 150000 UNT/ML / penicillin G procaine 150000 UNT/ML Injectable Suspension	623695
Penicillin G benzathine 2,400,000 UNT per 4 ML Prefilled Syringe	731570
Penicillin G benzathine 300000 UNT/ML / penicillin G procaine 300000 UNT/ML Injectable Suspension	623677
Penicillin G benzathine 300000 UNT/ML Injectable Suspension	731575
Penicillin G benzathine 450000 UNT/ML / penicillin G procaine 150000 UNT/ML 2 ML Prefilled Syringe	836306
Penicillin G benzathine 600,000 UNT per 1 ML Prefilled Syringe	731564
Penicillin G benzathine 600000 UNT/ML Injectable Suspension	731564
Penicillin G benzathine 900000 UNT/ML / penicillin G procaine 300000 UNT/ML Injectable Suspension	745477
Penicillin G Injectable Solution	373262
Penicillin G Injectable Suspension	373260
Penicillin G Potassium 10000 UNT/ML Injectable Solution	745464
Penicillin G Potassium 100000 UNT/ML Injectable Solution	745300

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	**2.16.840.1.113883.6.88**
RxNORM Code	**RxNORM description**
Penicillin G Potassium 1000000 UNT/ML Injectable Solution	863538
Penicillin G Potassium 20000 UNT/ML Injectable Solution	207390
Penicillin G Potassium 40000 UNT/ML Injectable Solution	204466
Penicillin G Potassium 60000 UNT/ML Injectable Solution	207391
Penicillin G Prefilled Syringe	727620
penicillin G procaine 1,200,000 UNT per 2 ML Prefilled Syringe	745462
penicillin G procaine 300000 UNT/ML Injectable Suspension	745303
penicillin G procaine 600,000 UNT per 1 ML Prefilled Syringe	745560
penicillin G procaine 600,000 UNT/ML Injectable Suspension	745561
Penicillin G Sodium 100000 UNT/ML Injectable Solution	745302
Penicillium camemberti allergenic extract 50 MG/ML Injectable Solution	966946
Penicillium chrysogenum var. chrysogenum extract 1 MG/ML	966947
Penicillium chrysogenum var. chrysogenum extract 100 MG/ML	854131
Penicillium chrysogenum var. chrysogenum extract 100 UNT/ML	966949
Penicillium chrysogenum var. chrysogenum extract 1000 UNT/ML	883527
Penicillium chrysogenum var. chrysogenum extract 10000 UNT/ML	966951
Penicillium chrysogenum var. chrysogenum extract 20000 UNT/ML	966953
Penicillium chrysogenum var. chrysogenum extract 40000 UNT/ML	966959
Penicillium chrysogenum var. chrysogenum extract 50 MG/ML	966959
Penicillium italicum extract 0.05 GM/ML Injectable Solution	967963
Penicillium roquefortii allergenic extract 50 MG/ML Injectable Solution	966993
Piperacillin / tazobactam Injectable Solution	376858
Piperacillin 200 MG/ML / tazobactam 25 MG/ML Injectable Solution	312447
Piperacillin 200 MG/ML Injectable Solution	239186
Piperacillin 30 MG/ML Injectable Solution	312442
Piperacillin 40 MG/ML / tazobactam 5 MG/ML Injectable Solution	312446
Piperacillin 40 MG/ML Injectable Solution	315178
Piperacillin 400 MG/ML Injectable Solution	312444
Piperacillin 60 MG/ML / tazobactam 7.5 MG/ML Injectable Solution	312443
Piperacillin 80 MG/ML / tazobactam 10 MG/ML Injectable Solution	1043464
Piperacillin Injectable Solution	373467
Vancomycin 10 MG/ML Injectable Solution	796488
Vancomycin 100 MG/ML Injectable Solution	239209
Vancomycin 3 MG/ML Injectable Solution	415868
Vancomycin 3.5 MG/ML Injectable Solution	998241

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
Vocabulary	2.16.840.1.113883.6.88
RxNORM Code	RxNORM description
Vancomycin 4 MG/ML Injectable Solution	415869
Vancomycin 5 MG/ML Injectable Solution	313574
Vancomycin 50 MG/ML Injectable Solution	313572
Vancomycin 6 MG/ML Injectable Solution	998239
Vancomycin 6.67 MG/ML Injectable Solution	796484
Vancomycin 7 MG/ML Injectable Solution	796490
Vancomycin 8 MG/ML Injectable Solution	796492
Vancomycin 8.33 MG/ML Injectable Solution	796486
Vancomycin Injectable Solution	375983
Zidovudine 10 MG/ML Injectable Solution	204534
Zidovudine Injectable Solution	379126

A.5 MCH HBS IV Medication Administration Codes

A.5.1 Metadata

910 IV Medication Administration Route Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4
Name	This is the name of the value set	MCH HBS IV Medication Administration Route Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that IV Medication Administration Route was used to administer a medication
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7 Route of Administration
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org/Memonly/downloads/Standards_Messaging_v251/HL7_Messaging_v251_PDF.zip
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.5.2 MCH HBS IV Medication Administration Route Value Set

Route indicating IV Administration Route uses the HL7 Route of Administration code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4
Vocabulary :	2.16.840.1.113883.12.162
Data Element	HL7 Route of Administration
IV	INTRAVENOUS

A.6 MCH HBS Intramuscular Medication Administration Route Codes

A.6.1 Metadata

Intramuscular Medication Administration Route Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5
Name	This is the name of the value set	MCH HBS Intramuscular Administration Route Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that Intramuscular Medication Administration Route was used to administer a medication

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7 Route of Administration
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org/Memonly/downloads/Standards_Messaging_v251/HL7_Messaging_v251_PDF.zip
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.6.2 MCH HBS Intramuscular Administration Route Value Set

Route indicating Intramuscular Administration Route uses the HL7 Route of Administration code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5
Vocabulary	2.16.840.1.113883.12.162
Data Element	HL7 Route of Administration
IM	INTRAMUSCULAR

A.7 MCH HBS Neonatal Sepsis Codes

A.7.1 Metadata

Neonatal Sepsis Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6
Name	This is the name of the value set	MCH HBS Neonatal Sepsis Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn was provided assisted ventilation immediately following delivery reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.7.2 MCH HBS Neonatal Sepsis Value Set

Problems or indications indicating Neonatal Sepsis use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

935

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6
Vocabulary	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
276669000	Bacterial sepsis of newborn (disorder)
211420008	Neonatal candida septicemia (disorder)
359646002	Neonatal disseminated listeriosis (disorder)
403000003	Neonatal systemic candidosis (disorder)
206380000	Sepsis of newborn due to anaerobes (disorder)
206379003	Sepsis of newborn due to Escherichia coli (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
206378006	Sepsis of newborn due to Staphylococcus aureus (disorder)
206376005	Sepsis of the newborn (disorder)
41229001	Septicemia of newborn (disorder)
43424001	Tetanus neonatorum (disorder)

A.8 QRPH MCH HBS Assisted Ventilation Immediately Following Delivery Codes

A.8.1 Metadata

940 Assisted Ventilation Immediately Following Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7
Name	This is the name of the value set	MCH HBS Assisted Ventilation Immediately Following Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn was provided assisted ventilation immediately following delivery reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010

Metadata Element	Description	Mandatory
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.8.2 MCH HBS Assisted Ventilation Immediately Following Delivery Value Set

Assisted Ventilation Immediately Following Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
	Pending

A.9 MCH HBS Assisted Ventilation for 6 or More Hours Codes

A.9.1 Metadata

Assisted Ventilation for 6 or More Hours Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.8
Name	This is the name of the value set	MCH HBS Assisted Ventilation for 6 or More Hours Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn was provided assisted ventilation for 6 or more hours reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.9.2 MCH HBS Assisted Ventilation for 6 or More Hours Value Set

Assisted Ventilation for 6 or More Hours Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	**1.3.6.1.4.1.19376.1.7.3.1.1.13.8.8**
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Procedure Code	**SNOMED-CT Description**
	Pending

A.10 QRPH MCH HBS Significant Birth Injury Codes

A.10.1 Metadata

Significant Birth Injury Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9
Name	This is the name of the value set	MCH HBS Significant Birth Injury Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	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
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.10.2MCH HBS Significant Birth Injury Value Set

Significant Birth Injury Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

965

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
56110009	Birth trauma of fetus (disorder)
206253009	Birth injury to face (disorder)
37384000	Birth injury to scalp (disorder)
268822004	Fetal monitoring scalp injury (disorder)
276704001	Electrode injury to scalp during birth (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
276705000	Sampling injury to scalp during birth (disorder)
206199003	Scalp injuries due to birth trauma (disorder)
206200000	Cephalhematoma due to birth trauma (disorder)
403849006	Scalp injury due to vacuum extraction (disorder)
240312009	Cerebral injury due to birth trauma (disorder)
206196005	Cerebral hemorrhage due to birth injury (disorder)
206195009	Extradural hemorrhage in fetus or newborn (disorder)
206188000	Subdural and cerebral hemorrhage due to birth trauma (disorder)
206192007	Tentorial tear due to birth trauma (disorder)
206234004	Cranial nerve injury due to birth trauma (disorder)
55712002	Facial nerve injury as birth trauma (disorder)
111465000	Erb-Duchenne palsy as birth trauma (disorder)
50263004	Hematoma of vulva of fetus or newborn as birth trauma (disorder)
16581008	Injury of spine AND/OR spinal cord as birth trauma (disorder)
53785005	Injury to brachial plexus as birth trauma (disorder)
206226005	Brachial plexus palsy due to birth trauma (disorder)
81774005	Klumpke-Déjerine paralysis as birth trauma (disorder)
240317003	Kidney injury due to birth trauma (disorder)
206245001	Liver rupture due to birth trauma (disorder)
371129000	Paralysis from birth trauma (disorder)
40980002	Spastic paralysis due to birth injury (disorder)
28534004	Spastic paralysis due to intracranial birth injury (disorder)
79591004	Spastic paralysis due to spinal birth injury (disorder)
403848003	Perinatal forceps injury (disorder)
403847008	Perinatal skin trauma due to obstetric injury (disorder)
206235003	Peripheral nerve injury due to birth trauma (disorder)
206233005	Birth injury to phrenic nerve (disorder)
28778005	Phrenic nerve paralysis as birth trauma (disorder)
206228006	Birth plexus injury - whole plexus (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
240314005	Skeletal injury due to birth trauma (disorder)
206216003	Birth dislocation of the shoulder (disorder)
20596003	Fracture of long bone, as birth trauma (disorder)
275365008	Birth fracture of radius (disorder)
275366009	Birth fracture of ulna (disorder)
206209004	Fracture of clavicle due to birth trauma (disorder)
206213006	Fracture of femur due to birth trauma (disorder)
206211008	Fracture of humerus due to birth trauma (disorder)
240315006	Fracture of nose due to birth trauma (disorder)
268824003	Fracture of radius and/or ulna due to birth trauma (disorder)
64728002	Fracture of spine due to birth trauma (disorder)
206214000	Fracture of tibia and/or fibula due to birth trauma (disorder)
206221000	Spine dislocation due to birth trauma (disorder)
206220004	Spine or spinal cord injury due to birth trauma (disorder)
206223002	Spinal cord laceration due to birth trauma (disorder)
206224008	Spinal cord rupture due to birth trauma (disorder)
268826001	Spleen rupture due to birth trauma (disorder)
206252004	Sternomastoid injury due to birth injury (disorder)
30671001	Tentorial tear as birth trauma (disorder)
268808004	Fetus or neonate affected by breech delivery and extraction (disorder)
206054009	Fetus or neonate affected by breech presentation before labor (disorder)

A.11 QRPH MCH HBS Seizure or Serious Neurologic Dysfunction Codes

A.11.1 Metadata

970 Seizure or Serious Neurologic Dysfunction Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10
Name	This is the name of the value set	MCH HBS Seizure or Serious Neurologic Dysfunction Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn suffered a Seizure or Serious Neurologic Dysfunction reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.11.2 MCH HBS Seizure or Serious Neurologic Dysfunction Value Set

Seizure or Serious Neurologic Dysfunction Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

975

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10
Vocabulary	**2.16.840.1.113883.6.96**
SNOMED-CT Procedure Code	**SNOMED-CT Description**
91175000	Seizure (finding)
444229001	Afebrile seizure (finding)
41119002	Akinetic seizure without atonia (finding)
41510006	Anoxic seizure (finding)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
438156004	Anoxic epileptic seizure (finding)
440443001	Reflex anoxic seizure (finding)
59754009	Brief atonic seizure (finding)
58895005	Central convulsion (finding)
313307000	Epileptic seizure (finding)
192982004	Epileptic seizures - akinetic (finding)
192981006	Epileptic seizures - atonic (finding)
192991000	Epileptic seizures - clonic (finding)
192993002	Epileptic seizures - tonic (finding)
433083002	Complex febrile seizure (finding)
246545002	Generalized seizure (finding)
6208003	Clonic seizure (finding)
2665008	Coordinate convulsion (finding)
54200006	Tonic-clonic seizure (finding)
65155005	Grand mal seizure (finding)
163590008	On examination - grand mal fit (finding)
20544001	Secondarily generalized seizures (finding)
87185006	Long atonic seizure (finding)
19593003	Movement partial seizure (finding)
371129000	Paralysis from birth trauma (disorder)
40980002	Spastic paralysis due to birth injury (disorder)
28534004	Spastic paralysis due to intracranial birth injury (disorder)
79591004	Spastic paralysis due to spinal birth injury (disorder)
95628005	Neonatal encephalopathy (disorder)
277480002	Neonatal asphyxial encephalopathy (disorder)
277479000	Postnatal hypoxic encephalopathy (disorder)

A.12 QRPH MCH HBS Newborn Receiving Surfactant Replacement Therapy Codes

A.12.1 Metadata

Seizure or Serious Neurologic Dysfunction Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11
Name	This is the name of the value set	MCH HBS Newborn Receiving Surfactant Replacement Therapy Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn Newborn Received Surfactant Replacement Therapy reflecting an abnormal condition of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	**http://www.nlm.nih.gov/research/umls/rxnorm/**
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.12.2 MCH HBS Newborn Receiving Surfactant Replacement Therapy Value Set

Newborn Receiving Surfactant Replacement Therapy Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11
Vocabulary	2.16.840.1.113883.6.88
RXNORM Code	RXNORM Description
259034	beractant 25 MG/ML Injectable Suspension
379138	beractant Injectable Suspension
259611	calfactant 35 MG/ML Inhalant Solution
379477	calfactant Inhalant Solution
141920	Colfosceril 13.5 MG/ML Injectable Suspension
385921	Colfosceril Injectable Suspension
259216	Poractant alfa 80 MG/ML Injectable Suspension
375227	Poractant alfa Injectable Suspension

A.13 QRPH MCH HBS Neonatal Death Codes

A.13.1 Metadata

990 Neonatal Death Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Name	This is the name of the value set	MCH HBS Neonatal Death Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that the newborn died
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A

Metadata Element	Description	Mandatory
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.13.2 MCH HBS Neonatal Death Value Set

Neonatal death Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Procedure Code	SNOMED-CT Description
6254007	Neonatal death (finding)
391181005	Early neonatal death (finding)
276505002	Late neonatal death (finding)
56102008	Neonatal death of female (within 4 weeks, USA) (finding)
55225009	Neonatal death of female (within 7 days, WHO) (finding)
91519006	Neonatal death of male (within 4 weeks, USA) (finding)
60257006	Neonatal death of male (within 7 days, WHO) (finding)

A.14 QRPH MCH HBS 5 Min Apgar Score Codes

A.14.1 Metadata

5 Min Apgar Score Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12
Name	This is the name of the value set	MCH HBS 5 Min Apgar Score Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the 5 Min Apgar Score

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.14.2 MCH HBS 5 Min Apgar Score Value Set

5 Min Apgar Score Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12
Vocabulary	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
9274-2	Score^5M post birth

A.15 QRPH MCH HBS 10 Min Apgar Score Codes

A.15.1 Metadata

10 Min Apgar Score Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13
Name	This is the name of the value set	MCH HBS 10 Min Apgar Score Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect the 10 Min Apgar Score
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.15.2 MCH HBS 10 Min Apgar Score Value Set

10 Min Apgar Score Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13
Vocabulary	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
9271-8	Score^10M post birth

A.16 QRPH MCH HBS Delivery Codes

A.16.1 Metadata

Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Name	This is the name of the value set	MCH HBS Delivery Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Delivery Procedure
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.16.2 MCH HBS Delivery Value Set

Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1015

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
133905007	Delivery room care (regime/therapy)
177184002	Normal delivery procedure (procedure)
1807002	Failed forceps delivery (procedure)
2321005	Delivery by Ritgen maneuver (procedure)
5556001	Manually assisted spontaneous delivery (procedure)
10745001	Delivery of transverse presentation (procedure)
15413009	High forceps delivery with episiotomy (procedure)
16819009	Delivery of face presentation (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
17744000	Subtotal hysterectomy after cesarean delivery (procedure)
17860005	Low forceps delivery with episiotomy (procedure)
18625004	Low forceps delivery (procedure)
19390001	Partial breech delivery with forceps to aftercoming head (procedure)
22633006	Vaginal delivery, medical personnel present (procedure)
25296001	Delivery by Scanzoni maneuver (procedure)
25828002	Mid forceps delivery with episiotomy (procedure)
26313002	Delivery by vacuum extraction with episiotomy (procedure)
29613008	Delivery by double application of forceps (procedure)
30476003	Barton's forceps delivery (procedure)
38479009	Frank breech delivery (procedure)
40219000	Delivery by Malstrom's extraction with episiotomy (procedure)
45718005	Vaginal delivery with forceps including postpartum care (procedure)
48204000	Spontaneous unassisted delivery, medical personnel present (procedure)
54973000	Total breech delivery with forceps to aftercoming head (procedure)
56620000	Delivery of placenta following delivery of infant outside of hospital (procedure)
57411006	Colpoperineorrhaphy following delivery (procedure)
61586001	Delivery by vacuum extraction (procedure)
62508004	Mid forceps delivery (procedure)
71166009	Forceps delivery with rotation of fetal head (procedure)
72059007	Destructive procedure on fetus to facilitate delivery (procedure)
72492007	Footling breech delivery (procedure)
89346004	Delivery by Kielland rotation (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
89849000	High forceps delivery (procedure)
90438006	Delivery by Malstrom's extraction (procedure)
177128002	Induction and delivery procedures (procedure)
177152009	Breech extraction delivery with version (procedure)
177157003	Spontaneous breech delivery (procedure)
177158008	Assisted breech delivery (procedure)
177161009	Forceps cephalic delivery (procedure)
177162002	High forceps cephalic delivery with rotation (procedure)
177164001	Midforceps cephalic delivery with rotation (procedure)
177167008	Barton forceps cephalic delivery with rotation (procedure)
177168003	DeLee forceps cephalic delivery with rotation (procedure)
177170007	Piper forceps delivery (procedure)
177173009	High vacuum delivery (procedure)
177174003	Low vacuum delivery (procedure)
177175002	Vacuum delivery before full dilation of cervix (procedure)
177179008	Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
177180006	Manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
177181005	Non-manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
177184002	Normal delivery procedure (procedure)
177185001	Water birth delivery (procedure)
177212000	Normal delivery of placenta (procedure)
199771001	Piper forceps delivery by application to aftercoming head (procedure)
236973005	Delivery procedure (procedure)
236974004	Instrumental delivery (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
236975003	Nonrotational forceps delivery (procedure)
236976002	Outlet forceps delivery (procedure)
236977006	Forceps delivery, face to pubes (procedure)
236978001	Forceps delivery to the aftercoming head (procedure)
236982004	Delivery of the after coming head (procedure)
236989008	Abdominal delivery for shoulder dystocia (procedure)
236991000	Operation to facilitate delivery (procedure)
236994008	Placental delivery procedure (procedure)
237008007	Maneuvers for delivery in shoulder dystocia (procedure)
237311001	Breech delivery (procedure)
248273008	Aspiration curettage of uterus after delivery (procedure)
265639000	Midforceps delivery without rotation (procedure)
275168001	Neville-Barnes forceps delivery (procedure)
275169009	Simpson's forceps delivery (procedure)
287976008	Breech/instrumental delivery operations (procedure)
287977004	Dilation/incision of cervix - delivery aid (procedure)
288193006	Supervision - normal delivery (procedure)
302383004	Forceps delivery (procedure)
306727001	Breech presentation, delivery, no version (procedure)
315308008	Dilatation of cervix for delivery (procedure)
359943008	Partial breech delivery (procedure)
384729004	Delivery of vertex presentation (procedure)
386338001	Intrapartal care: high-risk delivery (regime/therapy)
386622003	Duhrssen's incisions of cervix to assist delivery (procedure)
387711001	Pubiotomy to assist delivery (procedure)
391998006	Dilation and curettage of uterus after delivery (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
397990008	Analgesia for labor/delivery (procedure)
408817009	Amniotomy at delivery (procedure)
408819007	Delivery of placenta by maternal effort (procedure)

A.17 QRPH MCH HBS Physician Codes

A.17.1 Metadata

1020 Physician Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15
Name	This is the name of the value set	MCH HBS Physician Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Title of the Attendant responsible for the delivery Procedure as a Physician
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.17.2 MCH HBS Physician Value Set

Physician Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15
Vocabulary	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
158967008	Consultant physician (occupation)
158973009	Occupational physician (occupation)
23278007	Community health physician (occupation)
309343006	Physician (occupation)
309345004	Chest physician (occupation)
309346003	Thoracic physician (occupation)
309358003	Genitourinary medicine physician (occupation)
309359006	Palliative care physician (occupation)
309360001	Rehabilitation physician (occupation)
310172001	Audiological physician (occupation)
405277009	Resident physician (occupation)
405279007	Attending physician (occupation)
56466003	Public health physician (occupation)
59058001	General physician (occupation)
69280009	Specialized physician (occupation)

A.18 QRPH MCH HBS Doctor of Osteopathic Medicine Codes

A.18.1 Metadata

Doctor of Osteopathic Medicine Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16
Name	This is the name of the value set	MCH Doctor of Osteopathic Medicine Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect the Title of the Attendant responsible for the delivery Procedure as a Doctor of Osteopathic Medicine
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.18.2 MCH Doctor of Osteopathic Medicine Value Set

Doctor of Osteopathic Medicine Value Set will use SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
76231001	Osteopath (occupation)

A.19 QRPH MCH HBS Certified Midwife Medicine Codes

A.19.1 Metadata

Certified Midwife Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17
Name	This is the name of the value set	MCH HBS Certified Midwife Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Title of the Attendant responsible for the delivery Procedure as a Certified Midwife
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.19.2 MCH HBS Certified Midwife Value Set

Certified Midwife Value Set will use SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
309453006	Registered midwife (occupation)

A.20 QRPH MCH HBS Midwife Medicine Codes

A.20.1 Metadata

Midwife Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
Name	This is the name of the value set	MCH HBS Midwife Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	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
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.20.2 MCH HBS Midwife Value Set

Midwife Value Set will use SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
158995008	Staff midwife (occupation)
158999002	Community midwife (occupation)
224534008	Health visitor, nurse/midwife (occupation)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
225727002	Midwife counselor (occupation)
309454000	Student midwife (occupation)
310188001	Hospital midwife (occupation)
312485001	Integrated midwife (occupation)
75271001	Professional midwife (occupation)
79898004	Auxiliary midwife (occupation)

A.21 QRPH MCH HBS U.S. Territories Codes

A.21.1 Metadata

1050 U.S. Territories Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19
Name	This is the name of the value set	MCH HBS U.S. Territories Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the U.S. Territories
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from FIPS 5-2
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.itl.nist.gov/fipspubs/fip5-2.htm
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.21.2 MCH HBS U.S. Territories Value Set

U.S. Territories Value Set will use the Federal Information Processing Standards (FIPS) [5]code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1055

Value Set :	U.S. Territories Value 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.19
Vocabulary :	2.16.840.1.101.3.4.2.1
FIPS Code	FIPS Description
AS	American Samoa
FM	Federated States of Micronesia
GU	Guam
MH	Marshall Islands
MP	Northern Mariana Islands
PW	Palau
PR	Puerto Rico
UM	U.S. Minor Outlying Islands
VI	Virgin Islands of the U.S.

A.22 QRPH MCH HBS Birth Weight Code

A.22.1Metadata

Birth Weight Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
Name	This is the name of the value set	MCH HBS Birth Weight Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Birth Weight
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC

[5] FIPS 5-2 will be superseded by INCITS 38:200X when that specification becomes available. The content of the two are the same, but the maintainer of the code set has been changed.

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

Birth Weight Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

A.22.2 MCH HBS Birth Weight Value Set

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
3141-9	Birth Weight

A.23 QRPH MCH HBS Measured Height Codes

A.23.1 Metadata

Measured Height Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.117
Name	This is the name of the value set	MCH HBS Measured Height Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the mother's height

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.23.2 MCH HBS Measured Height Value Set

Measured Height Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1070

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.117
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
3137-7	Body height (measured)

A.24 QRPH MCH HBS Pre-Pregnancy Weight Codes

A.24.1 Metadata

Pre-Pregnancy Weight Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118
Name	This is the name of the value set	MCH HBS Pre-Pregnancy Weight Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect the mother's Pre-Pregnancy Weight
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.24.2 MCH HBS Pre-Pregnancy Weight Value Set

Pre-Pregnancy Weight Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.118
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
56077-1	Body weight^pre current pregnancy
8348-5	Body weight^pre pregnancy

A.25 QRPH MCH HBS Mother's Delivery Weight Codes

A.25.1 Metadata

Mother's Delivery Weight Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120
Name	This is the name of the value set	MCH HBS Mother's Delivery Weight Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Mother's Delivery Weight
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.25.2 MCH HBS Mother's Delivery Weight Value Set

Mother's Delivery Weight Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
8345-1	Body weight^post partum

A.26 QRPH MCH HBS Previous Other Pregnancy Outcomes Codes

A.26.1 Metadata

Previous Other Pregnancy Outcomes Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121

Metadata Element	Description	Mandatory
Name	This is the name of the value set	MCH HBS Previous Other Pregnancy Outcomes Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Previous Other Pregnancy Outcomes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.26.2 MCH HBS Previous Other Pregnancy Outcomes Value Set

Previous Other Pregnancy Outcomes Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121
Vocabulary :	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.27 QRPH MCH HBS Number of Previous Live Births Now Dead Codes

A.27.1 Metadata

Number of Previous Live Births Now Dead Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122
Name	This is the name of the value set	MCH HBS Number of Previous Live Births Now Dead Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Previous Other Pregnancy Outcomes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.27.2 MCH HBS Number of Previous Live Births Now Dead Value Set

Number of Previous Live Births Now Dead Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1100

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.28 QRPH MCH HBS Number of Previous Live Births Now Living Codes

A.28.1 Metadata

Number of Previous Live Births Now Living Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123
Name	This is the name of the value set	MCH HBS Number of Previous Live Births Now Living Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Previous Other Pregnancy Outcomes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.28.2 MCH HBS Number of Previous Live Births Now Living Value Set

Number of Previous Live Births Now Living Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
11638-4	Births still living

A.29 QRPH MCH HBS Obstetric Estimate of Gestation Codes

A.29.1 Metadata

Obstetric Estimate of Gestation Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124
Name	This is the name of the value set	MCH HBS Obstetric Estimate of Gestation Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the mother's Obstetric Estimate of Gestation
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.29.2 MCH HBS Obstetric Estimate of Gestation Value Set

Obstetric Estimate of Gestation Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124	
Vocabulary:	2.16.840.1.113883.6.1	
LOINC Code	LOINC Description	
11884-4	Gestational age	Clinical.estimated
53695-3	Gestational age	Clinical.estimated from prior assessment

A.30 QRPH MCH HBS Birth Plurality of Delivery Codes

A.30.1 Metadata

Birth Plurality of Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132
Name	This is the name of the value set	MCH HBS Birth Plurality of Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Birth Plurality of Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.30.2 A.32.2 MCH HBS Birth Plurality of Delivery Value Set

Birth Plurality of Delivery Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
57722-1	Birth plurality

A.31 QRPH MCH HBS First Prenatal Care Visit Codes

A.31.1 Metadata

First Prenatal Care Visit Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
Name	This is the name of the value set	MCH HBS First Prenatal Care Visit Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the First Prenatal Care Visit
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.31.2 MCH HBS First Prenatal Care Visit Value Set

First Prenatal Care Visit Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
Vocabulary :	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
424441002	Prenatal initial visit (regime/therapy)

A.32 QRPH MCH HBS Last Prenatal Care Visit Codes

A.32.1 Metadata

1135 Last Prenatal Care Visit Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
Name	This is the name of the value set	MCH HBS Prenatal Care Visit Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Last Prenatal Care Visit
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.32.2 MCH HBS Last Prenatal Care Visit Value Set

Last Prenatal Care Visit Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
Vocabulary :	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	Pending

A.33 QRPH MCH HBS Number Prenatal Care Visits Codes

A.33.1 Metadata

Number Prenatal Care Visits Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
Name	This is the name of the value set	MCH HBS Number Prenatal Care Visits Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Number Prenatal Care Visits
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.33.2 MCH HBS Number Prenatal Care Visits Value Set

Number Prenatal Care Visits Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
Vocabulary :	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.34 QRPH MCH HBS Augmentation of Labor – Procedure Codes

A.34.1 Metadata

Augmentation of Labor - Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22
Name	This is the name of the value set	MCH HBS Augmentation of Labor - Procedure Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect a procedure of Augmentation of Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.34.2 MCH HBS Augmentation of Labor - Procedure Value Set

Augmentation of Labor - Procedure Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
237001001	Augmentation of labor (procedure)
237002008	Stimulation of labor (procedure)

A.35 QRPH MCH HBS Augmentation of Labor – Medication Codes

A.35.1 Metadata

Augmentation of Labor - Medication Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23
Name	This is the name of the value set	MCH HBS Augmentation of Labor - Medication Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect a medication used for the of Augmentation of Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.35.2 MCH HBS Augmentation of Labor - Medication Value Set

Augmentation of Labor - Medication Value Set will use the RxNorm code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23
Vocabulary	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23
Vocabulary	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
238013	Oxytocin 10 UNT/ML Injectable Solution

A.36 QRPH MCH HBS Chorioamnionitis During Labor Codes

A.36.1 Metadata

Chorioamnionitis During Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24
Name	This is the name of the value set	MCH HBS Chorioamnionitis During Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect a Chorioamnionitis During Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.36.2 MCH HBS Chorioamnionitis During Labor Value Set

Chorioamnionitis During Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24
Vocabulary	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
11612004	Chorioamnionitis (disorder)
55730009	Fetus OR newborn affected by chorioamnionitis (disorder)
206102001	Fetus or neonate affected by chorioamnionitis (disorder)

A.37 QRPH MCH HBS Fever Greater Than 100.4 Codes

A.37.1 Metadata

Fever Greater Than 100.4 Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25
Name	This is the name of the value set	MCH HBS Fever Greater Than 100.4 Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect a Fever Greater Than 100.4 During Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.37.2 MCH HBS Fever Greater Than 100.4 Value Set

Fever Greater Than 100.4 Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
426000000	Fever greater than 100.4 Fahrenheit (finding)

A.38 QRPH MCH HBS Epidural Anesthesia – Medication Codes

A.38.1 Metadata

Epidural Anesthesia - Medication Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26
Name	This is the name of the value set	MCH HBS Epidural Anesthesia - Medication Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect an Epidural Anesthesia
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.38.2 MCH HBS Epidural Anesthesia - Medication Value Set

Epidural Anesthesia - Medication Value Set will use the RxNorm code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26
Vocabulary :	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
403803	bupivacaine 0.0375 % / fentanyl 5 MCG/ML Injectable Solution
578142	bupivacaine 0.05 % / fentanyl 3 MCG/ML Injectable Solution
898637	bupivacaine 0.06 % / hydromorphone hydrochloride 2 MG per 100 ML Injectable Solution
604078	bupivacaine 0.0625 % / fentanyl 2 MCG/ML Injectable Solution
359521	bupivacaine 0.0625 % / fentanyl 5 MCG/ML Injectable Solution
898639	bupivacaine 0.0625 % / hydromorphone hydrochloride 10 MCG/ML Injectable Solution
991609	bupivacaine 0.0625 % / hydromorphone hydrochloride 5 MCG/ML Injectable Solution
403802	bupivacaine 0.1 % / fentanyl 4 MCG/ML Injectable Solution
991439	bupivacaine 0.1 % / hydromorphone hydrochloride 10 MCG/ML Injectable Solution
389167	bupivacaine 0.1 % Injectable Solution
359517	bupivacaine 0.125 % / fentanyl 2 MCG/ML Injectable Solution
898642	bupivacaine 0.125 % / hydromorphone hydrochloride 20 MCG/ML Injectable Solution
359285	bupivacaine 0.125 % Injectable Solution
282472	bupivacaine 0.25 % Injectable Solution
108469	bupivacaine 0.375 % Injectable Solution
308818	bupivacaine 0.5 % / epinephrine 1:200,000 Injectable Solution
282473	bupivacaine 0.5 % Injectable Solution
578135	Bupivacaine 0.625 MG/ML / Fentanyl 0.0025 MG/ML Injectable Solution
359520	Bupivacaine 0.625 MG/ML / Fentanyl 0.004 MG/ML Injectable Solution
359284	Bupivacaine 0.625 MG/ML Injectable Solution
359518	Bupivacaine 1 MG/ML / Fentanyl 0.002 MG/ML Injectable Solution

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26
Vocabulary :	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
578143	Bupivacaine 1 MG/ML / Fentanyl 0.003 MG/ML Injectable Solution
359523	Bupivacaine 1 MG/ML / Fentanyl 0.005 MG/ML Injectable Solution
403804	Bupivacaine 1 MG/ML / Fentanyl 0.01 MG/ML Injectable Solution
107627	Bupivacaine 1.05 MG/ML Injectable Solution
700625	Bupivacaine 1.25 MG/ML / Fentanyl 0.0025 MG/ML Injectable Solution
578136	Bupivacaine 1.25 MG/ML / Fentanyl 0.003 MG/ML Injectable Solution
700626	Bupivacaine 1.25 MG/ML / Fentanyl 0.004 MG/ML Injectable Solution
359522	Bupivacaine 1.25 MG/ML / Fentanyl 0.005 MG/ML Injectable Solution
727503	bupivacaine 100 MG per 20 ML Prefilled Syringe
727417	bupivacaine 125 MG per 50 ML Prefilled Syringe
700624	Bupivacaine 2 MG/ML Injectable Solution
317067	Bupivacaine 2.5 MG/ML / Epinephrine 0.005 MG/ML Injectable Solution
403805	Bupivacaine 2.5 MG/ML / Fentanyl 0.02 MG/ML Injectable Solution
415205	Bupivacaine 3.75 MG/ML / Lidocaine 10 MG/ML Injectable Solution
308820	Bupivacaine 7.5 MG/ML / Epinephrine 0.005 MG/ML Injectable Solution
308819	Bupivacaine 7.5 MG/ML Injectable Solution
415410	Bupivacaine 8.25 MG/ML Injectable Solution
477303	Bupivacaine Hydrochloride 2 MG/ML Injectable Solution
992805	chloroprocaine 2 % Injectable Solution
992801	Chloroprocaine hydrochloride 10 MG/ML Injectable Solution
992809	Chloroprocaine hydrochloride 30 MG/ML Injectable Solution
415205	Bupivacaine 3.75 MG/ML / Lidocaine 10 MG/ML Injectable Solution
309697	Dexamethasone 4 MG/ML / Lidocaine 10 MG/ML Injectable Solution
245841	Lidocaine 10 MG/ML / Methylprednisolone 40 MG/ML Injectable Solution

A.39 QRPH MCH HBS Epidural Anesthesia - Procedure Codes

A.39.1 Metadata

Epidural Anesthesia - Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27
Name	This is the name of the value set	MCH HBS Epidural Anesthesia - Procedure Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect an Epidural Anesthesia Procedure
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.39.2 MCH HBS Epidural Anesthesia - Procedure Value Set

Epidural Anesthesia - Procedure Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
18946005	Epidural anesthesia (procedure)
58611004	Epidural injection of anesthetic substance,

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	therapeutic, lumbar, continuous (procedure)
180886007	Local anesthetic sacral epidural block (procedure)
112943005	Epidural injection of anesthetic substance, diagnostic, caudal, continuous (procedure)
67716003	Epidural injection of anesthetic substance, therapeutic, caudal, continuous (procedure)
398044000	Low dose epidural (procedure)
64817005	Anesthesia for vaginal delivery (procedure)

A.40 QRPH MCH HBS Spinal Anesthesia – Medication Codes

A.40.1 Metadata

Spinal Anesthesia - Medication Value Set Metadata Shall contain the following content:

1195

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28
Name	This is the name of the value set	MCH HBS Spinal Anesthesia - Medication Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect a Spinal Anesthesia
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active

Metadata Element	Description	Mandatory
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.40.2 MCH HBS Spinal Anesthesia - Medication Value Set

Spinal Anesthesia - Medication Value Set will use the RxNorm code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28
Vocabulary:	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
403803	bupivacaine 0.0375 % / fentanyl 5 MCG/ML Injectable Solution
578142	bupivacaine 0.05 % / fentanyl 3 MCG/ML Injectable Solution
898637	bupivacaine 0.06 % / hydromorphone hydrochloride 2 MG per 100 ML Injectable Solution
604078	bupivacaine 0.0625 % / fentanyl 2 MCG/ML Injectable Solution
359521	bupivacaine 0.0625 % / fentanyl 5 MCG/ML Injectable Solution
898639	bupivacaine 0.0625 % / hydromorphone hydrochloride 10 MCG/ML Injectable Solution
991609	bupivacaine 0.0625 % / hydromorphone hydrochloride 5 MCG/ML Injectable Solution
403802	bupivacaine 0.1 % / fentanyl 4 MCG/ML Injectable Solution
991439	bupivacaine 0.1 % / hydromorphone hydrochloride 10 MCG/ML Injectable Solution
389167	bupivacaine 0.1 % Injectable Solution
359517	bupivacaine 0.125 % / fentanyl 2 MCG/ML Injectable Solution
898642	bupivacaine 0.125 % / hydromorphone hydrochloride 20 MCG/ML Injectable Solution

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28
Vocabulary:	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
359285	bupivacaine 0.125 % Injectable Solution
282472	bupivacaine 0.25 % Injectable Solution
108469	bupivacaine 0.375 % Injectable Solution
308818	bupivacaine 0.5 % / epinephrine 1:200,000 Injectable Solution
282473	bupivacaine 0.5 % Injectable Solution
578135	Bupivacaine 0.625 MG/ML / Fentanyl 0.0025 MG/ML Injectable Solution
359520	Bupivacaine 0.625 MG/ML / Fentanyl 0.004 MG/ML Injectable Solution
359284	Bupivacaine 0.625 MG/ML Injectable Solution
359518	Bupivacaine 1 MG/ML / Fentanyl 0.002 MG/ML Injectable Solution
578143	Bupivacaine 1 MG/ML / Fentanyl 0.003 MG/ML Injectable Solution
359523	Bupivacaine 1 MG/ML / Fentanyl 0.005 MG/ML Injectable Solution
403804	Bupivacaine 1 MG/ML / Fentanyl 0.01 MG/ML Injectable Solution
107627	Bupivacaine 1.05 MG/ML Injectable Solution
700625	Bupivacaine 1.25 MG/ML / Fentanyl 0.0025 MG/ML Injectable Solution
578136	Bupivacaine 1.25 MG/ML / Fentanyl 0.003 MG/ML Injectable Solution
700626	Bupivacaine 1.25 MG/ML / Fentanyl 0.004 MG/ML Injectable Solution
359522	Bupivacaine 1.25 MG/ML / Fentanyl 0.005 MG/ML Injectable Solution
727503	bupivacaine 100 MG per 20 ML Prefilled Syringe
727417	bupivacaine 125 MG per 50 ML Prefilled Syringe
700624	Bupivacaine 2 MG/ML Injectable Solution
317067	Bupivacaine 2.5 MG/ML / Epinephrine 0.005 MG/ML Injectable Solution
403805	Bupivacaine 2.5 MG/ML / Fentanyl 0.02 MG/ML Injectable Solution
415205	Bupivacaine 3.75 MG/ML / Lidocaine 10

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28
Vocabulary:	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
	MG/ML Injectable Solution
308820	Bupivacaine 7.5 MG/ML / Epinephrine 0.005 MG/ML Injectable Solution
308819	Bupivacaine 7.5 MG/ML Injectable Solution
415410	Bupivacaine 8.25 MG/ML Injectable Solution
477303	Bupivacaine Hydrochloride 2 MG/ML Injectable Solution
992805	chloroprocaine 2 % Injectable Solution
992801	Chloroprocaine hydrochloride 10 MG/ML Injectable Solution
992809	Chloroprocaine hydrochloride 30 MG/ML Injectable Solution
415205	Bupivacaine 3.75 MG/ML / Lidocaine 10 MG/ML Injectable Solution
309697	Dexamethasone 4 MG/ML / Lidocaine 10 MG/ML Injectable Solution
245841	Lidocaine 10 MG/ML / Methylprednisolone 40 MG/ML Injectable Solution

A.41 QRPH MCH HBS Spinal Anesthesia - Procedure Labor Codes

A.41.1 Metadata

Spinal Anesthesia - Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29
Name	This is the name of the value set	MHC HBS Spinal Anesthesia - Procedure Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect an Spinal Anesthesia Procedure
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.41.2MHC HBS Spinal Anesthesia - Procedure Value Set

1205 Spinal Anesthesia - Procedure Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
108215007	Anesthesia for procedure on spine AND/OR spinal cord (procedure)
15624001	Anesthesia for spinal fluid shunting procedure (procedure)
22048001	Anesthesia for spinal cord procedure (procedure)
40365004	Anesthesia for procedure on lumbosacral spinal cord (procedure)
417724007	Referral to epidural anesthesia for spinal pain (procedure)
434546004	Care of subject following combined spinal-epidural anesthesia (regime/therapy)
57580002	Anesthesia for procedure on thoracic spinal cord (procedure)
86583004	Anesthesia for procedure on cervical spinal cord (procedure)
231255000	Spinal subdural local anesthetic block (procedure)
231043002	Local anesthetic block on spinal nerve root (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
231044008	Local anesthetic block on spinal nerve ganglion (procedure)
231261002	Combined spinal/epidural local anesthetic block (procedure)
303358008	Neurolytic nerve block around spinal cord meninges (procedure)
303356007	Local anesthetic nerve block around spinal cord meninges (procedure)
431928000	Local anesthetic block of spinal nerve root using fluoroscopic guidance (procedure)
231253007	Local anesthetic lumbar intrathecal block (procedure)
9166009	Injection of anesthetic substance, diagnostic, subarachnoid, continuous (procedure)
47188007	Injection of anesthetic substance, therapeutic, subarachnoid, continuous (procedure)
20381001	Injection of anesthetic substance, therapeutic, subarachnoid, differential (procedure)

A.42 QRPH MCH HBS Fetal Intolerance of Labor Codes

A.42.1 Metadata

Fetal Intolerance of Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30
Name	This is the name of the value set	MCH HBS Fetal Intolerance of Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect that there was a Fetal Intolerance of Labor requiring In-utero Resuscitation measures including maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.42.2 MCH HBS Fetal Intolerance of Labor Value Set

Fetal Intolerance of Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1215

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
163545004	On examination - fetal heart 40-80 (finding)
163546003	On examination - fetal heart 80-100 (finding)
240299002	Fetal bradycardia
312668007	Abnormal fetal heart rate (finding)
231958008	Abnormal fetal heart beat, not clear if noted before OR after onset of labor in liveborn infant (finding)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
163550005	On examination - fetal heart 180-200 (finding)
163551009	On examination - fetal heart > 200 (finding)
130955003	Non-reassuring fetal status

A.43 QRPH MCH HBS In-utero Resuscitation Codes

A.43.1 Metadata

In-utero Resuscitation Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31
Name	This is the name of the value set	MCH HBS In-utero Resuscitation Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that there was a Fetal Intolerance of Labor requiring In-utero Resuscitation measures including maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010

Metadata Element	Description	Mandatory
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.43.2 MCH HBS In-utero Resuscitation Value Set

In-utero Resuscitation Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
297751002	Infusion of saline solution (procedure)
236956008	Amnioinfusion (procedure)

A.44 QRPH MCH HBS Further Fetal Assessment Codes

A.44.1 Metadata

Further Fetal Assessment Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32
Name	This is the name of the value set	MCH HBS Further Fetal Assessment Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that there was a Fetal Intolerance of Labor Further Fetal Assessment including scalp pH, scalp stimulation, acoustic stimulation
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active

Metadata Element	Description	Mandatory
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.44.2 MCH HBS Further Fetal Assessment Value Set

Further Fetal Assessment Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
259096003	Scalp pH measurement (procedure)
391898007	Fetal oxytocin stress test (procedure)
75444003	Fetal electrocardiogram (procedure)
252949007	Fetal stimulation test (procedure)
252949007	Fetal acoustical stimulation test
391899004	Contraction stress test

A.45 QRPH MCH HBS Operative Delivery Assessment Codes

A.45.1 Metadata

Operative Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
Name	This is the name of the value set	MCH HBS Operative Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect that there was an Operative Delivery including operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.45.2MCH HBS Operative Delivery Value Set

Operative Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
15413009	High forceps delivery with episiotomy (procedure)
177161009	Forceps cephalic delivery (procedure)
177162002	High forceps cephalic delivery with rotation (procedure)
177167008	Barton forceps cephalic delivery with rotation (procedure)
177168003	DeLee forceps cephalic delivery with rotation (procedure)
177170007	Piper forceps delivery (procedure)

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
17860005	Low forceps delivery with episiotomy (procedure)
1807002	Failed forceps delivery (procedure)
18625004	Low forceps delivery (procedure)
19390001	Partial breech delivery with forceps to aftercoming head (procedure)
236975003	Nonrotational forceps delivery (procedure)
236976002	Outlet forceps delivery (procedure)
236977006	Forceps delivery, face to pubes (procedure)
236978001	Forceps delivery to the aftercoming head (procedure)
25828002	Mid forceps delivery with episiotomy (procedure)
275168001	Neville-Barnes forceps delivery (procedure)
275169009	Simpson's forceps delivery (procedure)
29613008	Delivery by double application of forceps (procedure)
302383004	Forceps delivery (procedure)
30476003	Barton's forceps delivery (procedure)
45718005	Vaginal delivery with forceps including postpartum care (procedure)
54973000	Total breech delivery with forceps to aftercoming head (procedure)
62508004	Mid forceps delivery (procedure)
69422002	Trial forceps delivery (procedure)
71166009	Forceps delivery with rotation of fetal head (procedure)
89849000	High forceps delivery (procedure)
177174003	Low vacuum delivery (procedure)
177173009	High vacuum delivery (procedure)
177176001	Trial of vacuum delivery (procedure)
61586001	Delivery by vacuum extraction (procedure)
90438006	Delivery by Malstrom's extraction (procedure)
40219000	Delivery by Malstrom's extraction with episiotomy (procedure)

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
26313002	Delivery by vacuum extraction with episiotomy (procedure)
177175002	Vacuum delivery before full dilation of cervix (procedure)
11466000	Cesarean section (procedure)
177141003	Elective cesarean section (procedure)
177142005	Elective upper segment cesarean section (procedure)
177143000	Elective lower segment cesarean section (procedure)
17744000	Subtotal hysterectomy after cesarean delivery (procedure)
236985002	Emergency lower segment cesarean section (procedure)
236986001	Emergency upper segment cesarean section (procedure)
236987005	Emergency cesarean hysterectomy (procedure)
236988000	Elective cesarean hysterectomy (procedure)
236990004	Postmortem cesarean section (procedure)
24806008	Anesthesia for cesarean hysterectomy (procedure)
274130007	Emergency cesarean section (procedure)
398307005	Low cervical cesarean section (procedure)
41059002	Cesarean hysterectomy (procedure)
57271003	Extraperitoneal cesarean section (procedure)
84195007	Classical cesarean section (procedure)
89053004	Vaginal cesarean section (procedure)
63407004	Episioproctotomy (procedure)
65240009	Obstetrical version (procedure)
64809002	Combined obstetrical version (procedure)
33807004	Internal and combined version with extraction (procedure)
26688007	Internal and combined version without extraction (procedure)
387678005	External obstetrical version (procedure)

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
240278000	External cephalic version (procedure)
5048009	External cephalic version with tocolysis (procedure)
177122001	External version of breech (procedure)
387678005	External obstetrical version (procedure)
28107008	Wright's obstetrical version (procedure)
40704000	Wright's obstetrical version with extraction (procedure)
3177009	Internal obstetrical version (procedure)
13380003	Braxton Hicks obstetrical version (procedure)
14119008	Braxton Hicks obstetrical version with extraction (procedure)
302382009	Breech extraction with internal podalic version (procedure)
89703000	Potter's obstetrical version (procedure)
4504004	Potter's obstetrical version with extraction (procedure)
387679002	Manual conversion of position (procedure)
61543001	Wigand's obstetrical version (procedure)

1240

A.46 QRPH MCH HBS Induction of Labor Codes

A.46.1 Metadata

Induction of Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34
Name	This is the name of the value set	MCH HBS Induction of Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that there was an Induction of Labor

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.46.2 MCH HBS Induction of Labor Value Set

1245 Induction of Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
177135005	Oxytocin induction of labor (procedure)
177136006	Prostaglandin induction of labor (procedure)
180221005	Intravenous induction of labor (procedure)
236958009	Induction of labor (procedure)
236969007	Acupuncture for induction of labor (procedure)
308037008	Syntocinon induction of labor (procedure)
31208007	Medical induction of labor (procedure)
408818004	Induction of labor by artificial rupture of membranes (procedure)
315308008	Dilatation of cervix for delivery (procedure)
425861005	Cervical ripening with balloon (procedure)
236965001	Cervical ripening with drug (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
236967009	Cervical ripening with ethinyl estradiol (procedure)
236966000	Cervical ripening with Prostaglandin E2 (procedure)
236968004	Cervical ripening with relaxin (procedure)
236962003	Cervical ripening with Foley catheter (procedure)
236963008	Cervical ripening with tents (procedure)
236964002	Cervical ripening with synthetic tent (procedure)
85179000	Insertion of laminaria into cervix (procedure)
236960006	Sweeping of membrane (procedure)

A.47 QRPH MCH HBS Spontaneous Onset of Labor Codes

A.47.1 Metadata

Spontaneous Onset of Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35
Name	This is the name of the value set	MCH HBS Spontaneous Onset of Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that there was a Spontaneous Onset of Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.47.2 MCH HBS Spontaneous Onset of Labor Value Set

Spontaneous Onset of Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1255

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.35
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
84457005	Spontaneous onset of labor (finding)

A.48 QRPH MCH HBS Meconium Staining Codes

A.48.1 Metadata

Meconium Staining Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36
Name	This is the name of the value set	MCH HBS Meconium Staining Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that there was moderate or heavy Meconium staining
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active

Metadata Element	Description	Mandatory
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.48.2 MCH HBS Meconium Staining Value Set

Meconium staining Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
408793000	Meconium stained liquor - grade II (finding)
408794006	Meconium stained liquor - grade III (finding)
289294000	Thick meconium stained liquor (finding)

A.49 QRPH MCH HBS Non-vertex presentation in active phase of labor and delivery Codes

A.49.1 Metadata

Non-vertex presentation in active phase of labor and delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.37
Name	This is the name of the value set	MCH HBS Non-vertex presentation in active phase of labor and delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect that there was Non-vertex presentation in active phase of labor and delivery including breech, shoulder, brow, face presentations, and transverse lie
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.49.2 MCH HBS Non-vertex presentation in active phase of labor and delivery Value Set

Non-vertex presentation in active phase of labor and delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.37
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
6096002	Breech presentation (finding)
199354004	Breech presentation - delivered (finding)
49168004	Complete breech presentation (finding)
249097002	Footling breech presentation (finding)
48906005	Breech presentation, double footling (finding)
58903006	Breech presentation, single footling (finding)
18559007	Frank breech presentation (finding)
38049006	Incomplete breech presentation (finding)
163514003	On examination - breech presentation (finding)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.37
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
124736009	Compound presentation (finding)
46200004	Funic presentation (finding)
50724007	Longitudinal fetal presentation (finding)

A.50 QRPH MCH HBS Glucocortico Steroids Codes

A.50.1 Metadata

Glucocortico Steroids Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38
Name	This is the name of the value set	MCH HBS Glucocortico Steroids Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect administration of Glucocortico Steroids
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.50.2 MCH HBS Glucocortico Steroids Value Set

Glucocortico Steroids Value Set will use the RxNorm code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38
Vocabulary:	2.16.840.1.113883.6.88
RxNORM Code	RxNorm Description
308717	Betamethasone 3 MG/ML Injectable Solution
308718	Betamethasone 4 MG/ML Injectable Solution
578803	Betamethasone 3 MG/ML (as betamethasone sodium phosphate) / Betamethasone acetate 3 MG/ML Injectable Suspension
309697	Dexamethasone 4 MG/ML / Lidocaine 10 MG/ML Injectable Solution
881355	Dexamethasone 0.02 MG/ML Injectable Solution
436510	Dexamethasone 0.133 MG/ML Injectable Solution
309696	Dexamethasone 10 MG/ML Injectable Solution
393267	Dexamethasone 16 MG/ML Injectable Solution
435681	Dexamethasone 2 MG/ML Injectable Solution
315061	Dexamethasone 20 MG/ML Injectable Solution
197584	Dexamethasone 24 MG/ML Injectable Solution
880649	Dexamethasone 3 MG/ML Injectable Solution
309698	Dexamethasone 4 MG/ML Injectable Solution
105394	Dexamethasone 5 MG/ML Injectable Solution
387080	Dexamethasone 8 MG/ML Injectable Solution
309687	Dexamethasone 16 MG/ML Injectable Suspension
309688	Dexamethasone 8 MG/ML Injectable Suspension

A.51 QRPH MCH HBS Breastfed Infant Codes

A.51.1 Metadata

Breastfed Infant Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41
Name	This is the name of the value set	MCH HBS Breastfed Infant Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Breastfed Infant at discharge
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.51.2 MCH HBS Breastfed Infant Value Set

Breastfed Infant Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1290

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
169741004	Breast fed (finding)
169751003	Bottle changed to breast (finding)
169745008	Breastfeeding started (finding)
169743001	Breastfeeding with supplement (finding)

A.52 QRPH MCH HBS Male Gender Codes

A.52.1 Metadata

1295 Male Gender Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42
Name	This is the name of the value set	MCH HBS Male Gender Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Male Gender
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7 AministrativeGender
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.52.2 MCH HBS Male Gender Value Set

Male Gender Value Set will use the HL7 AdministrativeGender code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42
Vocabulary :	*2.16.840.1.113883.12.1*
HL7 AdministrativeGender Code	HL7 AdministrativeGender Description
M	Male

A.53 QRPH MCH HBS Female Gender Codes

A.53.1 Metadata

Female Gender Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
Name	This is the name of the value set	MCH HBS Female Gender Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Female Gender
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from HL7 AministrativeGender
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.hl7.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.53.2 MCH HBS Female Gender Value Set

Female Gender Value Set will use the HL7 AministrativeGender code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
Vocabulary:	*2.16.840.1.113883.12.1*
HL7 AministrativeGender Code	HL7 AministrativeGender Description
F	Female

A.54 QRPH MCH HBS Discharge Transfer Codes

A.54.1 Metadata

Discharge Transfer Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44
Name	This is the name of the value set	MCH HBS Discharge Transfer Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Discharge of the newborn as Transfer
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.54.2 MCH HBS Discharge Transfer Value Set

Discharge Transfer Value Set will use the UB-04/NUBC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44
Vocabulary:	2.16.840.1.113883.6.21
UB-04/NUBC Code	**Description**
02	Discharged/transferred to a short-term general hospital for inpatient care.

A.55 QRPH MCH HBS Anencephaly of the Newborn Codes

A.55.1 Metadata

Anencephaly of the Newborn Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53
Name	This is the name of the value set	MCH HBS Anencephaly of the Newborn Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Anencephaly of the Newborn as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.55.2 MCH HBS Anencephaly of the Newborn Value Set

Anencephaly of the Newborn Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
359824007	Incomplete anencephaly (disorder)
203922009	Anencephalus and similar anomalies (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
89369001	Anencephalus (disorder)
417658006	Holoanencephaly (disorder)
57480000	Known OR suspected fetal anencephaly affecting obstetrical care (disorder)
203923004	Acrania (disorder)
32219008	Craniorachischisis (disorder)
2438005	Iniencephaly (disorder)
203927003	Iniencephaly - closed (disorder)
203928008	Iniencephaly - open (disorder)
30915001	Holoprosencephaly sequence (disorder)

A.56 QRPH MCH HBS Cyanotic Congenital Heart Disease Codes

A.56.1 Metadata

Cyanotic Congenital Heart Disease Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
Name	This is the name of the value set	MCH HBS Cyanotic Congenital Heart Disease Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Cyanotic Congenital Heart Disease as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.56.2MCH HBS Cyanotic Congenital Heart Disease Value Set

Cyanotic Congenital Heart Disease Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
12770006	Cyanotic congenital heart disease (disorder)
399216004	D - transposition of the great vessels (disorder)
204300001	Incomplete great vessel transposition (disorder)
399046008	L - transposition of the great vessels (disorder)
204297006	Total great vessel transposition (disorder)
253297008	Transposition of aorta (disorder)
86299006	Tetralogy of Fallot (disorder)
253514004	Dextraposition of aorta in Fallot's tetralogy (disorder)
204306007	Pentalogy of Fallot (disorder)
399228007	Tetralogy of Fallot with absent pulmonary valve (disorder)
253513005	Tetralogy of Fallot with pulmonary atresia (disorder)
253512000	Tetralogy of Fallot with pulmonary stenosis (disorder)
253515003	Ventricular septal defect in Fallot's tetralogy (disorder)
111323005	Total anomalous pulmonary venous return (disorder)
204456001	Subdiaphragmatic total anomalous pulmonary venous return (disorder)
204457005	Supradiaphragmatic total anomalous pulmonary venous return (disorder)
62067003	Hypoplastic left heart syndrome (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
61959006	Common truncus arteriosus (disorder)
73699003	Truncus arteriosus, Edwards' type I (disorder)
60106004	Truncus arteriosus, Edwards' type II (disorder)
85081000	Truncus arteriosus, Edwards' type III (disorder)
111319002	Truncus arteriosus, Edwards' type IV (disorder)
218728005	Interrupted aortic arch (disorder)
253683008	Interrupted aortic arch between left common carotid and brachiocephalic artery (disorder)
253682003	Interrupted aortic arch between left subclavian and left common carotid artery (disorder)
253681005	Interrupted aortic arch distal to left subclavian artery (disorder)
204467000	Pulmonary vein atresia (disorder)
253623006	Pulmonary trunk atresia (disorder)
253625004	Pulmonary atresia with absent pulmonary artery (disorder)
253624000	Pulmonary atresia with confluent pulmonary arteries (disorder)
204443008	Pulmonary artery atresia (disorder)
253594000	Muscular pulmonary atresia (disorder)
123643003	Acquired atresia of pulmonary valve (disorder)
10930001	Congenital atresia of pulmonary artery (disorder)
253590009	Pulmonary atresia with intact ventricular septum (disorder)
253591008	Pulmonary atresia with ventricular septal defect (disorder)
253592001	Pulmonary valve atresia without ventricular outflow tract (disorder)
253513005	Tetralogy of Fallot with pulmonary atresia (disorder)
253303001	Solitary aortic trunk with pulmonary atresia (disorder)
253304007	Solitary pulmonary trunk with aortic atresia (disorder)
204448004	Atresia of pulmonary artery with septal defect (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
253590009	Pulmonary atresia with intact ventricular septum (disorder)
253591008	Pulmonary atresia with ventricular septal defect (disorder)
410068002	Acquired and/or congenital pulmonary valve atresia (disorder)
70756004	Bronchial atresia with segmental pulmonary emphysema (disorder)
253592001	Pulmonary valve atresia without ventricular outflow tract (disorder)
234062003	Pulmonary vein stenosis (disorder)
11614003	Congenital stenosis of pulmonary veins (disorder)
253621008	Pulmonary trunk stenosis (disorder)
95441000	Pulmonary artery stenosis (disorder)
26780008	Coarctation of pulmonary artery (disorder)
52757001	Congenital supravalvular pulmonary stenosis (disorder)
253631001	Peripheral pulmonary artery stenosis (disorder)
253621008	Pulmonary trunk stenosis (disorder)
194997002	Pulmonary stenosis, non-rheumatic (disorder)
91442002	Rheumatic pulmonary valve stenosis (disorder)
85971001	Rheumatic pulmonary valve stenosis with insufficiency (disorder)
251006007	Pulmonary valve stenosis with doming (disorder)
67278007	Congenital stenosis of pulmonary valve (disorder)
204351007	Fallot's trilogy (disorder)
251007003	Pulmonary valve stenosis with narrow jet (disorder)
52757001	Congenital supravalvular pulmonary stenosis (disorder)
195000004	Pulmonary valve stenosis with insufficiency (disorder)
253512000	Tetralogy of Fallot with pulmonary stenosis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
403820003	Café-au-lait macules with pulmonary stenosis (disorder)
276793003	Pulmonary hypertension with occult mitral stenosis (disorder)
85971001	Rheumatic pulmonary valve stenosis with insufficiency (disorder)
253691004	Stenosis of systemic to pulmonary artery collateral artery (disorder)
83330001	Patent ductus arteriosus (disorder)
253685001	Patent ductus arteriosus - delayed closure (disorder)
125963005	Patent ductus arteriosus with left-to-right shunt (disorder)
125964004	Patent ductus arteriosus with right-to-left shunt (disorder)
63042009	Congenital atresia of tricuspid valve (disorder)
204354004	Congenital tricuspid atresia and stenosis (disorder)
204357006	Ebstein's anomaly of tricuspid valve (disorder)
17394001	Ebstein's anomaly with atrial septal defect (disorder)
253496001	Ebstein's anomaly of left atrioventricular valve (disorder)
253468007	Ebstein's anomaly of right atrioventricular valve (disorder)
253443005	Ebstein's anomaly of common atrioventricular valve (disorder)
7305005	Coarctation of aorta (disorder)
13867009	Preductal coarctation of aorta (disorder)
72242008	Postductal coarctation of aorta (disorder)
109426009	Single left ventricle (disorder)
109425008	Single right ventricle (disorder)
443379009	Functional single ventricle (disorder)

1330

A.57 QRPH MCH HBS Congenital Diaphragmatic Hernia Codes

A.57.1 Metadata

Congenital Diaphragmatic Hernia Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55
Name	This is the name of the value set	MCH HSB Congenital Diaphragmatic Hernia Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Congenital Diaphragmatic Hernia as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.57.2 MCH HSB Congenital Diaphragmatic Hernia Value Set

Congenital Diaphragmatic Hernia Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
17190001	Congenital diaphragmatic hernia (disorder)
84089009	Hiatal hernia (disorder)
47028006	Congenital hiatus hernia (disorder)
74827000	Gangrenous hiatal hernia (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
309752000	Hiatus hernia with gangrene (disorder)
60507002	Hiatal hernia with gangrene AND obstruction (disorder)
309751007	Hiatus hernia - irreducible (disorder)
309753005	Hiatus hernia with obstruction (disorder)
88639006	Hiatal hernia with obstruction but no gangrene (disorder)
309754004	Simple hiatus hernia (disorder)
236053002	Sliding hiatus hernia (disorder)
236055009	Mixed hiatus hernia (disorder)

A.58 QRPH MCH HBS Karyotype Confirmed Codes

A.58.1 Metadata

Karyotype Confirmed Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56
Name	This is the name of the value set	MCH HBS Karyotype Confirmed Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Karyotype Confirmed in an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A

Metadata Element	Description	Mandatory
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.58.2 MCH HBS Karyotype Confirmed Value Set

Karyotype Confirmed Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
442124003	Karyotype evaluation abnormal (finding)

A.59 QRPH MCH HBS Suspected Chromosomal Disorder Codes

A.59.1 Metadata

Suspected Chromosomal Disorder Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Name	This is the name of the value set	MCH HBS Suspected Chromosomal Disorder Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Suspected Chromosomal Disorder as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.59.2MCH HBS Suspected Chromosomal Disorder Value Set

Suspected Chromosomal DisorderValue Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
312654000	Maternal care for suspected chromosomal abnormality in fetus (disorder)
41040004	Complete trisomy 21 syndrome (disorder)
205615000	Trisomy 21- meiotic nondisjunction (disorder)
205616004	Trisomy 21- mitotic nondisjunction mosaicism (disorder)
254264002	Partial trisomy 21 in Down's syndrome (disorder)
371045000	Translocation Down syndrome (disorder)
254268004	Partial trisomy 13 in Patau's syndrome (disorder)
548004	13p partial trisomy syndrome (disorder)
10572007	13q partial trisomy syndrome (disorder)
21111006	Complete trisomy 13 syndrome (disorder)
205620000	Trisomy 13 - mitotic nondisjunction mosaicism (disorder)
205619006	Trisomy 13, meiotic nondisjunction (disorder)
4199009	18p partial trisomy syndrome (disorder)
66985009	18q partial trisomy syndrome (disorder)
51500006	Complete trisomy 18 syndrome (disorder)
205623003	Trisomy 18 - meiotic nondisjunction (disorder)
205624009	Trisomy 18 - mitotic nondisjunction mosaicism (disorder)
254266000	Partial trisomy 18 in Edward's syndrome

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(disorder)
42712003	Cri du chat (finding)
70173007	5p partial monosomy syndrome (disorder)
19550003	22q partial monosomy syndrome (disorder)
77128003	DiGeorge sequence (disorder)
83092002	Shprintzen syndrome (disorder)
205644003	Balanced autosomal translocation (disorder)
38804009	Turner syndrome (disorder)
205686009	Karyotype 46, X iso (Xq) (disorder)
205687000	Karyotype 46, X with abnormal sex chromosome except iso (Xq) (disorder)
83579008	Mixed gonadal dysgenesis (disorder)
205689002	Mosaicism 45, X / other cell line with abnormal sex chromosome (disorder)
302960008	Mosaicism 45, X; 46, XX (disorder)
254281006	Turner's phenotype - ring chromosome karyotype (disorder)
205684007	Turner's phenotype, karyotype normal (disorder)
205688005	Turner's phenotype, mosaicism 45, X; 46, XX or 45, X; 46, XY (disorder)
254280007	Turner's phenotype, partial X deletion karyotype (disorder)
205719003	46, XX true hermaphrodite (disorder)
268300003	Klinefelter's syndrome - male with more than two X chromosomes (disorder)
275264009	Klinefelter's syndrome XXXXY (disorder)
275263003	Klinefelter's syndrome XXXY (disorder)
405769009	Klinefelter's syndrome, XXY (disorder)
205699007	Klinefelter's syndrome, XXYY (disorder)
205700008	Klinefelter's syndrome, XY/XXY mosaic (disorder)
254273005	Autosomal deletion - mosaicism (disorder)
62599000	9p partial monosomy syndrome (disorder)
78740005	Complete monosomy 21 syndrome (disorder)
205634000	Deletion seen only at prometaphase (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
274908005	Deletion with complex rearrangement (disorder)
205638002	Monosomy 21, mosaicism (disorder)
205636003	Whole chromosome monosomy - meiotic nondisjunction (disorder)
270520003	Whole chromosome monosomy - mitotic nondisjunction mosaicism (disorder)
409709004	Chromosomal disorder (disorder)
254259001	Absence of sex chromosome (disorder)
403759001	Autosomal chromosomal disorder (disorder)
428113000	Autosomal aneuploidy (disorder)
254275003	Balanced rearrangement and structural marker (disorder)
205673000	Balanced autosomal rearrangement in abnormal individual (disorder)
205644003	Balanced autosomal translocation (disorder)
205674006	Balanced sex/autosomal rearrangement in abnormal individual (disorder)
254276002	Balanced translocation and insertion in normal individual (disorder)
205672005	Chromosome inversion in normal individual (disorder)
205676008	Individual with autosomal fragile site (disorder)
205675007	Individual with marker heterochromatin (disorder)
444655009	Extra unidentified structurally abnormal chromosome (disorder)
445580008	Familial extra unidentified structurally abnormal chromosome (disorder)
419900000	Gelatinous droplike corneal dystrophy (disorder)
60258001	Macular corneal dystrophy (disorder)
95488001	Congenital macular corneal dystrophy (disorder)
231933003	Lattice corneal dystrophy, isolated form (disorder)
418054005	Macular corneal dystrophy Type I (disorder)
418435001	Macular corneal dystrophy Type II (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
419398009	Meretoja syndrome (disorder)
419087002	Lattice corneal dystrophy Type II (disorder)
254262003	Unbalanced translocation and insertion (disorder)
371045000	Translocation Down syndrome (disorder)
444858009	Unbalanced translocation of chromosome (disorder)

A.60 QRPH MCH HBS Cleft Lip with/without Cleft Palate Codes

A.60.1 Metadata

Cleft Lip with/without Cleft Palate Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58
Name	This is the name of the value set	MCH HBS Cleft Lip with/without Cleft Palate Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Cleft Lip with/without Cleft Palate as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A

Metadata Element	Description	Mandatory
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.60.2MCH HBS Cleft Lip with/without Cleft Palate Value Set

Cleft Lip with/without Cleft Palate Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
80281008	Cleft lip (disorder)
304068004	Bilateral cleft lip (disorder)
253984004	Bilateral complete and incomplete cleft lip (disorder)
80446009	Complete bilateral cleft lip (disorder)
62815003	Incomplete bilateral cleft lip (disorder)
253989009	Bilateral incomplete cleft lip and alveolus (disorder)
204608004	Central cleft lip (disorder)
6936002	Cleft lip sequence (disorder)
66948001	Cleft palate with cleft lip (disorder)
204614006	Bilateral complete cleft palate with cleft lip (disorder)
204615007	Bilateral incomplete cleft palate with cleft lip (disorder)
204616008	Central complete cleft palate with cleft lip (disorder)
204617004	Central incomplete cleft palate with cleft lip (disorder)
339502006	Cheilognathopalatoschisis (disorder)
77414002	Cheilognathoschisis (disorder)
88659005	Cheilognathoprosoposchisis (disorder)
338486003	Cheilognathouranoschisis (disorder)
253983005	Cheilopalatoschisis (disorder)
204620007	Cleft hard palate with cleft lip, bilateral (disorder)
337471007	Cleft upper lip, upper jaw AND palate

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(disorder)
253986002	Palatoschisis (disorder)
79261008	Van der Woude syndrome (disorder)

A.61 QRPH MCH HBS Karyotype Result Codes

A.61.1 Metadata

Karyotype Result Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59
Name	This is the name of the value set	MCH HBS Karyotype Result Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Karyotyping to determine that the result is pending
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.61.2 MCH HBS Karyotype Result Value Set

Karyotype Result Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59
Vocabulary:	1.3.6.1.4.1.19376.1.5.3.1.3.28
LOINC Code	LOINC Description
29770-5	Karyotype [Identifier] in Blood or Tissue NominalKaryotype | Amniotic Fluid
33773-3	Karyotype [Identifier] in Amniotic fluid NominalKaryotype | Blood cord
33774-1	Karyotype [Identifier] in Chorionic villus sample NominalKaryotype | Blood or Tissue
35129-6	Karyotype [Identifier] in Unspecified specimen NominalKaryotype | Chorionic villus sample
38471-9	Karyotype [Identifier] in Urine NominalKaryotype | Urine
48818-9	Karyotype [Identifier] in Blood or Tissue by High resolution NominalKaryotype | XXX
48819-7	Karyotype [Identifier] in Tissue from fetus NominalKaryotype | Fetus | Tissue & Smears
48820-5	Karyotype [Identifier] in Cord blood Nominal
50619-6	Karyotype [Identifier] in Blood or Tissue Narrative
56030-0	Karyotype [Identifier] in Urine by Fluorescent in situ hybridization (FISH) Narrative

A.62 QRPH MCH HBS Cleft Lip without Cleft Palate Codes

A.62.1 Metadata

Cleft Lip without Cleft Palate Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60
Name	This is the name of the value set	MCH HSB Cleft Lip without Cleft Palate Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Cleft Lip without Cleft Palate as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.62.2 MCH HSB Cleft Lip without Cleft Palate Value Set

Cleft Lip without Cleft Palate Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
80281008	Cleft lip (disorder)
304068004	Bilateral cleft lip (disorder)
253984004	Bilateral complete and incomplete cleft lip (disorder)
80446009	Complete bilateral cleft lip (disorder)
62815003	Incomplete bilateral cleft lip (disorder)
253989009	Bilateral incomplete cleft lip and alveolus (disorder)
204608004	Central cleft lip (disorder)
6936002	Cleft lip sequence (disorder)

A.63 QRPH MCH HBS Downs Syndrome Codes

A.63.1 Metadata

Downs Syndrome Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
Name	This is the name of the value set	MCH HSB Downs Syndrome Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Downs Syndrome as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.63.2 MCH HSB Downs Syndrome Value Set

1380 Downs Syndrome Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
41040004	Complete trisomy 21 syndrome (disorder)
205615000	Trisomy 21- meiotic nondisjunction (disorder)
205616004	Trisomy 21- mitotic nondisjunction mosaicism (disorder)
254264002	Partial trisomy 21 in Down's syndrome (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
371045000	Translocation Down syndrome (disorder)

A.64 QRPH MCH HBS Gastroschisis of the Newborn Codes

A.64.1 Metadata

Gastroschisis of the Newborn Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62
Name	This is the name of the value set	MCH HBS Gastroschisis of the Newborn Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Gastroschisis of the Newborn as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.64.2 MCH HBS Gastroschisis of the Newborn Value Set

Gastroschisis of the Newborn Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1390

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
72951007	Gastroschisis (disorder)

A.65 QRPH MCH HBS Hypospadias Codes

A.65.1 Metadata

Hypospadias Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63
Name	This is the name of the value set	MCH HBS Hypospadias Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Hypospadias as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

1395 ### A.65.2 MCH HBS Hypospadias Value Set

Hypospadias Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
416010008	Hypospadias (disorder)
57514000	3-Oxo-5 alpha-steroid delta 4-dehydrogenase deficiency (disorder)
204891000	Hypospadias, balanic (disorder)
205027003	Hypospadias, female (disorder)
204888000	Hypospadias, penile (disorder)
204889008	Hypospadias, penoscrotal (disorder)
204890004	Hypospadias, perineal (disorder)
81771002	Opitz-Frias syndrome (disorder)

A.66 QRPH MCH HBS Limb Reduction Defect Codes

A.66.1 Metadata

Limb Reduction Defect Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	6.1.4.1.19376.1.7.3.1.1.13.8.64
Name	This is the name of the value set	MCH HSB Limb Reduction Defect Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Limb Reduction Defect as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010

Metadata Element	Description	Mandatory
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.66.2 MCH HSB Limb Reduction Defect Value Set

Limb Reduction Defect Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1405

Value Set :	6.1.4.1.19376.1.7.3.1.1.13.8.64
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
45806008	Reduction deformity of upper limb (disorder)
29155003	Ectromelia of upper limb (disorder)
64008009	Hemimelia of upper limb (disorder)
3699000	Transverse deficiency of upper limb (disorder)
205159008	Transverse deficiency of arm, forearm level (disorder)
205164007	Transverse deficiency of arm, upper arm level - long (disorder)
205163001	Transverse deficiency of arm, upper arm level - short (disorder)
253926000	Phocomelia of the upper limb (disorder)
78018008	Complete phocomelia of upper limb (disorder)
1967001	Longitudinal absence of radius AND ulna (disorder)
205168005	Rudimentary arm (disorder)
205160003	Transverse deficiency of arm, shoulder level (disorder)
77595004	Reduction deformity of lower limb (disorder)
361214005	Absent pelvis and lower limb (disorder)
253960007	Brachymelia of leg (disorder)
49226005	Brachymetapody (disorder)
205378003	Brachymetapodia of first metatarsal (disorder)
205379006	Brachymetapodia of fourth metatarsal (disorder)
30592006	Brachymetatarsia (disorder)
310800007	Brachyphalangia of toe (disorder)

Value Set :	6.1.4.1.19376.1.7.3.1.1.13.8.64
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
205349004	Brachyphalangia of little toe (disorder)
205093009	Congenital short Achilles tendon (disorder)
205111008	Congenital short quadriceps (disorder)
253963009	Phocomelia of the lower limb (disorder)
55852007	Complete phocomelia of lower limb (disorder)
205211001	Proximal femoral focal deficiency (disorder)
253962004	Rudimentary leg (disorder)
68551007	Limb reduction-ichthyosis syndrome (disorder)

A.67 QRPH MCH HBS Meningomyelocele/Spina Bifida of the Newborn Codes

A.67.1 Metadata

Meningomyelocele/Spina Bifida of the Newborn Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65
Name	This is the name of the value set	MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Meningomyelocele/Spina Bifida of the Newborn as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A

Metadata Element	Description	Mandatory
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.67.2 MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set

Meningomyelocele/Spina Bifida of the Newborn Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1415

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
414667000	Meningomyelocele (disorder)
203985009	Cervical meningomyelocele (disorder)
81526008	Hydromeningomyelocele (disorder)
37382001	Known OR suspected fetal spina bifida with myelomeningocele affecting obstetrical care (disorder)
203987001	Lumbar meningomyelocele (disorder)
203967002	Spinal hydromeningocele (disorder)
203986005	Thoracic meningomyelocele (disorder)
271571006	Meningomyelocele/myelocele (disorder)
67531005	Spina bifida (disorder)
253117002	Closed spina bifida with Arnold-Chiari malformation (disorder)
253112008	Fissured spine (disorder)
253116006	Fissured spine with hydrocephalus (disorder)
253119004	Hemimyelocele (disorder)
253120005	Lipomeningocele (disorder)
203998000	Lumbar myelocystocele (disorder)
204005000	Lumbar spina bifida without hydrocephalus - open (disorder)
70534000	Occult spinal dysraphism sequence (disorder)
61819007	Rachischisis (disorder)
93557001	Holorachischisis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
253113003	Rachischisis with hydrocephalus (disorder)
204006004	Sacral spina bifida without hydrocephalus - open (disorder)
58557008	Spina bifida aperta (disorder)
425687007	Spina bifida aperta of cervical spine (disorder)
429466000	Spina bifida aperta of lumbar spine (disorder)
427216002	Spina bifida aperta of thoracic spine (disorder)
32232003	Spina bifida of cervical region (disorder)
203934001	Cervical spina bifida with hydrocephalus (disorder)
203948001	Cervical spina bifida with hydrocephalus - closed (disorder)
204010001	Cervical spina bifida without hydrocephalus - closed (disorder)
204003007	Cervical spina bifida without hydrocephalus - open (disorder)
30620003	Spina bifida of dorsal region (disorder)
203935000	Thoracic spina bifida with hydrocephalus (disorder)
203949009	Thoracic spina bifida with hydrocephalus - closed (disorder)
203942000	Thoracic spina bifida with hydrocephalus - open (disorder)
204011002	Thoracic spina bifida without hydrocephalus - closed (disorder)
204004001	Thoracic spina bifida without hydrocephalus - open (disorder)
77224008	Spina bifida of lumbar region (disorder)
203950009	Lumbar spina bifida with hydrocephalus - closed (disorder)
204012009	Lumbar spina bifida without hydrocephalus - closed (disorder)
53318002	Spina bifida with hydrocephalus (disorder)
203936004	Lumbar spina bifida with hydrocephalus (disorder)
203943005	Lumbar spina bifida with hydrocephalus - open (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
253114009	Myelocele with hydrocephalus (disorder)
203946002	Spina bifida with hydrocephalus - closed (disorder)
203951008	Sacral spina bifida with hydrocephalus - closed (disorder)
253118007	Thoracolumbar spina bifida with hydrocephalus - closed (disorder)
268143001	Spina bifida with hydrocephalus - open (disorder)
203944004	Sacral spina bifida with hydrocephalus - open (disorder)
203954000	Spina bifida with hydrocephalus of late onset (disorder)
203955004	Spina bifida with stenosis of aqueduct of Sylvius (disorder)
40130009	Spina bifida without hydrocephalus (disorder)
268146009	Spina bifida without hydrocephalus - open (disorder)
204008003	Spina bifida without hydrocephalus - closed (disorder)
204013004	Sacral spina bifida without hydrocephalus - closed (disorder)
253111001	Thoracolumbar spina bifida without hydrocephalus - closed (disorder)

A.68 QRPH MCH HBS Omphalocele of the Newborn Codes

A.68.1 Metadata

Omphalocele of the NewbornValue Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66
Name	This is the name of the value set	MCH HBS Omphalocele of the Newborn Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To reflect Omphalocele of the Newborn as an anomality of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.68.2 MCH HBS Omphalocele of the Newborn Value Set

Omphalocele of the Newborn Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
18735004	Congenital omphalocele (disorder)
36631002	Hepatomphalocele (disorder)
196864001	Omphalocele - irreducible (disorder)
196856007	Omphalocele with gangrene (disorder)
1542009	Omphalocele with obstruction (disorder)
196868003	Simple omphalocele (disorder)

A.69 QRPH MCH HBS Date of Last Live Birth Codes

A.69.1 Metadata

Date of Last Live Birth Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67
Name	This is the name of the value set	MCH HSB Date of Last Live Birth Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Date of Last Live Birth
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.69.2 MCH HSB Date of Last Live Birth Value Set

Date of Last Live Birth Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1430

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.70 QRPH MCH HBS Number of Live Births Codes

A.70.1 Metadata

Number of Live Births Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
Name	This is the name of the value set	MCH HBS Number of Live Births Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Number of Live Births
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.70.2 MCH HBS Number of Live Births Value Set

Number of Live Births Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
11636-8	Births.live

A.71 QRPH MCH HBS Date of Last Menses Codes

A.71.1 Metadata

Date of Last Menses Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
Name	This is the name of the value set	MCH HBS Date of Last Menses Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Date of Last Menses
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.71.2 MCH HBS Date of Last Menses Value Set

1445 Date of Last Menses Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
3145-0	Menstrual period start.last
33066-2	Estimated last menstrual period

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
8665-2	Date last menstrual period

A.72 QRPH MCH HBS Date of Last Other Pregnancy Outcome Codes

A.72.1 Metadata

1450 Date of Last Other Pregnancy Outcome Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70
Name	This is the name of the value set	MCH HBS Date of Last Other Pregnancy Outcome Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Date of Last Other Pregnancy Outcome
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.72.2 MCH HBS Date of Last Other Pregnancy Outcome Value Set

Date of Last Other Pregnancy Outcome Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.73 QRPH MCH HBS Number of Prior Pregnancies Codes

A.73.1 Metadata

Number of Prior Pregnancies Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71
Name	This is the name of the value set	MCH Number of Prior Pregnancies Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Number of Prior Pregnancies
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.73.2 MCH Number of Prior Pregnancies Value Set

Number of Prior Pregnancies Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.71
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
11996-6	Pregnancies
11977-6	Parity

A.74 MCH HBS Problem Status Active Codes

A.74.1 Metadata

Problem Status Active Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119
Name	This is the name of the value set	MCH HBS Problem Status Active Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect the Problem Status Active
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.74.2 MCH HBS Problem Status Active Value Set

Problem Status Active Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
55561003	Active

A.75 QRPH MCH HBS Chlamydia Codes

A.75.1 Metadata

Chlamydia Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93
Name	This is the name of the value set	MCH HBS Clamydia Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Chlamydia as Infections present and treated during this pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.75.2 MCH HBS Clamydia Value Set

Chlamydia Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93
Vocabulary:	1.3.6.1.4.1.19376.1.5.3.1.3.6
SNOMED-CT Code	SNOMED-CT Description
413079006	Chlamydia PCR positive (finding)
240589008	Chlamydia trachomatis infection (disorder)
426247003	Acute genitourinary Chlamydia trachomatis infection (disorder)
420910002	Chlamydia trachomatis infection of anus and rectum (disorder)
428015005	Chlamydia trachomatis infection of genital structure (disorder)
189312004	Pelvic inflammation with female sterility due to Chlamydia trachomatis (disorder)
198176005	Female chlamydial pelvic inflammatory disease (disorder)
186946009	Lymphogranuloma venereum (disorder)
240602008	Early lymphogranuloma venereum (disorder)
272262003	Esthiomene (disorder)
240603003	Late lymphogranuloma venereum (disorder)
240604009	Latent lymphogranuloma venereum (disorder)
2576002	Trachoma (disorder)
266109000	Inclusion conjunctivitis (disorder)
276683003	Neonatal inclusion body conjunctivitis (disorder)
240591000	Neonatal chlamydial conjunctivitis (disorder)
52812002	Trachoma, active stage (disorder)
29976007	Trachoma, initial stage (disorder)
27020006	Trachomatous follicular conjunctivitis (disorder)
90060000	Trachomatous granular conjunctivitis (disorder)
55555001	Trachomatous pannus (disorder)
179101003	Urethritis due to Chlamydia trachomatis (disorder)
314527009	Chlamydia antigen ELISA positive (finding)
312099009	Genitourinary chlamydia infection (disorder)
426165006	Acute genitourinary chlamydia infection (disorder)
237106009	Chlamydial bartholinitis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93
Vocabulary:	1.3.6.1.4.1.19376.1.5.3.1.3.6
SNOMED-CT Code	SNOMED-CT Description
237084006	Chlamydial cervicitis (disorder)
236683007	Chlamydial urethritis (disorder)
237039009	Chlamydial salpingitis (disorder)
237097008	Chlamydial vulvovaginitis (disorder)
179101003	Urethritis due to Chlamydia trachomatis (disorder)
426165006	Acute genitourinary chlamydia infection (disorder)
415798001	Urine chlamydia trachomatis test positive (finding)
420910002	Chlamydia trachomatis infection of anus and rectum (disorder)
426247003	Acute genitourinary Chlamydia trachomatis infection (disorder)
428015005	Chlamydia trachomatis infection of genital structure (disorder)

A.76 QRPH MCH HBS Gonorrhea Codes

A.76.1 Metadata

Gonorrhea Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Name	This is the name of the value set	MCH HBS Gonorrhea Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Gonorrhea as Infections present and treated during this pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html

Metadata Element	Description	Mandatory
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.76.2MCH HBS Gonorrhea Value Set

Gonorrhea Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
15628003	Gonorrhea (disorder)
235861001	Abscess gonococcal (disorder)
240573005	Gonococcal Bartholin's gland abscess (disorder)
236688003	Gonococcal periurethral gland abscess (disorder)
237046000	Gonococcal tubo-ovarian abscess (disorder)
236687008	Gonococcal urethral abscess (disorder)
240578001	Gonococcal Littré gland abscess (disorder)
240579009	Gonococcal paraurethral gland abscess (disorder)
17305005	Acute gonorrhea of genitourinary tract (disorder)
80604007	Acute gonococcal bartholinitis (disorder)
20943002	Acute gonococcal cervicitis (disorder)
65295003	Acute gonococcal endometritis (disorder)
45377007	Acute gonococcal salpingitis (disorder)
17305005	Acute gonorrhea of genitourinary tract (disorder)
2390000	Acute gonococcal vulvovaginitis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
54825009	Acute gonorrhea of lower genitourinary tract (disorder)
24868007	Acute gonococcal cystitis (disorder)
29864006	Acute gonococcal urethritis (disorder)
50970007	Acute gonorrhea of upper genitourinary tract (disorder)
27681008	Chronic gonorrhea (disorder)
28572009	Chronic gonorrhea of genitourinary tract (disorder)
12373006	Chronic gonococcal bartholinitis (disorder)
76802005	Chronic gonococcal cervicitis (disorder)
31999004	Chronic gonococcal endometritis (disorder)
11906007	Chronic gonococcal vulvovaginitis (disorder)
186915005	Chronic gonorrhea lower genitourinary tract (disorder)
88813005	Chronic gonococcal cystitis (disorder)
80388004	Chronic gonorrhea of upper genitourinary tract (disorder)
53529004	Chronic gonococcal salpingitis (disorder)
186931002	Gonococcal anal infection (disorder)
46699001	Gonococcal bursitis (disorder)
197848003	Gonococcal cystitis (disorder)
240581006	Gonococcal female pelvic infection (disorder)
237083000	Gonococcal cervicitis (disorder)
237069002	Gonococcal endometritis (disorder)
237038001	Gonococcal salpingitis (disorder)
237095000	Gonococcal vulvovaginitis (disorder)
237096004	Neonatal gonococcal vulvovaginitis (disorder)
9241004	Gonococcal heart disease (disorder)
61048000	Gonococcal endocarditis (disorder)
235863003	Gonococcal hepatitis (disorder)
35876006	Gonococcal infection of eye (disorder)
231858009	Gonococcal conjunctivitis (disorder)
28438004	Gonococcal conjunctivitis neonatorum

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(disorder)
111807001	Gonococcal endophthalmia (disorder)
9091006	Gonococcal iridocyclitis (disorder)
40149008	Gonococcal keratitis (disorder)
406581000	Gonococcal infection of the central nervous system (disorder)
151004	Gonococcal meningitis (disorder)
60335002	Gonococcal keratosis (disorder)
237042003	Gonococcal perihepatitis (disorder)
186939000	Gonococcal peritonitis (disorder)
307423008	Gonococcal pelvic peritonitis (disorder)
53664003	Gonococcal spondylitis (disorder)
266138002	Gonococcal synovitis or tenosynovitis (disorder)
240582004	Gonococcal synovitis (disorder)
240039005	Gonococcal tenosynovitis (disorder)
240575003	Gonococcal Tysonitis (disorder)
236682002	Gonococcal urethritis (disorder)
44412000	Chronic gonococcal urethritis (disorder)
240576002	Gonococcal Cowperitis (disorder)
240577006	Gonococcal Littritis (disorder)
240574004	Gonococcal Skenitis (disorder)
5085001	Gonococcemia (disorder)
44743006	Gonococcal infection of joint (disorder)
272006008	Gonococcal arthritis dermatitis syndrome (disorder)
74372003	Gonorrhea of pharynx (disorder)
42746002	Gonorrhea of rectum (disorder)
186932009	Gonococcal rectal infection (disorder)
240572000	Gonorrhea with local complication (disorder)
199161008	Maternal gonorrhea during pregnancy, childbirth and the puerperium (disorder)
35255008	Gonorrhea in mother complicating pregnancy, childbirth AND/OR puerperium (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
199163006	Maternal gonorrhea during pregnancy - baby delivered (disorder)
199165004	Maternal gonorrhea during pregnancy - baby not yet delivered (disorder)
199164000	Maternal gonorrhea in the puerperium - baby delivered during current episode of care (disorder)
199166003	Maternal gonorrhea in the puerperium - baby delivered during previous episode of care (disorder)
240571007	Neonatal gonococcal infection (disorder)
240583009	Cutaneous gonorrhea (disorder)
402958005	Gonococcal bacteremia-induced pustular vasculitis (disorder)
402956009	Localized cutaneous gonococcal infection (disorder)
402957000	Gonococcal bartholinitis (disorder)
74372003	Gonorrhea of pharynx (disorder)
240572000	Gonorrhea with local complication (disorder)
17305005	Acute gonorrhea of genitourinary tract (disorder)
28572009	Chronic gonorrhea of genitourinary tract (disorder)
186915005	Chronic gonorrhea lower genitourinary tract (disorder)
54825009	Acute gonorrhea of lower genitourinary tract (disorder)
80388004	Chronic gonorrhea of upper genitourinary tract (disorder)
199163006	Maternal gonorrhea during pregnancy - baby delivered (disorder)
199165004	Maternal gonorrhea during pregnancy - baby not yet delivered (disorder)
199161008	Maternal gonorrhea during pregnancy, childbirth and the puerperium (disorder)
35255008	Gonorrhea in mother complicating pregnancy, childbirth AND/OR puerperium (disorder)
199164000	Maternal gonorrhea in the puerperium - baby delivered during current episode of care

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(disorder)
199166003	Maternal gonorrhea in the puerperium - baby delivered during previous episode of care (disorder)

1485

A.77 QRPH MCH HBS Hepatitis B Codes

A.77.1 Metadata

Hepatitis B Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96
Name	This is the name of the value set	MCH HBS Hepatitis B Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Hepatitis B as Infections present and treated during this pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.77.2 MCH HBS Hepatitis B Value Set

Hepatitis B Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
271511000	Hepatitis B immune (finding)
442374005	Hepatitis B and hepatitis C (disorder)
165808001	Hepatitis B non-immune (finding)
235864009	Acute hepatitis B with hepatitis D (disorder)
186624004	Acute hepatitis B with delta agent (coinfection) with hepatic coma (disorder)
186626002	Acute hepatitis B with delta-agent (coinfection) without hepatic coma (disorder)
186623005	Viral hepatitis B with coma (disorder)
424460009	Hepatitis B with hepatitis D superinfection (disorder)
26206000	Viral hepatitis B with hepatic coma (disorder)
424099008	Acute hepatitis B with hepatic coma (disorder)
424340000	Chronic hepatitis B with hepatic coma (disorder)
424340000	Chronic hepatitis B with hepatic coma (disorder)
60498001	Congenital viral hepatitis B infection (disorder)
111891008	Viral hepatitis B without hepatic coma (disorder)
186639003	Chronic viral hepatitis B without delta-agent (disorder)

A.78 QRPH MCH HBS Hepatitis C Codes

A.78.1 Metadata

Hepatitis C Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97
Name	This is the name of the value set	MCH HBS Hepatitis C Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Hepatitis C as Infections present and treated during this pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.78.2MCH HBS Hepatitis C Value Set

Hepatitis C Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1500

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
50711007	Viral hepatitis C (disorder)
235866006	Acute hepatitis C (disorder)
128302006	Chronic hepatitis C (disorder)
278929008	Congenital hepatitis C infection (disorder)
186628001	Viral hepatitis C with coma (disorder)
442374005	Hepatitis B and hepatitis C (disorder)
370988000	Hepatitis C antibody positive with elevated ALT (finding)
406104003	Hepatitis C virus enzyme-linked immunosorbent

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	assay test positive (finding)
371140008	Polymerase chain reaction (PCR) positive for hepatitis C viral ribonucleic acid (genotype 1A) (finding)

A.79 QRPH MCH HBS Syphilis Codes

A.79.1 Metadata

Syphilis Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Name	This is the name of the value set	MCH HBS Syphilis Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Syphilis as Infections present and treated during this pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

1505

A.79.2 MCH HBS Syphilis Value Set

Syphilis Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
76272004	Syphilis (disorder)
240555007	Acquired syphilis (disorder)
266130009	Acquired syphilis - early latent (disorder)
186868000	Serological relapse after treatment of latent early syphilis (disorder)
266136003	Acquired syphilis - late latent (disorder)
35742006	Congenital syphilis (disorder)
87318008	Congenital syphilis with gumma (disorder)
186841000	Congenital syphilitic gumma (disorder)
9941009	Congenital syphilitic choroiditis (disorder)
192008	Congenital syphilitic hepatomegaly (disorder)
6267005	Congenital syphilitic meningitis (disorder)
230152000	Late congenital syphilitic meningitis (disorder)
58392004	Congenital syphilitic osteochondritis (disorder)
59721007	Congenital syphilitic pemphigus (disorder)
27648007	Congenital syphilitic periostitis (disorder)
56118002	Congenital syphilitic splenomegaly (disorder)
4359001	Early congenital syphilis (less than 2 years) (disorder)
83492008	Congenital syphilitic coryza (disorder)
66083000	Congenital syphilitic epiphysitis (disorder)
54069001	Congenital syphilitic mucous patches (disorder)
276700005	Congenital syphilitic rhinitis (disorder)
275376007	Congenital syphilitic chronic coryza (disorder)
186833000	Early congenital syphilis - latent (disorder)
266125005	Early congenital syphilis with symptoms (disorder)
46235002	Early latent congenital syphilis, positive serology, negative spinal fluid (disorder)
82323002	Late congenital syphilis (2 years OR more) (disorder)
19290004	Clutton's joints (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
266126006	Late congenital neurosyphilis (disorder)
32735002	Congenital syphilitic encephalitis (disorder)
82959004	Dementia paralytica juvenilis (disorder)
37028008	Juvenile tabes (disorder)
68764005	Juvenile taboparesis (disorder)
230563005	Late congenital syphilitic polyneuropathy (disorder)
240553000	Late congenital neurovascular syphilis (disorder)
827006	Late congenital syphilis, latent (+ sero., - C.S.F., 2 years OR more) (disorder)
186842007	Late congenital syphilitic oculopathy (disorder)
186846005	Early symptomatic syphilis (disorder)
13095005	Primary symptomatic early syphilis (disorder)
13731006	Secondary symptomatic early syphilis (disorder)
91554004	Condyloma latum (disorder)
402944008	Condylomata lata of perianal skin (disorder)
402946005	Condylomata lata of vulva (disorder)
51960003	Secondary syphilis of pharynx (disorder)
81339006	Secondary syphilis of tonsil (disorder)
58227000	Secondary syphilis of viscera (disorder)
66281009	Secondary syphilitic chorioretinitis (disorder)
72083004	Late syphilis (disorder)
83883001	Cardiovascular syphilis (disorder)
266131008	Late cardiovascular syphilis (disorder)
234017002	Syphilitic aneurysm (disorder)
12232008	Syphilitic aneurysm of aorta (disorder)
61612001	Syphilitic aortic incompetence (disorder)
20735004	Syphilitic aortitis (disorder)
230735006	Syphilitic cerebral arteritis (disorder)
278480000	Syphilitic endocarditis of aortic valve (disorder)
233849007	Syphilitic valve disease (disorder)
58056005	Syphilis of mitral valve (disorder)
186875004	Syphilitic endocarditis of mitral valve (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
45058001	Syphilis of pulmonary valve (disorder)
186878002	Syphilitic endocarditis of pulmonary valve (disorder)
42770003	Syphilis of tricuspid valve (disorder)
186877007	Syphilitic endocarditis of tricuspid valve (disorder)
82355002	Syphilitic aortic stenosis (disorder)
240567009	Syphilitic coronary artery disease (disorder)
62207008	Syphilitic ostial coronary disease (disorder)
67391006	Syphilitic endocarditis (disorder)
4082005	Syphilitic myocarditis (disorder)
194947001	Acute myocarditis - syphilitic (disorder)
3589003	Syphilitic pericarditis (disorder)
194907008	Acute syphilitic pericarditis (disorder)
232313005	Endocochlear syphilis (disorder)
198175009	Female syphilitic pelvic inflammatory disease (disorder)
197347003	Hepatitis in late syphilis (disorder)
193786000	Keratitis due to syphilis (disorder)
186903006	Late latent syphilis (disorder)
197757004	Late syphilis of kidney (disorder)
405635002	Late syphilis with clinical manifestations other than neurosyphilis (disorder)
66887000	Late syphilis, latent (positive serology, negative cephalospinal fluid 2 years after) (disorder)
26039008	Neurosyphilis (disorder)
266133006	Late quaternary neurosyphilis (disorder)
37754005	Asymptomatic neurosyphilis (disorder)
51928006	General paresis - neurosyphilis (disorder)
230182006	Late syphilitic encephalitis (disorder)
240568004	Meningovascular syphilis - quaternary stage (disorder)
75299005	Spastic spinal syphilitic paralysis (disorder)
302813001	Syphilitic acoustic neuritis - quaternary stage (disorder)
38523005	Syphilitic parkinsonism (disorder)
240569007	Syphilitic polyneuropathy (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
13310005	Taboparesis (disorder)
314840009	Progressive locomotor ataxia (disorder)
240564002	Secondary neurosyphilis (disorder)
240565001	Asymptomatic secondary neurosyphilis (disorder)
192647003	Secondary syphilitic meningitis (disorder)
186863009	Acute secondary syphilitic meningitis (disorder)
22386003	Syphilitic optic atrophy (disorder)
36276008	Syphilitic retrobulbar neuritis (disorder)
19206003	Syphilitic acoustic neuritis (disorder)
26135000	Syphilitic encephalitis (disorder)
21523006	Syphilitic gumma of central nervous system (disorder)
315826004	Tabetic neurosyphilis (disorder)
316841006	Tabes dorsalis (disorder)
240552005	Juvenile tabes dorsalis (disorder)
402949003	Nodular syphilide (disorder)
402951004	Oral mucous membrane lesion due to late syphilis (disorder)
64102008	Syphilitic gumma (disorder)
240566000	Gummatous neurosyphilis (disorder)
235064008	Syphilitic gumma of oral cavity (disorder)
402950003	Syphilitic leukoplakia of tongue (disorder)
444150000	Latent syphilis (disorder)
186867005	Latent early syphilis (disorder)
67125004	Latent syphilis with positive serology (disorder)
31137003	Early latent syphilis, positive serology, negative cerebrospinal fluid, less than 2 years after infection (disorder)
1107004	Early latent syphilis, positive serology, negative cerebrospinal fluid, with relapse after treatment (disorder)
199154009	Maternal syphilis during pregnancy, childbirth and the puerperium (disorder)
199156006	Maternal syphilis during pregnancy - baby delivered (disorder)
199158007	Maternal syphilis during pregnancy - baby not yet delivered (disorder)
199157002	Maternal syphilis in the puerperium - baby delivered during current episode of care (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
199159004	Maternal syphilis in the puerperium - baby delivered during previous episode of care (disorder)
34242002	Syphilis in mother complicating pregnancy, childbirth AND/OR puerperium (disorder)
232367004	Nasal syphilis (disorder)
410478005	Ocular syphilis (disorder)
410470003	Syphilitic retinitis (disorder)
312934004	Syphilitic chorioretinitis (disorder)
77939001	Syphilitic disseminated retinochoroiditis (disorder)
312955002	Tertiary syphilitic chorioretinitis (disorder)
186854007	Uveitis due to secondary syphilis (disorder)
235062007	Oral syphilis (disorder)
60528006	Secondary syphilis of mouth (disorder)
402942007	Syphilitic chancre of oral mucous membranes (disorder)
235032001	Syphilitic oral leukoplakia (disorder)
235065009	Syphilitic oral snail track ulcer (disorder)
266127002	Primary syphilis (disorder)
240556008	Primary extragenital syphilis (disorder)
31015008	Primary anal syphilis (disorder)
27460003	Primary syphilis of breast (disorder)
54274001	Primary syphilis of fingers (disorder)
28198007	Primary syphilis of lip (disorder)
10345003	Primary syphilis of tonsils (disorder)
186847001	Primary genital syphilis (disorder)
237447001	Primary syphilis of nipple (disorder)
402941000	Syphilitic chancre of vulva (disorder)
278481001	Quaternary syphilis (disorder)
240557004	Secondary syphilis (disorder)
197348008	Hepatitis in secondary syphilis (disorder)
402947001	Late secondary syphilis (disorder)
63751007	Secondary syphilis of bone (disorder)
69595007	Secondary syphilitic periostitis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
80770009	Secondary syphilis of liver (disorder)
186850003	Secondary syphilis of skin and mucous membrane (disorder)
39085002	Secondary syphilis of mucous membrane (disorder)
77028001	Secondary syphilis of anus (disorder)
59233003	Secondary syphilis of skin (disorder)
266128007	Rash of secondary syphilis (disorder)
240558009	Macular syphilide (disorder)
240560006	Papular syphilide (disorder)
240561005	Corona veneris (disorder)
240562003	Pustular syphilide (disorder)
52414005	Secondary syphilis of vulva (disorder)
186861006	Secondary syphilis relapse (disorder)
85857008	Secondary syphilis, relapse (treated) (disorder)
62861003	Secondary syphilis, relapse (untreated) (disorder)
59934002	Secondary syphilitic adenopathy (disorder)
30080002	Secondary syphilitic iridocyclitis (disorder)
70983007	Secondary syphilitic uveitis (disorder)
59307008	Syphilitic alopecia (disorder)
11338007	Syphilitic episcleritis (disorder)
44568006	Syphilitic interstitial keratitis (disorder)
55768006	Syphilitic leukoderma (disorder)
240563008	Syphilitic mucosal ulceration (disorder)
50528008	Syphilis of bone (disorder)
237446005	Syphilis of breast (disorder)
59530001	Syphilis of kidney (disorder)
86028001	Syphilis of liver (disorder)
16070004	Syphilitic cirrhosis (disorder)
197305002	Syphilitic portal cirrhosis (disorder)
8555001	Syphilis of lung (disorder)
88943008	Syphilis of muscle (disorder)
49923008	Syphilis of tendon (disorder)
37430004	Syphilis of synovium (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
186899004	Syphilis of synovium, tendon or bursa (disorder)
23550005	Syphilis of bursa (disorder)
202933002	Syphilitic bursitis (disorder)
4483005	Syphilitic punched out ulcer (disorder)
371237000	Syphilitic skin disorder (disorder)
286882004	Syphilitic/venereal/spirochetal disease (disorder)

A.80 QRPH MCH HBS Conception Date Codes

A.80.1 Metadata

Conception Date Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180
Name	This is the name of the value set	MCH HBS Conception Date Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Conception Date
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A

Metadata Element	Description	Mandatory
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.80.2 MCH HBS Conception Date Value Set

Conception Date Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.180
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
33067-0	Conception date

A.81 QRPH MCH HBS Transfusion Whole Blood or Packed Red Blood Codes

A.81.1 Metadata

Transfusion Whole Blood or Packed Red Blood Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99
Name	This is the name of the value set	MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Transfusion Whole Blood or Packed Red Blood as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.81.2MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set

Transfusion Whole Blood or Packed Red Blood Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
33389009	Transfusion of whole blood (procedure)
11397000	Autotransfusion of whole blood (procedure)
180206004	Intra-arterial blood transfusion (procedure)
225284006	Transfusing whole blood under pressure (procedure)
116863004	Transfusion of red blood cells (procedure)
425513008	Transfusion of leucoreduced red blood cells (procedure)
71493000	Transfusion of packed red blood cells (procedure)
180207008	Intravenous blood transfusion of packed cells (procedure)
426290002	Transfusion of washed red blood cells (procedure)
12719002	Platelet transfusion (procedure)
180208003	Intravenous blood transfusion of platelets (procedure)
117078000	Transfusion of platelet concentrate (procedure)
116810007	Transfusion of plateletpheresis product (procedure)
116797000	Transfusion of factor IX (procedure)
74287006	Transfusion of coagulation factors (procedure)
274502001	Antihemophilic factor transfusion (procedure)
425524005	Transfusion antithrombin III factor (procedure)

Value Set:	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
116798005	Transfusion of factor VII (procedure)

1530

A.82 QRPH MCH HBS Third Degree Perineal Laceration Codes

A.82.1 Metadata

Third Degree Perineal Laceration Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100
Name	This is the name of the value set	MCH HBS Third Degree Perineal Laceration Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Third Degree Perineal Laceration as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

1535

A.82.2 MCH HBS Third Degree Perineal Laceration Value Set

Third Degree Perineal Laceration Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100
Vocabulary :	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
10217006	Third degree perineal laceration (disorder)
199930000	Third degree perineal tear during delivery - delivered (disorder)
199931001	Third degree perineal tear during delivery with postnatal problem (disorder)
199934009	Fourth degree perineal tear during delivery - delivered (disorder)
199935005	Fourth degree perineal tear during delivery with postnatal problem (disorder)

A.83 QRPH MCH HBS Fourth Degree Perineal Laceration Codes

A.83.1 Metadata

Fourth Degree Perineal Laceration Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101
Name	This is the name of the value set	MCH HBS Fourth Degree Perineal Laceration Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Fourth Degree Perineal Laceration as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010

Metadata Element	Description	Mandatory
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.83.2 MCH HBS Fourth Degree Perineal Laceration Value Set

Fourth Degree Perineal Laceration Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
399031001	Fourth degree perineal laceration (disorder)
16950007	Fourth degree perineal laceration involving anal mucosa (disorder)
34262005	Fourth degree perineal laceration involving rectal mucosa (disorder)
199934009	Fourth degree perineal tear during delivery - delivered (disorder)
199935005	Fourth degree perineal tear during delivery with postnatal problem (disorder)

A.84 QRPH MCH HBS Ruptured Uterus Codes

A.84.1 Metadata

Ruptured Uterus Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102
Name	This is the name of the value set	MCH HBS Ruptured Uterus Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Ruptured Uterus as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html

Metadata Element	Description	Mandatory
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.84.2 MCH HBS Ruptured Uterus Value Set

Ruptured Uterus Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
199958008	Ruptured uterus before labor (disorder)
199960005	Rupture of uterus before labor - delivered (disorder)
199961009	Rupture of uterus before labor with antenatal problem (disorder)
69270005	Rupture of uterus during AND/OR after labor (disorder)
199964001	Rupture of uterus during and after labor - delivered (disorder)
199965000	Rupture of uterus during and after labor - delivered with postnatal problem (disorder)
15504009	Rupture of gravid uterus (disorder)
49561003	Rupture of gravid uterus before onset of labor (disorder)
34430009	Rupture of uterus (disorder)

A.85 QRPH MCH HBS Unplanned Hysterectomy Codes

A.85.1 Metadata

Unplanned Hysterectomy Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103
Name	This is the name of the value set	MCH HBS Unplanned Hysterectomy Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Ruptured Uterus as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.85.2 MCH HBS Unplanned Hysterectomy Value Set

Unplanned Hysterectomy Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
625654015	**Emergency cesarean hysterectomy (procedure)**

A.86 QRPH MCH HBS Unplanned Operation Codes

A.86.1 Metadata

1565 Unplanned Operation Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105
Name	This is the name of the value set	MCH HBS Unplanned Operation Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect Ruptured Uterus as a maternal morbidity
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.86.2MCH HBS Unplanned Operation Value Set

Unplanned Operation Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
259863001	Removal of Shirodkar suture from cervix (procedure)
372456005	Repair of obstetric laceration (procedure)
177217006	Immediate repair of obstetric laceration (procedure)
177221004	Immediate repair of minor obstetric laceration (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
177219009	Immediate repair of obstetric laceration of perineum and sphincter of anus (procedure)
177218001	Immediate repair of obstetric laceration of uterus or cervix uteri (procedure)
177220003	Immediate repair of obstetric laceration of vagina and floor of pelvis (procedure)
9724000	Repair of current obstetric laceration of uterus (procedure)
31939001	Repair of obstetric laceration of cervix (procedure)
315307003	Repair of obstetric laceration of lower urinary tract (procedure)
61353001	Repair of obstetric laceration of bladder (procedure)
42390009	Repair of obstetric laceration of bladder and urethra (procedure)
36248000	Repair of obstetric laceration of urethra (procedure)
48775002	Repair of obstetric laceration of pelvic floor (procedure)
441619002	Repair of obstetric laceration of perineum and anal sphincter and mucosa of rectum (procedure)
112925006	Repair of obstetric laceration of vulva (procedure)
55669006	Repair of obstetrical laceration of perineum (procedure)
367476005	Colpoepisiorrhaphy (procedure)
177227000	Secondary repair of obstetric laceration (procedure)
112926007	Suture of obstetric laceration of vagina (procedure)
57411006	Colpoperineorrhaphy following delivery (procedure)

1570

A.87 QRPH MCH HBS Fetal Presentation at Birth- Breech Codes

A.87.1 Metadata

Fetal Presentation at Birth- Breech Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108
Name	This is the name of the value set	MCH HBS Fetal Presentation at Birth- Breech Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Fetal Presentation at Birth- Breech method of delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.87.2 MCH HBS Fetal Presentation at Birth- Breech Value Set

Fetal Presentation at Birth- Breech Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
6096002	Breech presentation (finding)
199354004	Breech presentation - delivered (finding)
199355003	Breech presentation with antenatal problem

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(finding)
49168004	Complete breech presentation (finding)
249097002	Footling breech presentation (finding)
48906005	Breech presentation, double footling (finding)
58903006	Breech presentation, single footling (finding)
18559007	Frank breech presentation (finding)
38049006	Incomplete breech presentation (finding)
163514003	On examination - breech presentation (finding)
271370008	Deliveries by breech extraction (finding)
237325000	Head entrapment during breech delivery (disorder)
271373005	Deliveries by spontaneous breech delivery (finding)
199751005	Obstructed labor due to breech presentation (finding)
364748006	Finding of position of breech presentation (finding)
79888005	Sacroanterior position (finding)
408812003	Direct sacroanterior position (finding)
64433002	Left sacroanterior position (finding)
79643007	Right sacroanterior position (finding)
249103009	Sacrolateral position (finding)
54486001	Left sacrolateral position (finding)
89550007	Right sacrolateral position (finding)
58261003	Sacroposterior position (finding)
249102004	Direct sacroposterior position (finding)
2138000	Left sacroposterior position (finding)
112073004	Right sacroposterior position (finding)

1580

A.88 QRPH MCH HBS Fetal Presentation at Birth- Cephalic Codes

A.88.1 Metadata

Fetal Presentation at Birth- Cephalic Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109
Name	This is the name of the value set	MCH HBS Fetal Presentation at Birth- Cephalic Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Fetal Presentation at Birth- Cephalic method of delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.88.2 MCH HBS Fetal Presentation at Birth- Cephalic Value Set

Fetal Presentation at Birth- Cephalic Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
70028003	Vertex presentation (finding)
163513009	On examination - vertex presentation (finding)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
441640001	Vertex presentation with caput succedaneum (finding)
309469004	Spontaneous vertex delivery (finding)
441640001	Vertex presentation with caput succedaneum (finding)
14058000	Asynclitism
46017002	Anterior asynclitism
90731001	Posterior asynclitism
90381008	Occiptoanterior position
408813008	Direct occiptoanterior position
14409005	Left occiptoanterior position
39889007	Right occiptoanterior position
249071008	Occipitolateral position
18905000	Left occipitolateral position
37040008	Right occipitolateral position
37235006	Occiptoposterior position
249070009	Direct occiptoposterior position
31477000	Left occiptoposterior position
36547009	Right occiptoposterior position

A.89 QRPH MCH HBS Fetal Presentation at Birth- Other Codes

A.89.1 Metadata

Fetal Presentation at Birth- Other Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110
Name	This is the name of the value set	MCH HBS Fetal Presentation at Birth- Other Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Fetal Presentation at Birth- Other

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.89.2MCH HBS Fetal Presentation at Birth- Other Value Set

Fetal Presentation at Birth- Other Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
249079005	Fontanelles presenting (finding)
249082000	Anterior fontanelle presenting (finding)
249081007	Both fontanelles presenting (finding)
249083005	Posterior fontanelle presenting (finding)
23954006	Acromion presentation (finding)
14058000	Asynclitism (finding)
8014007	Brow presentation (finding)
124736009	Compound presentation (finding)
21882006	Face presentation (finding)
46200004	Funic presentation (finding)
50724007	Longitudinal fetal presentation (finding)
15028002	Abnormal fetal presentation (finding)

A.90 QRPH MCH HBS Route and Method of Delivery - Spontaneous Delivery Codes

A.90.1 Metadata

Route and Method of Delivery - Spontaneous Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Spontaneous Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.90.2 MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set

Route and Method of Delivery - Spontaneous Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
309469004	Spontaneous vertex delivery (finding)
199329004	Multiple delivery, all spontaneous (finding)
271373005	Deliveries by spontaneous breech delivery (finding)

A.91 QRPH MCH HBS Route and Method of Delivery - Forceps Delivery Codes

A.91.1 Metadata

Route and Method of Delivery - Forceps Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Forceps Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Forceps Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.91.2MCH HBS Route and Method of Delivery - Forceps Delivery Value Set

Route and Method of Delivery - Forceps Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
15413009	High forceps delivery with episiotomy (procedure)
177161009	Forceps cephalic delivery (procedure)
177162002	High forceps cephalic delivery with rotation (procedure)
177167008	Barton forceps cephalic delivery with rotation (procedure)
177168003	DeLee forceps cephalic delivery with rotation (procedure)
177170007	Piper forceps delivery (procedure)
17860005	Low forceps delivery with episiotomy (procedure)
1807002	Failed forceps delivery (procedure)
18625004	Low forceps delivery (procedure)
19390001	Partial breech delivery with forceps to aftercoming head (procedure)
236975003	Nonrotational forceps delivery (procedure)
236976002	Outlet forceps delivery (procedure)
236977006	Forceps delivery, face to pubes (procedure)
236978001	Forceps delivery to the aftercoming head (procedure)
25828002	Mid forceps delivery with episiotomy (procedure)
275168001	Neville-Barnes forceps delivery (procedure)
275169009	Simpson's forceps delivery (procedure)
29613008	Delivery by double application of forceps (procedure)
302383004	Forceps delivery (procedure)
30476003	Barton's forceps delivery (procedure)
45718005	Vaginal delivery with forceps including postpartum care (procedure)
54973000	Total breech delivery with forceps to aftercoming

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	head (procedure)
62508004	Mid forceps delivery (procedure)
71166009	Forceps delivery with rotation of fetal head (procedure)
89849000	High forceps delivery (procedure)

A.92 QRPH MCH HBS Route and Method of Delivery - Vacuum Delivery Codes

A.92.1 Metadata

Route and Method of Delivery - Vacuum Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Vacuum Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A

Metadata Element	Description	Mandatory
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.92.2 MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set

Route and Method of Delivery - Vacuum Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
177174003	Low vacuum delivery (procedure)
177173009	High vacuum delivery (procedure)
61586001	Delivery by vacuum extraction (procedure)
90438006	Delivery by Malstrom's extraction (procedure)
40219000	Delivery by Malstrom's extraction with episiotomy (procedure)
26313002	Delivery by vacuum extraction with episiotomy (procedure)
177175002	Vacuum delivery before full dilation of cervix (procedure)

A.93 QRPH MCH HBS Route and Method of Delivery - Cesarean Delivery Codes

A.93.1 Metadata

Route and Method of Delivery - Cesarean Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Cesarean Delivery

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.93.2MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set

Route and Method of Delivery - Cesarean Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
11466000	Cesarean section (procedure)
177141003	Elective cesarean section (procedure)
177142005	Elective upper segment cesarean section (procedure)
177143000	Elective lower segment cesarean section (procedure)
17744000	Subtotal hysterectomy after cesarean delivery (procedure)
236985002	Emergency lower segment cesarean section (procedure)
236986001	Emergency upper segment cesarean section (procedure)
236987005	Emergency cesarean hysterectomy (procedure)
236988000	Elective cesarean hysterectomy (procedure)
236990004	Postmortem cesarean section (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
24806008	Anesthesia for cesarean hysterectomy (procedure)
274130007	Emergency cesarean section (procedure)
398307005	Low cervical cesarean section (procedure)
41059002	Cesarean hysterectomy (procedure)
4847005	Anesthesia for cesarean section (procedure)
57271003	Extraperitoneal cesarean section (procedure)
84195007	Classical cesarean section (procedure)
89053004	Vaginal cesarean section (procedure)

A.94 QRPH MCH HBS Route and Method of Delivery – Trial of Labor Codes

A.94.1 Metadata

Route and Method of Delivery - Trial of Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Trial of Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Trial of Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.94.2 MCH HBS Route and Method of Delivery - Trial of Labor Value Set

Route and Method of Delivery – Trial of Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.115
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
90306000	Trial labor (finding)
23332002	Failed trial of labor (disorder)
413339006	Failed trial of labor - delivered (disorder)

A.95 QRPH MCH HBS Route and Method of Delivery - Scheduled Cesarean Codes

A.95.1 Metadata

Route and Method of Delivery - Scheduled Cesarean Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116
Name	This is the name of the value set	MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Route and Method of Delivery as Scheduled Cesarean
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.95.2 MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set

Route and Method of Delivery – Scheduled Cesarean Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
177141003	Elective cesarean section (procedure)
177142005	Elective upper segment cesarean section (procedure)
177143000	Elective lower segment cesarean section (procedure)
236988000	Elective cesarean hysterectomy (procedure)

A.96 QRPH MCH HBS Cervical Cerclage Codes

A.96.1 Metadata

Cervical Cerclage Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125

Metadata Element	Description	Mandatory
Name	This is the name of the value set	MCH HBS Cervical Cerclage Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Obstetric Procedures as Cervical Cerclage
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.96.2 MCH HBS Cervical Cerclage Value Set

1665 Cervical Cerclage Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
265636007	Cerclage of cervix (procedure)
236946009	Macdonald's cervical cerclage (procedure)
46681009	Cerclage of cervix during pregnancy by abdominal approach (procedure)
90442009	Cerclage of cervix during pregnancy by vaginal approach (procedure)
360399007	Marckwald operation on cervix (procedure)
176785004	Non-obstetric encircling suture of cervical os

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	(procedure)
236947000	Shirodkar's cervical cerclage (procedure)

A.97 QRPH MCH HBS Stated Height Codes

A.97.1 Metadata

1670 Stated Height Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.179
Name	This is the name of the value set	MCH HBS Height Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the mother's height
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.97.2 MCH HBS Stated Height Value Set

Stated Height Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.179
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
3138-5	Body height (stated)

A.98 QRPH MCH HBS External Cephalic Version Code

A.98.1 Metadata

External Cephalic VersionValue Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127
Name	This is the name of the value set	MCH HBS External Cephalic VersionValue Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Obstetric Procedures as External Cephalic Version
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.98.2 MCH HBS External Cephalic VersionValue Set

External Cephalic Version Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
240278000	External cephalic version (procedure)
5048009	External cephalic version with tocolysis (procedure)

A.99 QRPH MCH HBS Tocolysis Codes

A.99.1 Metadata

Tocolysis Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128
Name	This is the name of the value set	MCH HBS Tocolysis Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Obstetric Procedures as Tocolysis
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.99.2 MCH HBS Tocolysis Value Set

Tocolysis Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
103747003	Tocolysis (procedure)
5048009	External cephalic version with tocolysis (procedure)
237003003	Tocolysis for hypertonicity of uterus (procedure)

A.100 QRPH MCH HBS Premature Rupture Codes

A.100.1 Metadata

Premature Rupture Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129
Name	This is the name of the value set	MCH HBS Premature Rupture Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Onset of labor with Premature Rupture
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.100.2 MCH HBS Premature Rupture Value Set

Premature Rupture Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1695

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
44223004	Premature rupture of membranes (disorder)
288207006	Membrane rupture with delivery delay (disorder)
199658006	Premature rupture of membranes - delivered (disorder)
199659003	Premature rupture of membranes with antenatal problem (disorder)
199662000	Premature rupture of membranes with onset of labor after 24 hours of the rupture (disorder)
199660008	Premature rupture of membranes with onset of labor within 24 hours of the rupture (disorder)
199661007	Premature rupture of membranes, labor delayed by therapy (disorder)
312974005	Preterm premature rupture of membranes (disorder)
237267007	Prolonged premature rupture of membranes (disorder)
12729009	Prolonged rupture of membranes
199670005	Prolonged artificial rupture of membranes
199672002	Prolonged artificial rupture of membranes – delivered
199673007	Prolonged artificial rupture of membranes with antenatal problem
237267007	Prolonged premature rupture of membranes
237262008	Prolonged spontaneous rupture of membranes

A.101 QRPH MCH HBS Precipitous Labor Codes

A.101.1 Metadata

Precipitous Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130
Name	This is the name of the value set	MCH HBS Precipitous Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Onset of labor with Precipitous Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.101.2 MCH HBS Precipitous Labor Value Set

Precipitous Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
51920004	Precipitate labor (disorder)
199833004	Precipitate labor - delivered (disorder)
199834005	Precipitate labor with antenatal problem (disorder)

A.102 QRPH MCH HBS Prolonged Labor Codes

A.102.1 Metadata

Prolonged Labor Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131
Name	This is the name of the value set	MCH HBS Prolonged Labor Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Onset of labor with Prolonged Labor
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.102.2 MCH HBS Prolonged Labor Value Set

Prolonged Labor Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
53443007	Prolonged labor (disorder)
35347003	Delayed delivery after artificial rupture of membranes (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
21987001	Delayed delivery of second of multiple births (disorder)
237321009	Delayed delivery of triplet (disorder)
275429002	Delayed delivery of second twin (disorder)
199860006	Delayed delivery of second twin, triplet etc. (disorder)
199862003	Delayed delivery second twin - delivered (disorder)
199863008	Delayed delivery second twin with antenatal problem (disorder)
33627001	Prolonged first stage of labor (disorder)
199847000	Prolonged first stage - delivered (disorder)
199848005	Prolonged first stage with antenatal problem (disorder)
387700009	Prolonged latent phase of labor (disorder)
77259008	Prolonged second stage of labor (disorder)
199857004	Prolonged second stage - delivered (disorder)
199858009	Prolonged second stage with antenatal problem (disorder)

A.103 QRPH MCH HBS Prepregnancy Diabetes Codes

A.103.1 Metadata

Prepregnancy Diabetes Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Name	This is the name of the value set	MCH HBS Prepregnancy Diabetes Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Prepregnancy Diabetes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.103.2 MCH HBS Prepregnancy Diabetes Value Set

Prepregnancy Diabetes Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
4855003	Diabetic retinopathy
5368009	drug-induced diabetes mellitus
5969009	diabetes mellitus associated with genetic syndrome
8801005	secondary diabetes mellitus
9859006	insulin-resistant diabetes mellitus AND acanthosis nigricans
11530004	brittle diabetes
23045005	insulin dependent diabetes mellitus type IA
25907005	Diabetic gangrene
26298008	Diabetic coma
28032008	insulin dependent diabetes mellitus type IB
28453007	maturity onset diabetes mellitus in young
33559001	pineal hyperplasia AND diabetes mellitus syndrome
34140002	Diabetic gastroparesis

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
38542009	Nodular glomerulosclerosis
39058009	Diabetic amyotrophy
39181008	Diabetic radiculopathy
42954008	diabetes mellitus associated with receptor abnormality
43959009	Diabetic cataract
44054006	Diabetes mellitus type 2
46635009	Diabetes mellitus type I
49455004	Diabetic polyneuropathy
50620007	Diabetic autonomic neuropathy
51002006	diabetes mellitus associated with pancreatic disease
53126001	Poisoning by adrenal cortical steroid
54181000	Diabetes-nephrosis syndrome
57886004	protein-deficient diabetes mellitus
59079001	diabetes mellitus associated with hormonal etiology
70694009	diabetes mellitus AND insipidus with optic atrophy AND deafness
73211009	Diabetes mellitus
75524006	malnutrition related diabetes mellitus
75682002	diabetes mellitus due to insulin receptor antibodies
76751001	Diabetes mellitus in mother complicatin pregtnancy, childbirth AND/OR puerperium
81531005	diabetes mellitus type 2 in obese
81830002	Diabetic mononeuropathy simplex
91352004	diabetes mellitus due to structurally abnormal insulin
111552007	diabetes mellitus without complication
111558006	Insulin coma
123763000	Houssay's syndrome
127013003	Diabetic renal disease
127014009	Diabetic peripheral angiopathy

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
190321005	diabetes mellitus with no mention of complication
190328004	Diabetes mellitus NOS with ketoacidosis
190330002	diabetes mellitus, juvenile type, with hyperosmolar coma
190331003	diabetes mellitus, adult onset, with hyperosmolar coma
190336008	Other specified diabetes mellitus with coma
190353001	Diabetes mellitus NOS with neurological manifestation
190361006	Diabetes mellitus NOS with peripheral circulatory disorder
190368000	Type I diabetes mellitus with ulcer
190369008	Type I diabetes mellitus with gangrene
190371008	Type I diabetes mellitus - poor control
190372001	Type I diabetes mellitus maturity onset
190383005	unspecified diabetes mellitus with multiple complications
190389009	Type II diabetes mellitus with ulcer
190390000	Type II diabetes mellitus with gangrene
190392008	Type II diabetes mellitus - poor control
190406000	malnutrition-related diabetes mellitus with ketoacidosis
190407009	malnutrition-related diabetes mellitus with renal complications
190410002	malnutrition-related diabetes mellitus with peripheral circulatory complications
190411003	malnutrition-related diabetes mellitus with multiple complications
190412005	malnutrition-related diabetes mellitus without complications
190416001	Diabetes mellitus NOS with unspecified complication
190416008	steroid-induced diabetes mellitus without complication
190417004	diabetes mellitus with other specified manifestation

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
190418009	diabetes mellitus, juvenile type, with other specified manifestation
190419001	diabetes mellitus, adult onset, with other specified manifestation
190422004	Diabetes with unspecified complication
190447002	steroid-induced diabetes
193184006	Chronic painful diabetic neuropathy
197605007	Nephrotic syndrome in diabetes mellitus
199223000	diabetes mellitus during pregnancy, childbirth and the puerperium
199227004	diabetes mellitus during pregnancy - baby not yet delivered
199229001	Pre-existing diabetes mellitus, insulin-dependent
199230006	pre-existing diabetes mellitus, non-insulin-dependent
199231005	Pre-existing malnutrition-related diabetes mellitus
199234002	Diabetes mellitus during pregnancy, childbirth or the puerperium NOS
201250006	Ischemic ulcer diabetic foot
201251005	Neuropathic diabetic ulcer - foot
201252003	Mixed diabetic ulcer - foot
230572002	Diabetic neuropathy
230577008	Diabetic mononeuropathy
237599002	insulin-treated non-insulin-dependent diabetes mellitus
237600004	malnutrition-related diabetes mellitus - fibrocalculous
237601000	secondary endocrine diabetes mellitus
237604008	Diabetes mellitus autosomal dominant type II
237613005	hyperproinsulinemia
237618001	insulin-dependent diabetes mellitus secretory diarrhea syndrome
237619009	diabetes-deafness syndrome maternally transmitted
237627000	pregnancy and non-insulin-dependent diabetes

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	mellitus
267379000	diabetes mellitus, juvenile type, with no mention of complication
267380002	diabetes mellitus, adult onset, with no mention of complication
275918005	unstable diabetes
290002008	unstable type I diabetes mellitus
309426007	Diabetic glomerulopathy
310387003	Diabetic intracapillary glomerulosclerosis
311366001	Kimmelstiel-Wilson syndrome
312903003	Mild non-proliferative diabetic retinopathy (disorder)
312904009	Moderate non proliferative diabetic retinopathy (disorder)
312905005	Severe nonproliferative diabetic retinopathy
312912001	Diabetic macular edema
313435000	Type I diabetes mellitus without complication
313436004	Type II diabetes mellitus without complication
314537004	Diabetic optic papillopathy
314771006	Type I diabetes mellitus with hypoglycemic coma
314772004	Type II diabetes mellitus with hypoglycemic coma
314893005	Type I diabetes mellitus with arthropathy
314902007	Type II diabetes mellitus with peripheral angiopathy
314903002	Type II diabetes mellitus with arthropathy
359611005	Diabetic neuropathy with neurologic complication
359638003	NIDDM in nonobese
359642000	diabetes mellitus type 2 in nonobese
360546002	Hypoglycemic shock
371087003	Diabetic foot ulcer
390834004	Nonproliferative diabetic retinopathy
408539000	insulin autoimmune syndrome

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
408540003	diabetes mellitus induced by non-steroid drugs
413183008	diabetes mellitus induced by non-steroid drugs without complication
414890007	O/E - left chronic diabetic foot ulcer
414906009	O/E -right chronic diabetic foot ulcer
420414003	multiple complications of type II diabetes mellitus
420422005	Diabetic ketoacidosis
420756003	Diabetic cataract associated with type II diabetes mellitus
420789003	Diabetic retinopathy associated with type I diabetes mellitus
421165007	Diabetic oculopathy assoicated with type I diabetes mellitus
421750000	Ketoacidosis in type II diabetes mellitus
421847006	Ketoacidotic coma in type II diabetes mellitus
421895002	Peripheral circulatory disorder associated with diabetes mellitus
421920002	Diabetic cataract assoicated with type I diabetes mellitus
422034002	Diabetic retinopathy associated with type II diabetes mellitus
422099009	Diabetic oculopathy associated with type II diabetes mellitus
422183001	Diabetic skin ulcer
422228004	multiple complications of type I diabetes mellitus
422275004	Gangrene associated with diabetes mellitus
423263001	Diabetic autonomic neuropathy associated with type 2 diabetes mellitus
424736006	Diabetic peripheral neuropathy
424989000	Diabetic gastroparesis associated with type 2 diabetes mellitus
425159004	Diabetic gastroparesis associated with type 1 diabetes mellitus
425442003	Diabetic autonomic neuropathy associated with type 1 diabetes mellitus

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
426705001	diabetes mellitus associated with cystic fibrosis
426875007	latent autoimmune diabetes mellitus in adult
426875007	latent autoimmune diabetes mellitus in adult
427089005	diabetes mellitus due to cystic fibrosis
428896009	Hyperosmolality due to uncontrolled type I diabetes mellitus
592760001	Proliferative diabetic retinopathy
441656006	Hyperglycemic crisis in diabetes mellitus (disorder)

1720

A.104 QRPH MCH HBS Gestational Diabetes Codes

A.104.1 Metadata

Gestational Diabetes Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137
Name	This is the name of the value set	MCH HBS Gestational Diabetes Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Gestational Diabetes
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.104.2 MCH HBS Gestational Diabetes Value Set

1725 Gestational Diabetes Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
237626009	Pregnancy and insulin-dependent diabetes mellitus (disorder)
237627000	Pregnancy and non-insulin-dependent diabetes mellitus (disorder)
199227004	Diabetes mellitus during pregnancy - baby not yet delivered (disorder)
199223000	Diabetes mellitus during pregnancy, childbirth and the puerperium (disorder)
76751001	Diabetes mellitus in mother complicating pregnancy, childbirth AND/OR puerperium (disorder)
46894009	gestational diabetes mellitus, class A>2<
71546005	gestational diabetes mellitus, class B>1<
75022004	gestational diabetes mellitus, class A>1<
420491007	gestational diabetes mellitus, class H
420738003	gestational diabetes mellitus, class T
420989005	gestational diabetes mellitus, class R
421223006	gestational diabetes mellitus, class F
421389009	gestational diabetes mellitus, class C
421443003	gestational diabetes mellitus, class D
422155003	gestational diabetes mellitus, class B
11687002	gestational diabetes mellitus
237625008	Hyperglycemic disorder in pregnancy (disorder)

A.105 QRPH MCH HBS Prepregnancy Hypertension Codes

A.105.1 Metadata

Prepregnancy Hypertension Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Name	This is the name of the value set	MCH HBS Prepregnancy Hypertension Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Prepregnancy Hypertension
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.105.2 MCH HBS Prepregnancy Hypertension Value Set

Prepregnancy Hypertension Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
8762007	Prepregnancy (chronic)
193003	Benign hypertensive renal disease

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
1201005	Benign essential hypertension (disorder)
8218002	Chronic hypertension complicating AND/OR reason for care during childbirth
8762007	Chronic hypertension in obstetric context
9901000	Essential hypertension complicating AND/OR reason for care during puerperium
10725009	Benign hypertension (disorder)
14973001	Renal sclerosis with hypertension
16147005	Arteriolar nephritis
18416000	Essential hypertension complicating AND/OR reason for care during childbirth
19769006	High-renin essential hypertensio
23130000	Paroxysmal hypertension
23717007	Benign essential hypertension complicating AND/OR reason for care during pregnancy
23786008	Malignant hypertension complicating AND/OR reason for care during puerperium
24042004	Chronic hypertension complicating AND/OR reason for care during puerperium
26078007	Hypertension secondary to renal disease complicating AND/OR reason for care during childbirth
28119000	Renal hypertension
29259002	Malignant hypertension complicating AND/OR reason for care during pregnancy
31407004	Pre-existing hypertension complicating AND/OR reason for care during puerperium
31992008	Secondary hypertension
32916005	Nephrosclerosis
34694006	Pre-existing hypertension complicating AND/OR reason for care during childbirth
35303009	Benign essential hypertension complicating AND/OR reason for care during puerperium
37618003	Chronic hypertension complicating AND/OR reason for care during pregnancy
38481006	Hypertensive renal disease
39018007	Renal arterial hypertension

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
39727004	Hypertension secondary to renal disease complicating AND/OR reason for care during puerperium
46481004	Low-renin essential hypertension
48146000	Diastolic hypertension
48552006	Hypertension secondary to renal disease complicating AND/OR reason for care during pregnancy
52698002	Transient hypertension
56218007	Systolic hypertension
57684003	Parenchymal renal hypertension
59621000	Essential hypertension
59720008	Sustained diastolic hypertension
59997006	Endocrine hypertension
62275004	Hypertensive episode
63287004	Benign essential hypertension in obstetric context
65402008	Pre-existing hypertension complicating AND/OR reason for care during pregnancy
65443008	Malignant hypertensive renal disease
65518004	Labile diastolic hypertension
70272006	Malignant hypertension
71874008	Benign essential hypertension complicating AND/OR reason for care during childbirth
72022006	Essential hypertension in obstetric context
73410007	Benign secondary renovascular hypertension
74451002	Secondary diastolic hypertension
78808002	Essential hypertension complicating AND/OR reason for care during pregnancy
78975002	Malignant essential hypertension
81626002	Malignant hypertension in obstetric context
84094009	Rebound hypertension
86041002	Pre-existing hypertension in obstetric context
89242004	Malignant secondary hypertension
123799005	Renovascular hypertension

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
123800009	Goldblatt hypertension
169465000	Hypertension induced by oral contraceptive pill
194774006	Hypertensive renal disease with renal failure
194783001	Malignant secondary renovascular hypertension
194785008	Benign secondary hypertension
194788005	Hypertension secondary to endocrine disorder
194791005	Hypertension secondary to drug
194793008	Other specified hypertensive disease
198942000	Benign essential hypertension complicating pregnancy, childbirth and the puerperium
198944004	Benign essential hypertension complicating pregnancy, childbirth and the puerperium - delivered
198945003	Benign essential hypertension complicating pregnancy, childbirth and the puerperium - delivered with postnatal complication
198946002	Benign essential hypertension complicating pregnancy, childbirth and the puerperium - not delivered
198947006	Benign essential hypertension complicating pregnancy, childbirth and the puerperium with postnatal complication
198949009	Renal hypertension complicating pregnancy, childbirth and the puerperium
198951008	Renal hypertension complicating pregnancy, childbirth and the puerperium - delivered
198952001	Renal hypertension complicating pregnancy, childbirth and the puerperium - delivered with postnatal complication
198953006	Renal hypertension complicating pregnancy, childbirth and the puerperium - not delivered
198954000	Renal hypertension complicating pregnancy, childbirth and the puerperium with postnatal complication
198956003	Other pre-existing hypertension in preg/childbirth/puerp
198958002	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium - delivered

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
198959005	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium - delivered with postnatal complication
199005000	Pre-existing hypertension complicating pregnancy, childbirth and puerperium
199007008	Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium
199008003	Pre-existing secondary hypertension complicating pregnancy, childbirth and puerperium
276789009	Labile hypertension
371125006	Labile essential hypertension
427889009	Hypertension associated with transplantation
428575007	Hypertension secondary to kidney transplant
429198000	Exertional hypertension
429457004	Systolic essential hypertension
10562009	Malignant hypertension complicating AND/OR reason for care during childbirth (disorder)
49220004	Hypertensive renal failure
50490005	Hypertensive encephalopathy
73030000	Hypertensive renal disease in obstetric context
78544004	Chronic hypertensive uremia
86234004	Hypertensive heart AND renal disease
111438007	Hypertension secondary to renal disease in obstetric context (disorder)
397748008	Hypertension with albuminuria

A.106 QRPH MCH HBS Gestational Hypertension Codes

A.106.1 Metadata

Gestational Hypertension Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139

Metadata Element	Description	Mandatory
Name	This is the name of the value set	MCH HBS Gestational Hypertension Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Gestational Hypertension
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.106.2 MCH HBS Gestational Hypertension Value Set

Gestational Hypertension Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
308551004	Gestational (PIH, preeclampsia)
41114007	Mild pre-eclampsia
46764007	Severe pre-eclampsia
48194001	Pregnancy-induced hypertension
67359005	Pre-eclampsia added to pre-existing hypertension
198941007	Hypertension complicating pregnancy, childbirth and the puerperium

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
198967002	Transient hypertension of pregnancy - not delivered
198968007	Transient hypertension of pregnancy with postnatal complication
198997005	Pre-eclampsia or eclampsia with pre-existing hypertension
198999008	Pre-eclampsia or eclampsia with pre-existing hypertension - delivered
199000005	Pre-eclampsia or eclampsia with pre-existing hypertension - delivered with postnatal complication
199002002	Pre-eclampsia or eclampsia with pre-existing hypertension - not delivered
199003007	Pre-eclampsia or eclampsia with pre-existing hypertension with postnatal complication
237279007	Transient hypertension of pregnancy
237281009	Moderate proteinuric hypertension of pregnancy
288250001	Maternal hypertension
307632004	Non-proteinuric hypertension of pregnancy
308551004	Gestational hypertension
398254007	Pre-eclampsia
367390009	Hypertension without albuminuria AND without edema in the obstetric context

A.107 QRPH MCH HBS Eclampsia Codes

A.107.1 Metadata

1745 Eclampsia Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140
Name	This is the name of the value set	MCH HBS Eclampsia Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Eclampsia
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.107.2 MCH HBS Eclampsia Value Set

Eclampsia Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
15938005	Eclampsia (disorder)
237283007	Eclampsia in labor (disorder)
237282002	Impending eclampsia (disorder)
198992004	Eclampsia in pregnancy (disorder)
69909000	Eclampsia added to pre-existing hypertension (disorder)
198997005	Pre-eclampsia or eclampsia with pre-existing hypertension

A.108 QRPH MCH HBS Preterm Birth Codes

A.108.1 Metadata

Preterm Birth Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141
Name	This is the name of the value set	MCH HBS Preterm Birth Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Preterm Birth (history)
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.108.2 MCH HBS Preterm Birth Value Set

Preterm Birth Value Set will use the SNOMED-CT code system to identify its contents. Codes
1755 that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
404970005	Preterm infant status: 24-37 weeks gestation (observable entity)
282020008	Premature delivery (finding)
59403008	Premature birth of newborn female (finding)
4886009	Premature birth of newborn male (finding)
161765003	History of premature delivery (situation)

A.109 QRPH MCH HBS Poor Pregnancy Outcome – History Codes

A.109.1 Metadata

Poor Pregnancy Outcome – History Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142
Name	This is the name of the value set	MCH HBS Poor Pregnancy Outcome – History Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Pregnancy Outcome of Perinatal Death - History
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.109.2 MCH HBS Poor Pregnancy Outcome – History Value Set

Poor Pregnancy Outcome – History Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
169583006	Antenatal care: history of perinatal death (situation)
169582001	Antenatal care: history of stillbirth (situation)
169585004	Antenatal care: history of trophoblastic disease (situation)
169584000	Antenatal care: poor obstetric history (situation)
161744009	History of Miscarriage
161747002	History of 1 Miscarriage
161748007	History of 2 Miscarriages
161749004	History of 3 Miscarriages
161750004	History of 4 Miscarriages
161751000	History of 5 Miscarriages
161752007	History of 6 Miscarriages
161804005	History of - antepartum hemorrhage (situation)
275569003	History of - delivery no details (situation)
161806007	History of - eclampsia (situation)
161763005	History of - ectopic pregnancy (situation)
161803004	History of - obstetric problem (situation)
161809000	History of - postpartum hemorrhage (situation)
161765003	History of - premature delivery (situation)
161810005	History of - prolonged labor (situation)
161807003	History of - severe pre-eclampsia (situation)
161743003	History of - stillbirth (situation)
428978004	History of choriocarcinoma of placenta (situation)
441493008	History of premature labor (situation)

1765

A.110 QRPH MCH HBS Infertility Treatment Codes

A.110.1 Metadata

Infertility Treatment Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143
Name	This is the name of the value set	MCH HBS Infertility Treatment Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Pregnancy Infertility Treatment
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.110.2 MCH HBS Infertility Treatment Value Set

Infertility Treatment Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
65046005	Infertility therapy (procedure)
183036001	Female infertility therapy (procedure)
236896006	Artificial insemination by donor (procedure)
236895005	Artificial insemination by husband (procedure)
57233006	Artificial insemination with sperm washing and capacitation (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
46249006	Artificial insemination, heterologous (procedure)
66601000	Artificial insemination, homologous (procedure)
176844003	Intracervical artificial insemination (procedure)
265064001	Intrauterine artificial insemination (procedure)
426250000	Intrauterine insemination using donor sperm (procedure)
426389008	Intrauterine insemination using partner sperm (procedure)
425644009	Intrauterine insemination with controlled ovarian hyperstimulation using donor sperm (procedure)
426968007	Intrauterine insemination with controlled ovarian hyperstimulation using partner sperm (procedure)
225250007	Intravaginal artificial insemination (procedure)
225249007	Subzonal insemination (procedure)
176843009	Gamete intrauterine transfer (procedure)
236912008	Gamete intrafallopian transfer (procedure)
176996001	Endoscopic intrafallopian transfer of gamete (procedure)
236913003	Fallopian replacement of egg with delayed insemination (procedure)
225249007	Subzonal insemination
236915005	Tubal embryo transfer
236914009	Zygote intrafallopian transfer
63487001	Assisted fertilization (procedure)

A.111 QRPH MCH HBS Fertility Enhancing Drugs Medications Codes

A.111.1 Metadata

Fertility Enhancing Drugs Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Name	This is the name of the value set	MCH HBS Fertility Enhancing Drugs Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect that Fertility Enhancing Drugs were administered as a risk factor for pregnancy
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from RxNORM
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/rxnorm/
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.111.2 MCH HBS Fertility Enhancing Drugs Value Set

Medication codes indicating Fertility Enhancing Drugs use the RxNorm code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Vocabulary:	2.16.840.1.113883.6.88
RxNorm Code	RxNorm Description
197523	Clomiphene 50 MG Oral Tablet
347764	Follicle Stimulating Hormone 150 UNT/ML / Luteinizing Hormone 150 UNT/ML Injectable Solution
314097	Follicle Stimulating Hormone 75 UNT/ML / Luteinizing Hormone 75 UNT/ML Injectable Solution

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Vocabulary:	2.16.840.1.113883.6.88
RxNorm Code	RxNorm Description
314097	Follicle Stimulating Hormone 75 UNT/ML / Luteinizing Hormone 75 UNT/ML Injectable Solution
313561	Urofollitropin 150 UNT/ML Injectable Solution
348522	Urofollitropin 300 UNT/ML Injectable Solution
854749	0.21 ML follitropin beta 833 UNT/ML Prefilled Syringe
854754	0.78 ML follitropin beta 833 UNT/ML Prefilled Syringe
854756	1.17 ML follitropin beta 833 UNT/ML Prefilled Syringe
854752	follitropin beta 350 UNT per 0.42 ML Prefilled Syringe
205320	follitropin beta 75 UNT/ML Injectable Solution
389216	follitropin beta 833 UNT/ML Injectable Solution
310413	Follitropin Alfa 300 UNT/ML Injectable Solution
351125	Follitropin Alfa 600 UNT/ML Injectable Solution
847960	follitropin alfa 75 UNT/ACTUAT Prefilled Pen, 12 ACTUAT
847953	Follitropin Alfa 75 UNT/ACTUAT Prefilled Syringe, 4 ACTUAT
847957	follitropin alfa 75 UNT/ACTUAT Prefilled Syringe, 6 ACTUAT
562724	Follitropin Alfa 75 UNT/ML Injectable Solution
896854	Chorionic Gonadotropin 10000 UNT/ML Injectable Solution
727505	chorionic gonadotropin 0.25 MG per 0.5 ML Prefilled Syringe
562725	Chorionic Gonadotropin 0.25 MG/ML Injectable Solution
403979	Chorionic Gonadotropin 0.5 MG/ML Injectable Solution
896854	Chorionic Gonadotropin 10000 UNT/ML Injectable Solution
562828	Chorionic Gonadotropin 500 UNT/ML Injectable Solution

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Vocabulary:	2.16.840.1.113883.6.88
RxNorm Code	RxNorm Description
314097	Follicle Stimulating Hormone 75 UNT/ML / Luteinizing Hormone 75 UNT/ML Injectable Solution
197411	Bromocriptine 2.5 MG Oral Tablet
197412	bromocriptine 5 MG (bromocriptine mesylate 5.74 MG) Oral Capsule
1043563	24 HR Metformin hydrochloride 1000 MG / saxagliptin 2.5 MG Extended Release Tablet
1043570	24 HR Metformin hydrochloride 1000 MG / saxagliptin 5 MG Extended Release Tablet
1043578	24 HR Metformin hydrochloride 500 MG / saxagliptin 5 MG Extended Release Tablet
861731	Glipizide 2.5 MG / Metformin hydrochloride 250 MG Oral Tablet
861736	Glipizide 2.5 MG / Metformin hydrochloride 500 MG Oral Tablet
861740	Glipizide 5 MG / Metformin hydrochloride 500 MG Oral Tablet
861743	Glyburide 1.25 MG / Metformin hydrochloride 250 MG Oral Tablet
861748	Glyburide 2.5 MG / Metformin hydrochloride 500 MG Oral Tablet
861753	Glyburide 5 MG / Metformin hydrochloride 500 MG Oral Tablet
861025	Metformin hydrochloride 100 MG/ML Oral Solution
899989	24 HR Metformin hydrochloride 1000 MG / pioglitazone 15 MG Extended Release Tablet
899994	Metformin hydrochloride 1000 MG / pioglitazone 15 MG Extended Release Tablet
899996	24 HR Metformin hydrochloride 1000 MG / pioglitazone 30 MG Extended Release Tablet
900001	Metformin hydrochloride 1000 MG / pioglitazone 30 MG Extended Release Tablet
861760	Metformin hydrochloride 1000 MG / rosiglitazone 2 MG Oral Tablet
861763	Metformin hydrochloride 1000 MG / rosiglitazone 4 MG Oral Tablet
1043568	Metformin hydrochloride 1000 MG / saxagliptin

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Vocabulary:	2.16.840.1.113883.6.88
RxNorm Code	RxNorm Description
	2.5 MG Extended Release Tablet
1043575	Metformin hydrochloride 1000 MG / saxagliptin 5 MG Extended Release Tablet
861769	Metformin hydrochloride 1000 MG / sitagliptin 50 MG Oral Tablet
860996	24 HR Metformin hydrochloride 1000 MG Extended Release Tablet
860999	Metformin hydrochloride 1000 MG Extended Release Tablet
861004	Metformin hydrochloride 1000 MG Oral Tablet
861783	Metformin hydrochloride 500 MG / pioglitazone 15 MG Oral Tablet
861787	Metformin hydrochloride 500 MG / repaglinide 1 MG Oral Tablet
861790	Metformin hydrochloride 500 MG / repaglinide 2 MG Oral Tablet
861795	Metformin hydrochloride 500 MG / rosiglitazone 1 MG Oral Tablet
861806	Metformin hydrochloride 500 MG / rosiglitazone 2 MG Oral Tablet
861816	Metformin hydrochloride 500 MG / rosiglitazone 4 MG Oral Tablet
1043583	Metformin hydrochloride 500 MG / saxagliptin 5 MG Extended Release Tablet
861819	Metformin hydrochloride 500 MG / sitagliptin 50 MG Oral Tablet
860975	24 HR Metformin hydrochloride 500 MG Extended Release Tablet
860978	Metformin hydrochloride 500 MG Extended Release Tablet
861007	Metformin hydrochloride 500 MG Oral Tablet
861021	Metformin hydrochloride 625 MG Oral Tablet
860981	24 HR Metformin hydrochloride 750 MG Extended Release Tablet
860984	Metformin hydrochloride 750 MG Extended Release Tablet
861822	Metformin hydrochloride 850 MG / pioglitazone 15 MG Oral Tablet

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
Vocabulary:	2.16.840.1.113883.6.88
RxNorm Code	RxNorm Description
861010	Metformin hydrochloride 850 MG Oral Tablet
378730	Metformin Oral Tablet
374635	Glyburide / Metformin Oral Tablet
899988	Metformin / pioglitazone Extended Release Tablet
577093	Metformin / pioglitazone Oral Tablet
802742	Metformin / repaglinide Oral Tablet
378729	Metformin / rosiglitazone Oral Tablet
1043561	Metformin / saxagliptin Extended Release Tablet
700516	Metformin / sitagliptin Oral Tablet
372804	Metformin Extended Release Tablet
406082	Metformin Oral Solution
372803	Metformin Oral Tablet

A.112 QRPH MCH HBS Artificial or Intrauterine Insemination Codes

A.112.1 Metadata

Artificial or Intrauterine Insemination Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145
Name	This is the name of the value set	MCH HBS Artificial or Intrauterine Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Artificial or Intrauterine Insemination as a Risk Factor in Pregnancey
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.112.2 MCH HBS Artificial or Intrauterine Value Set

Artificial or Intrauterine Insemination Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1790

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
236896006	Artificial insemination by donor (procedure)
236895005	Artificial insemination by husband (procedure)
57233006	Artificial insemination with sperm washing and capacitation (procedure)
46249006	Artificial insemination, heterologous (procedure)
66601000	Artificial insemination, homologous (procedure)
176844003	Intracervical artificial insemination (procedure)
265064001	Intrauterine artificial insemination (procedure)
426250000	Intrauterine insemination using donor sperm (procedure)
426389008	Intrauterine insemination using partner sperm (procedure)
425644009	Intrauterine insemination with controlled ovarian hyperstimulation using donor sperm (procedure)
426968007	Intrauterine insemination with controlled

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	ovarian hyperstimulation using partner sperm (procedure)
225250007	Intravaginal artificial insemination (procedure)

A.113 QRPH MCH HBS Assistive Reproductive Technology Codes

A.113.1 Metadata

1795 Assistive Reproductive Technology Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146
Name	This is the name of the value set	MCH HBS Assistive Reproductive Technology Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Assistive Reproductive Technology as a Risk Factor in Pregnancey
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.113.2 MCH HBS Assistive Reproductive Technology Value Set

Assistive Reproductive Technology Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
52637005	Test tube ovum fertilization (procedure)
63487001	Assisted fertilization (procedure)
176843009	Gamete intrauterine transfer (procedure)
176996001	Endoscopic intrafallopian transfer of gamete (procedure)
225244002	Direct injection of sperm into cytoplasm of the oocyte (procedure)
225247009	Direct intraperitoneal insemination
225248004	Zona drilling (procedure)
225249007	Subzonal insemination
236912008	Gamete intrafallopian transfer (procedure)
236913003	Fallopian replacement of egg with delayed insemination (procedure)
236914009	Zygote intrafallopian transfer (procedure)
236915005	Tubal embryo transfer (procedure)
238312005	Intraperitoneal insemination
425866000	In vitro fertilization using donor eggs (procedure)
425901007	In vitro fertilization with intracytoplasmic sperm injection (procedure)
426417003	In vitro fertilization with preimplantation genetic diagnosis (procedure)
426914002	In vitro fertilization using donor egg and intracytoplasmic sperm injection (procedure)
427664000	In vitro fertilization using donor sperm (procedure)
443633009	Conceived by in vitro fertilization (finding)

A.114 QRPH MCH HBS Previous Cesarean Codes

A.114.1 Metadata

Previous Cesarean Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147
Name	This is the name of the value set	MCH HBS Previous Cesarean Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Risk Factors of Pregnancy Previous Cesarean
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.114.2 MCH HBS Previous Cesarean Value Set

1805 Previous Cesarean Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
200151008	Cesarean section following previous cesarean section (finding)
302254004	Delivered by cesarean delivery following previous cesarean delivery (finding)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
237313003	Vaginal delivery following previous cesarean section (finding)
200144004	Deliveries by cesarean (finding)
200147006	Cesarean section - pregnancy at term (finding)
200151008	Cesarean section following previous cesarean section (finding)
302254004	Delivered by cesarean delivery following previous cesarean delivery (finding)
302253005	Delivered by cesarean section - pregnancy at term (finding)
200146002	Cesarean delivery - delivered (finding)
200148001	Delivery by elective cesarean section (finding)
200149009	Delivery by emergency cesarean section (finding)

A.115 QRPH MCH HBS Number of Previous Cesareans Codes

A.115.1 Metadata

Number of Previous Cesareans Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148
Name	This is the name of the value set	MCH HBS Number of Previous Cesareans Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Number of Previous Cesareans as a Risk Factor in Pregnancey
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.115.2 MCH Number of Previous Cesareans Value Set

Number of Previous Cesareans Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1815

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
	Pending

A.116 QRPH MCH HBS Time of Death Codes

A.116.1 Metadata

Time of Death Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Name	This is the name of the value set	MCH HBS Time of Death Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Time of Death
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0

Metadata Element	Description	Mandatory
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.116.2 MCH Time of Death Value Set

Time of Death Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
55287-7	Time of death

A.117 QRPH MCH HBS Hysterotomy/ Hysterectomy Codes

A.117.1 Metadata

Hysterotomy/ Hysterectomy Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150
Name	This is the name of the value set	MCH HBS Hysterotomy/ Hysterectomy Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To reflect hysterotomy/histerectomy as the method of delivery in fetal death
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html

Metadata Element	Description	Mandatory
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.117.2 MCH HBS Hysterotomy/Hysterectomy Value Set

Hysterotomy/ Hysterectomy Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1830

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
236886002	Hysterectomy (procedure)
116141005	Abdominal hysterectomy (procedure)
302191001	Abdominal hysterectomy and left salpingo-oophorectomy (procedure)
302190000	Abdominal hysterectomy and right salpingo-oophorectomy (procedure)
13254001	Abdominal hysterectomy with colpo-urethrocystopexy, Marshall-Marchetti-Krantz type (procedure)
413144006	Abdominal hysterectomy with conservation of ovaries (procedure)
309879006	Abdominal hysterocolpectomy (procedure)
116143008	Total abdominal hysterectomy (procedure)
307771009	Radical abdominal hysterectomy (procedure)
361222003	Wertheim-Meigs abdominal hysterectomy (procedure)
116144002	Total abdominal hysterectomy with bilateral salpingo-oophorectomy (procedure)
361223008	Wertheim operation (procedure)
11050006	Closure of vesicouterine fistula with hysterectomy (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
427107006	Excision of accessory uterus (procedure)
12398007	Excision of endometrial synechiae (procedure)
54261007	Excision of uterus and supporting structures (procedure)
288042004	Hysterectomy and fetus removal (procedure)
41059002	Cesarean hysterectomy (procedure)
236988000	Elective cesarean hysterectomy (procedure)
236987005	Emergency cesarean hysterectomy (procedure)
288043009	Hysterectomy in pregnancy (procedure)
84275009	Obstetrical hysterotomy (procedure)
392000009	Hysterotomy for retained placenta (procedure)
18302006	Therapeutic abortion by hysterotomy (procedure)
52660002	Induced abortion following intra-amniotic injection with hysterotomy (procedure)
84267003	Hysterotomy with removal of foreign body (procedure)
26578004	Hysterotomy with removal of hydatidiform mole (procedure)
387644004	Supracervical hysterectomy (procedure)
29529008	Supracervical hysterectomy with removal of both tubes and ovaries (procedure)
112917009	Supracervical hysterectomy with unilateral removal of tube and ovary (procedure)

A.118 QRPH MCH HBS Fetus Weight Codes

A.118.1 Metadata

Fetus Weight Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.151
Name	This is the name of the value set	MCH HBS Fetus Weight Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the weight of the fetus
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.118.2 MCH Fetus Weight Value Set

Fetus Weight Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.151
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
57067-1	Estimated by palpation

NOTE: Further Refinement of available LOINC codes to reflect more accurate representation of Fetal Weight at delivery pending.

A.119 QRPH MCH HBS Histological Placental Examination Codes

A.119.1 Metadata

Histological Placental Examination Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.152
Name	This is the name of the value set	MCH HBS Histological Placental Examination Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Histological Placental Examination for fetal death
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.119.2 MCH Histological Placental Examination Value Set

Histological Placental Examination Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.152
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	Pending

A.120 QRPH MCH HBS Fetal Autopsy Codes

A.120.1 Metadata

Fetal Autopsy Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153
Name	This is the name of the value set	MCH HBS Fetal Autopsy Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Fetal Autopsy was performed
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.120.2 MCH Fetal Autopsy Value Set

Fetal Autopsy Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1855

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
16361008	Autopsy, gross and microscopic examination, stillborn or newborn (procedure)
29240004	Autopsy examination (procedure)
41770000	Autopsy, gross and microscopic examination (procedure)
56417000	Autopsy, gross and microscopic examination with brain (procedure)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.153
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
41554000	Autopsy, gross and microscopic examination with brain and spinal cord (procedure)
74348008	Autopsy, gross and microscopic examination, limited (procedure)
57438004	Autopsy, gross and microscopic examination, regional (procedure)
4447001	Autopsy, gross and microscopic examination, stillborn or newborn without CNS (procedure)
82823006	Autopsy, gross examination with brain (procedure)
47197006	Autopsy, gross examination with brain and spinal cord (procedure)
72598009	Autopsy, gross examination, limited (procedure)
47847005	Autopsy, gross examination, limited, regional (procedure)
50333006	Autopsy, gross examination, macerated stillborn (procedure)
35459000	Autopsy, gross examination, stillborn or newborn (procedure)
5785009	Forensic autopsy (procedure)
61501008	Forensic autopsy, extensive (procedure)
26762004	Autopsy, gross examination, teaching, complete (procedure)
22677004	Autopsy, gross examination, teaching, limited (procedure)
168450005	Forensic examination (procedure)

A.121 QRPH MCH HBS Karyotype Determination Codes

A.121.1 Metadata

Karyotype Determination Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
Name	This is the name of the value set	MCH HBS Karyotype Determination Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Fetal Autopsy was performed

Metadata Element	Description	Mandatory
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.121.2 MCH Karyotype Determination Value Set

Karyotype Determination Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
312948004	Karyotype determination (procedure)
444309000	Determination of karyotype from blood specimen (procedure)

A.122 QRPH MCH HBS Number of Fetal Deaths This Delivery Codes

A.122.1 Metadata

Number of Fetal Deaths This Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164
Name	This is the name of the value set	MCH HBS Number of Fetal Deaths This Delivery Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the Number of Fetal Deaths This Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.122.2 MCH HBS Number of Fetal Deaths This Delivery Value Set

Number of Fetal Deaths This Delivery Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
57062-2	Births.stillborn

A.123 QRPH MCH HBS Listeria Codes

A.123.1 Metadata

Listeria Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16547

Metadata Element	Description	Mandatory
Name	This is the name of the value set	MCH HBS Listeria Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect infection with Listeria
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.123.2 MCH HBS Listeria Value Set

Listeria Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16547
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
4241002	Listeriosis (disorder)
7964000	Congenital listeriosis (disorder)
359646002	Neonatal disseminated listeriosis (disorder)
238420008	Cutaneous involvement in listeriosis (disorder)
402128003	Cutaneous listeriosis (disorder)
200426004	Disseminated infantile listeriosis (disorder)
57420002	Listeria abortion (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16547
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
29786001	Listeria conjunctivitis (disorder)
406590007	Listeria infection of the central nervous system (disorder)
240393003	Listeria cerebritis (disorder)
31568009	Listeria meningitis (disorder)
24630008	Listeria meningoencephalitis (disorder)
186317009	Listerial cerebral arteritis (disorder)
66380007	Listeria septicemia (disorder)
186318004	Listerial endocarditis (disorder)
186319007	Oculoglandular listeriosis (disorder)

A.124 QRPH MCH HBS Group B Streptococcus Codes

A.124.1 Metadata

Group B Streptococcus Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166
Name	This is the name of the value set	MCH HBS Group B Streptococcus Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Infection with Group B Streptococcus
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A

Metadata Element	Description	Mandatory
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.124.2 MCH HBS Group B Streptococcus Value Set

Group B Streptococcus Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

1890

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
405633009	Streptococcus group B infection of the infant (disorder)
405634003	Streptococcus group B infection of the infant - age less than 30 days (disorder)
406612005	Invasive Group B beta-hemolytic streptococcal disease (disorder)
170488007	Streptococcus carrier (finding)
186380004	Gp B streptococcal septicemia (disorder)
426933007	Streptococcus agalactiae infection (disorder)

A.125 QRPH MCH HBS Cytomegalovirus Codes

A.125.1 Metadata

Cytomegalovirus Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167
Name	This is the name of the value set	MCH HBS Cytomegalovirus Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect infection with Cytomegalovirus
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.125.2 MCH HBS Cytomegalovirus Value Set

Cytomegalovirus Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167
Vocabulary:	**2.16.840.1.113883.6.96**
SNOMED-CT Code	**SNOMED-CT Description**
28944009	Cytomegalovirus infection (disorder)
59527008	Congenital cytomegalovirus infection (disorder)
240551003	Chronic congenital cytomegalic inclusion disease (disorder)
422241000	Cytomegalic inclusion disease associated with AIDS (disorder)
426137009	Cytomegaloviral enteritis (disorder)
235749000	Cytomegaloviral colitis (disorder)
429300008	Cytomegaloviral gastritis (disorder)
16196000	Cytomegaloviral mononucleosis (disorder)
235947007	Cytomegaloviral pancreatitis (disorder)
7678002	Cytomegaloviral pneumonia (disorder)
22455005	Cytomegaloviral retinitis (disorder)
416491000	Immune recovery uveitis (disorder)
186698009	Cytomegalovirus hepatitis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
402122002	Cytomegalovirus infection of skin (disorder)
406570003	Cytomegalovirus infection of the central nervous system (disorder)
83159006	Cytomegalovirus encephalitis (disorder)
236590008	Cytomegalovirus-induced glomerulonephritis (disorder)
428217009	Disseminated cytomegalovirus infection (disorder)
232311007	Endocochlear cytomegalovirus infection (disorder)
276701009	Fetal cytomegalovirus syndrome (disorder)
186718002	Human immunodeficiency virus (HIV) disease resulting in cytomegaloviral disease (disorder)

A.126 QRPH MCH HBS Parvovirus Codes

A.126.1 Metadata

Parvovirus Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168
Name	This is the name of the value set	MCH HBS Parvovirus Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect infection with Parvovirus
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010

Metadata Element	Description	Mandatory
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.126.2 MCH HBS Parvovirus Value Set

Parvovirus Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
186748004	Parvovirus infection (disorder)
276663004	Congenital human parvovirus infection (disorder)
406599008	Parvovirus infection of the central nervous system (disorder)

A.127 QRPH MCH HBS Toxoplasmosis Codes

A.127.1 Metadata

Toxoplasmosis Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Name	This is the name of the value set	MCH HBS Toxoplasmosis Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect infection with Parvovirus
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT

Metadata Element	Description	Mandatory
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.127.2 MCH HBS Toxoplasmosis Value Set

Toxoplasmosis Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
187192000	Toxoplasmosis (disorder)
16116004	Acute lymphadenopathic toxoplasmosis (disorder)
73893000	Congenital toxoplasmosis (disorder)
281899002	Congenital hydrocephalus due to toxoplasmosis (disorder)
67372006	Conjunctivitis due to acquired toxoplasmosis (disorder)
240666009	Cutaneous toxoplasmosis (disorder)
17949000	Meningoencephalitis due to acquired toxoplasmosis (disorder)
22540004	Multisystemic disseminated toxoplasmosis (disorder)
416481006	Ocular toxoplasmosis (disorder)
46207001	Pneumonitis due to acquired toxoplasmosis (disorder)
415218004	Punctate outer retinal toxoplasmosis (disorder)

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
192701001	Toxoplasma encephalitis (disorder)
187197006	Toxoplasma hepatitis (disorder)
17681007	Hepatitis due to acquired toxoplasmosis (disorder)
187195003	Toxoplasma myocarditis (disorder)
194948006	Acute myocarditis - toxoplasmosis (disorder)
76534005	Myocarditis due to acquired toxoplasmosis (disorder)
416913007	Toxoplasma neuroretinitis (disorder)
187196002	Toxoplasma pneumonitis (disorder)
416589006	Toxoplasma retinitis (disorder)
421666009	Toxoplasmosis associated with AIDS (disorder)
187194004	Toxoplasmosis chorioretinitis (disorder)
314031009	Acute toxoplasmosis chorioretinitis (disorder)
88290000	Focal chorioretinitis due to acquired toxoplasmosis (disorder)
314032002	Inactive toxoplasmosis chorioretinitis (disorder)
441854007	Reactivation of toxoplasmosis chorioretinitis (disorder)
187199009	Toxoplasmosis of multiple sites (disorder)

A.128 QRPH MCH HBS State Codes

A.128.1 Metadata

State Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	2.16.840.1.113883.6.921.3.6.1.4.1.19376.1 .7.3.1.1.13.8.149
Name	This is the name of the value set	Codes for the Identification of the States, the District of Columbia and the Outlying Areas of the United States, and Associated Areas Publication # 5-2, May, 1987MCH HBS State Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	Federal Information Processing Standards Publication 5-2IHE Quality Research and Public Health Domain

Metadata Element	Description	Mandatory
Purpose	Brief description about the general purpose of the value set	To Reflect State of residence or birth
Definition	A text definition describing how concepts in the value set were selected	Intentional: Identifies addresses within the United States are recorded using the FIPS 5-2 two-letter alphabetic codes for the State, District of Columbia, or an outlying area of the United States or associated area
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.itl.nist.gov/fipspubs/fip5-2.htm
Version	A string identifying the specific version of the value set.	19870918Version 1.0
Type		Intensional
Binding		Dynamic
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/20109/18/1987
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/20109/18/1987
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.128.2 MCH HBS State Value Set

Codes are not further constrained from FIPS 5-2. As an Intensional value set, the codes are not enumerated here.

A.129 QRPH MCH HBS MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Codes

A.129.1 Metadata

MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176
Name	This is the name of the value set	MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set

Metadata Element	Description	Mandatory
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Transferred for Maternal Medical or Fetal Indications for Delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.129.2 MCH HBS MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set

MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176
Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	SNOMED-CT Description
	Pending

A.130 QRPH MCH HBS Transfer In Codes

A.130.1 Metadata

Transfer In Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177
Name	This is the name of the value set	MCH HBS Transfer In Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect admission through Transfer
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from UB-04 FL-15
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	www.nubc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.130.2 MCH HBS Transfer In Value Set

Transfer In Value Set will use the UB-04/NUBC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177
Vocabulary:	2.16.840.1.113883.6.21
UB-04/NUBC Code	Description
2	Clinic
4	Transfer from a Hospital (Different Facility)
6	Transfer from Another Health Care Facility

A.131 QRPH MCH HBS MCH HBS Antibiotic Administration Procedure Codes

A.131.1 Metadata

MCH HBS Antibiotic Administration Procedure Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178
Name	This is the name of the value set	MCH HBS Antibiotic Administration Procedure Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect Antibiotic Administration Procedure during labor and delivery
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from SNOMED-CT
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2010
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2010
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.131.2 MCH HBS Antibiotic Administration Procedure Value Set

MCH HBS Antibiotic Administration Procedure Value Set will use the SNOMED-CT code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178

Vocabulary:	2.16.840.1.113883.6.96
SNOMED-CT Code	**SNOMED-CT Description**
281790008	Intravenous antibiotic therapy (procedure)
307520009	Intramuscular antibiotic therapy (procedure)

1950

A.132 QRPH MCH HBS Gender Observation Value Set Codes

A.132.1 Metadata

MCH HBS Gender Observation Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.183
Name	This is the name of the value set	MCH HBS Gender Observation Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the gender observation of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2011
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2011
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.132.2 MCH HBS Gender Observation Value Set

1955 Gender Observation Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.183
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
11883-6	Gender
11883-8	Gender

A.133 QRPH MCH HBS Birthplace Value Set Codes

A.133.1 Metadata

1960 MCH HBS Birthplace Value Set Metadata Shall contain the following content:

Metadata Element	Description	Mandatory
Identifier	This is the unique identifier of the value set	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
Name	This is the name of the value set	MCH HBS Birthplace Value Set
Source	This is the source of the value set, identifying the originator or publisher of the information	IHE Quality Research and Public Health Domain
Purpose	Brief description about the general purpose of the value set	To Reflect the birthplace of the newborn
Definition	A text definition describing how concepts in the value set were selected	Extensional definition: The value set was constructed by enumerating the codes from LOINC
Source URI	Most sources also have a URL or document URI that provides further details regarding the value set.	http://loinc.org
Version	A string identifying the specific version of the value set.	Version 1.0
Status	Active (Current) or Inactive	Active
Effective Date	The date when the value set is expected to be effective	8/1/2011
Expiration Date	The date when the value set is no longer expected to be used	N/A
Creation Date	The date of creation of the value set	8/1/2011
Revision Date	The date of revision of the value set	N/A
Groups	The identifiers of the groups that include this value set. A group may also have an OID assigned.	IHE MCH:HBS

A.133.2 MCH HBS Birthplace Value Set

Birthplace Value Set will use the LOINC code system to identify its contents. Codes that are used within the scope of this profile are listed below:

Value Set :	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
Vocabulary:	2.16.840.1.113883.6.1
LOINC Code	LOINC Description
21842-0	Birthplace

1965

Glossary

Add the following terms to the Glossary:

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.

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)
Gestational age is the number of weeks elapsed between the first day of the last normal menstrual period and the date of delivery.

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.

Hearing test
Hearing function test, pure tone audiometry Audiology Any test that measures hearing or quantifies hearing loss; sound is perceived by intensity–loudness and by tone; both are measured in HTs, as is the ability to hear sound through air–air conduction and bone–bone conduction.

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.

Hemoglobin disease
Hemoglobin is produced by genes that control the expression of the hemoglobin protein. Defects in these genes can produce abnormal hemoglobins and anemia, which are conditions termed "hemoglobinopathies". Abnormal hemoglobins appear in one of three basic circumstances:

- Structural defects in the hemoglobin molecule.
- Diminished production of one of the two subunits of the hemoglobin molecule.
- Abnormal associations of otherwise normal subunits.

Hydrocephalus

Hydrocephalus is the abnormal accumulation of cerebrospinal fluid (CSF) in the ventricles, or cavities, of the brain. This may cause increased intracranial pressure inside the skull and progressive enlargement of the head, convulsion, and mental disability.

Immunoglobulin

Immunoglobulin is a concentrated preparation of gamma globulins, predominantly IgG, from a large pool of human donors; used for passive immunization against measles, hepatitis A, and varicella and for replacement therapy in patients with immunoglobulin deficiencies.

Induction of labor

Induction of labor is the initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun).

In-utero transfer

An in-utero transfer consists in transferring, while the fetus is still in-utero, of the high-risks pregnant mother to another specialized birthing facility. Conversely, post-natal transfers are transfers that occur after the delivery.

Intra-uterine growth retardation (IUGR)

Intrauterine growth retardation (IUGR) occurs when the unborn baby is at or below the 10th weight percentile for his or her age (in weeks).

Intubation

Tracheal intubation is the placement of a flexible plastic tube into the trachea to protect the patient's airway and provide a means of mechanical ventilation.

Meningomyelocele

Meningomyelocele is a herniation of the meninges and spinal cord tissue.

Neural tube defects

Neural tube defect will occur in human embryos if there is an interference with the closure of the neural tube.

Nonvertex Presentation

Nonvertex presentation is the presentation of other than the upper and back part of the infant’s head.

Nuchal translucency scan

Nuchal translucency scan is an ultrasonographic prenatal screening scan to help identify higher risks of Down syndrome in a fetus. The scan is carried out at 11-13 weeks pregnancy and assesses the amount of fluid behind the neck of the fetus. Fetuses at risk of Down tend to have a higher amount of fluid around the neck.

Omphalocele

Omphalocele is a defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk.

Pre-eclampsia

Pre-eclampsia is a disorder occurring during late pregnancy or immediately following parturition, characterized by hypertension, edema, and proteinuria. Also called toxemia of pregnancy.

Preterm birth

Preterm birth is a live birth of less than 37 completed weeks of gestation.

Premature labor

Premature labor describes the contractions of the uterus less than 37 weeks in a pregnancy.

Presentation

Presentation is the part of the fetus lying over the pelvic inlet; the presenting body part of the fetus.

Polymalformative syndrome

Polymalformative syndrome is set of non-random birth defects deriving from the same cause. It involves multiple systems of the organism (eyes, ears, central nervous system, heart, musculoskeletal...). Its screening, mostly by clinical examination means, is systematically made at birth.

Spina bifida

Spina bifida is a herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure.

Spinal anesthesia

Spinal anesthesia or sub-arachnoidal block is a form of regional anesthesia involving the injection of local anaesthetic 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 2 – Transactions

This supplement does not define any new transactions.

Volume 3 – Content Modules

6.3.1 CDA Document Content Modules

No new Document Content Modules will be added with this supplement

6.3.2 CDA Header Content Modules

No new header content modules

6.3.3 CDA Section Content Modules

No new section content modules

6.3.4 CDA Entry Content Modules

No new entry content modules

Volume 4 – National Extensions for IHE United States

5.0 National Extensions for IHE United States

5.x Pre-Population Specification for US Standards Certificate of Live Birth and US Standard Report of Fetal Death

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

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

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

5.x.1 Data Element Index

A relevant data set for HBS content reporting include those elements identified within the US efforts under the CDC/National Center for Health Statistics (NCHS) that can be computed from data elements in the electronic health record. The HBS CCD mapping rules described below overlays these data elements typically presented to the birth registrar in a form. This Derived Data Element Index is an attempt to describe which sections are intended to cover which

domains, the value sets to be used to interpret the CCD content, and rules for examining CCD content to determine whether or not the data element is satisfied. These rules may specify examination of one or more CCD 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. While any CCD document may be used to populate the form, the IHE PCC Labor and Delivery Document will result in the maximum number of pre-populated data elements

5.x.2 Form Manager Pre-population Data Element Mapping Specification

Table 5.X.2-1describes the pre-population rules to derive the data elements to populate the following forms for U.S. vital registration: Facility Worksheet for the Live Birth Certificate and the Facility Worksheet for the Report of Fetal Death This profile will not specify the data collected from the Mother's Worksheet. Additionally, these items will not be included for pre-population.

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

Table 5.X.2-1 Form Element Mapping Specification

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ANTI	Y	N	Abnormal conditions of the newborn: Antibiotics [received by the newborn for suspected neonatal sepsis]	Any antibacterial drug given systemically (intravenous or intramuscular.)(e.g. penicillin, ampicillin, gentamicin, cefotoxine, etc.)	IF (Indication CONTAINS ValueSet (MCH HBS Neonatal Sepsis Value Set) AND (Coded Product Name CONTAINS ValueSet (MCH HBS Antibiotics Value Set)) AND (Route CONTAINS ValueSet (MCH	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Antibiotics Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
						Newborn Delivery Information	MCH HBS Intramuscular

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					HBS Intramuscular Administration Route Value Set) OR ValueSet (MCH HBS IV Medication Administration Route Value Set))), OR IF Procedure ID CONTAINS ValueSet (MCH HBS Antibiotic Administration Procedure Value Set) THEN ANTI SHALL = "Y" ELSE "N"	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Route 1.3.6.1.4.1.19376.1.5.3.1.3.21	Administration Route Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5
							MCH HBS IV Medication Administration Route Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Indication 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Neonatal Sepsis Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.6
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19	MCH HBS Antibiotic Administration Procedure Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.178
AVEN 1	Y	N	Abnormal conditions of the newborn: Assisted ventilation [required immediately following delivery]	Infant given manual breaths with bag and mask or bag and endotracheal tube within the first several minutes from birth for any duration. Excludes oxygen only and laryngoscopy for aspiration of meconium.	IF (Procedure ID CONTAINS ValueSet (Assisted Ventilation immediately following delivery) THEN AVEN1 SHALL = "Y" ELSE "N" NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19	MCH Assisted Ventilation Immediately Following Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.7

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AVEN 6	Y	N	Abnormal conditions of the newborn: Assisted ventilation for 6 or more hours	Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).	IF (Procedure ID CONTAINS ValueSet (Assisted Ventilation for 6 or more hours) THEN AVEN6 SHALL = "Y" ELSE "N" NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19	MCH Assisted Ventilation for 6 or More Hours Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.8
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	IF Problem Code CONTAINS ValueSet (VR Significant birth injury), THEN "Significant Birth Injury" **SHALL** = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Significant Birth Injury Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.9

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	IF (Event Outcome CONTAINS (MCH HBS Facility Location NICU Value Set)), THEN "NICU" SHALL = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Event Outcome 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	MCH HBS Facility Location NICU Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.1
SEIZ	Y	N	Abnormal conditions of	Seizure defined as any	If (Problem Code CONTAINS	Newborn Delivery	MCH HBS Seizure or Serious

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			the newborn: Seizure or serious neurologic dysfunction	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.	ValueSet (VR Seizure or serious neurologic dysfunction)) THEN "SEIZ" SHALL = "Y" ELSE "N"	Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	Neurologic Dysfunction Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.10
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	IF (Procedure ID Coded Product Name CONTAINS ValueSet (Newborn Receiving Surfactant Replacement Therapy)), THEN "SURF" SHALL = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21 Procedure Entry Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.4.19	MCH HBS Newborn Receiving Surfactant Replacement Therapy Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.11

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				(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.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
DNA54	Y	N	Abnormal conditions of the newborn: Unknown	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((AVEN1 = "U") OR (AVEN6 = "U") OR (NICU = "U") OR (SURF = "U") OR (ANTI = "U") OR (SEIZ = "U") OR (BINJ = "U")), THEN "DNA54" SHALL = "1" ELSE "DNA54" SHALL = "0"	See: AVEN1, AVEN6, NICU, SURF, ANTI, SEIZ, BINJ	
APGAR5	Y	N	Apgar Score: 5 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. Enter the infant's Apgar score at 5 minutes.	If (Result Type CONTAINS ValueSet (5 Min Apgar Score)), THEN "APGAR5" = (Result Value)	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS 5 Min Apgar Score Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.12
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						.15.1	
APGAR 10	Y	N	Apgar Score: 10 Minute	A systematic measure for evaluating the physical condition of the infant at specific intervals following birth. If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes.	If ("APGAR5" <6), AND (Result Type CONTAINS ValueSet (10 Min Apgar Score), THEN "APGAR10" = (Result Value)	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS 10 Min Apgar Score Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.13
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
ATTENDN	Y	Y	Attendant's name	The name 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. For example, if an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician should be reported as the	"ATTENDN" **SHALL** be populated using Procedures and Interventions using Provider Name WHERE Procedure ID contains ValueSet (MCH HBS Delivery Value Set) where the provider is the person responsible for delivering the child	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Name 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				attendant. If the obstetrician is not physically present, the intern or nurse midwife must be reported as the attendant.			
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)	IF Procedure ID CONTAINS ValueSet (MCH HBS Delivery Value Set), THEN IF Provider Type CONTAINS ValueSet (MCH Physician Value Set), THEN "ATTEND" **SHALL** = "1", ELSE IF Provider Type CONTAINS ValueSet (MCH Doctor of Osteopathic Medicine Value Set), THEN "ATTEND" **SHALL** = "2", ELSE IF 4.04 Provider Type CONTAINS ValueSet (MCH Certified Midwife Value Set), THEN "ATTEND" **SHALL** = "3", ELSE IF Provider Type CONTAINS ValueSet (MCH Midwife Value Set), THEN "ATTEND" **SHALL** = "4", ELSE IF Provider Type NOT NULL THEN "ATTEND" **SHALL** = "5", ELSE "ATTEND" **SHALL** = "9"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Type 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Physician Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.15 MCH Doctor of Osteopathic Medicine Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.16 MCH HBS Certified Midwife Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.17 MCH HBS Midwife Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.18
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
ATTE	Y	Y	Attendant:	The specific	IF Procedure ID	Labor and Delivery	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
NDS			Other specified	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.	CONTAINS ValueSet (MCH HBS Delivery Value Set) AND "ATTEND" = "5", THEN ATTENDS SHALL = Provider Type	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider Type 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
NPI	Y	Y	Attendant's NPI	The National Provider Identification Number (NPI) of the person (attendant) responsible for delivering the child.	"NPI" **SHALL** be populated using the Provider ID of the Procedure ID contains ValueSet (MCH HBS Delivery Value Set) where the Procedure ID is expressed as the National Provider Identifier (NPI)	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Provider ID (NPI) 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
CNAME	Y	Y	Birthplace - Child: County of Birth	The name of the county where the birth occurred.	"CNAME" SHALL be populated using Child's Metadata Entry: Birth Place using the County part of Birth Place	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubj	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						ect/code[@code='NCHILD']/following-sibling::addr/county	
FLOC	Y	Y	Birthplace - Child: City, Town or Location of Birth	The name of the city, town, township, village, or other location where the birth occurred.	"FLOC" SHALL be populated Child's Metadata Entry: Birth Place using the City part of Birth Place.	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD']/following-sibling::addr/city	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
BWG	Y	N	Birth weight (Infant's)	Infant's birthweight in grams.	IF Newborn Delivery Information Coded Physical Exam Result Type CONTAINS ValueSet (MCH Birth Weight Value Set), THEN "BWG" **SHALL** = Result Value WHERE Result Value Units are expressed in grams	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Birth Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
BWO	Y	N	Birth weight (Infant's)	Infant's birthweight in ounces.	IF Newborn Delivery Information Coded Physical Exam Result Type CONTAINS ValueSet (MCH Birth Weight Value Set), THEN "BWO" **SHALL** = Result Value WHERE 15.05 Result Value Units are expressed in ounces	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Birth Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
BWP	Y	N	Birth weight (Infant's)	Infant's birthweight in pounds.	Newborn Delivery Information Coded Results Section Result Type CONTAINS ValueSet (MCH Birth Weight Value Set), THEN "BWP" **SHALL** = Result Value WHERE Result Value Units are expressed in pounds	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Birth Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.20
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
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.	IF (Coded Product Name CONTAINS ValueSet (MCH HBS Antibiotics Value Set)) AND (Route CONTAINS ValueSet (MCH HBS Intramuscular Administration Route Value Set) OR ValueSet (MCH HBS IV Medication Administration Route Value Set)) THEN "ANTI" SHALL = "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Antibiotics Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.3
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Route 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS IV Medication Administration Route Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.4
							MCH HBS Intramuscular Administration Route Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.5

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				Information about the course of labor and delivery.			
AUGL	Y	N	Characteristics of labor and delivery: Augmentation of labor	Augmentation of labor: Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun). Information about the course of labor and delivery.	IF (Procedure Code CONTAINS ValueSet (MCH HBS Augmentation of Labor - Procedure Value Set) OR (Coded Product Name CONTAINS (MCH HBS Augmentation of Labor - Medication Value Set)), THEN "AUGL" SHALL ="Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Augmentation of Labor - Procedure Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.22
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Augmentation of Labor - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.23
CHOR	Y	N	Characteristics of labor and delivery: [Clinical] Chorioamnionitis [diagnosed during labor or maternal temperature >=38 degrees (100.4F)]	Any recorded maternal temperature at or above 38oC (100.4oF) or clinical diagnosis of chorioamnionitis during labor made by the delivery attendant (usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, or fetal tachycardia). Information about the course of labor and delivery.	IF (Problem Code CONTAINS ValueSet ((Chorioamnionitis during labor) OR (MCH HBS Fever Greater Than 100.4 Value Set) THEN "CHOR" SHALL = "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Chorioamnionitis During Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.24
							MCH HBS Fever Greater Than 100.4 Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.25

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
ESAN	Y	N	Characteristics of labor and delivery: [Epidural or spinal]Anesthesia[during labor]	Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body. Information about the course of labor and delivery.	IF (Coded Product Name CONTAINS ValueSet (epidural anesthesia) OR ValueSet (spinal anesthesia) OR(Procedure ID CONTAINS (MCH HBS Epidural Anesthesia - Procedure Value Set) OR (MHC HBS Spinal Anesthesia - Procedure Value Set)) THEN "ESAN" SHALL be "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Epidural Anesthesia - Procedure Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.27
							MHC HBS Spinal Anesthesia - Procedure Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.29
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Epidural Anesthesia - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.26
							MCH HBS Spinal Anesthesia - Medication Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.28
FINT	Y	N	Characteristics of labor and delivery: Fetal intolerance [of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery]	Fetal intolerance of labor was such that one or more of the following actions was taken: In utero resuscitative measures, further fetal assessment, or operative delivery. Includes any of the following: Maternal position change; Oxygen Administration	IF (Problem Code CONTAINS ValueSet (Fetal Intolerance of labor) AND (Procedure ID CONTAINS ValueSet (MCH HBS In-utero Resuscitation Value Set) OR ValueSet (MCH HBS Further Fetal Assessment Value Set) OR ValueSet (MCH HBS Operative Delivery Value Set)), THEN "FINT" **SHALL** = "Y" ELSE "N" NOTE: The	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Fetal Intolerance of Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.30
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS In-utero Resuscitation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.31
							MCH HBS Operative Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.33

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				to the mother; Intravenous fluids administered to the mother; Amnioinfusion ; Support of maternal blood pressure; Administration of uterine relaxing agents. Further fetal assessment including any of the following: scalp pH, scalp stimulation, acoustic stimulation. Operative delivery to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.	SNOMED codes associated with the intolerance of labor value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Further Fetal Assessment Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.32
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	IF (Procedure ID CONTAINS ValueSet (MCH HBS Induction of Labor Value Set) THEN "INDL" **SHALL** = "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Induction of Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.34

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				(i.e., before labor has begun). Information about the course of labor and delivery.			
MECS	Y	N	Characteristics of labor and delivery: Meconium staining	Moderate or heavy meconium staining of the amniotic fluid Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery that is more than enough to cause a greenish color change of an otherwise clear fluid. Information about the course of labor and delivery.	IF (Problem Code CONTAINS ValueSet (MCH HBS Meconium staining Value Set) THEN "MECS" **SHALL** = "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Meconium staining Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.36 MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
STER	Y	N	Characteristics of labor and delivery: Steroids [(glucocorticoids) for fetal lung maturation received by the mother prior to delivery]	Steroids (glucocorticoids): For fetal lung maturation received by the mother before delivery. Includes: Betamethasone dexamethasone, or hydrocortisone specifically given to accelerate fetal lung	IF (Coded Product Name CONTAINS ValueSet (MCH HBS Glucocortico Steroids Value Set)) THEN "STER" **SHALL** ="Y"ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Glucocortico Steroids Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.38

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.			
NOA54	Y	N	Characteristics of labor and delivery: None of the above	None of the listed characteristics of labor and delivery that provide information about the course of labor and delivery.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
DNA04	Y	N	Characteristics of labor and delivery: Unknown	If the data are not available when the characteristics of labor and delivery are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((INDL = "U") OR (AUGL = "U") OR (NVPR = "U") OR (STER = "U") OR (ANTB = "U") OR (CHOR = "U") OR (MECS = "U") OR (FINT = "U") OR (ESAN = "U")), THEN "DNA04" **SHALL** = "1" ELSE "DNA04" **SHALL** = "0"	See INDL, AUGL, NVPR, STER, ANTB, CHOR, MECS, FINT, ESAN	
IDOB_YR	Y	N	Child: Date of Birth: Year	The infant's date (year) of birth.	"IDOB_YR" SHALL be populated using Child's Metadata Entry: Date of Birth	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/follo	

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

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			of Fetus(optional at the discretion of the parents)	the child as provided by the parents.	populated using Child's Metadata Entry: Person Name, using the Last Name part of Person Name	mponent/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD']/following-sibling::subject/name	
KIDSUFFX	Y	Y	Child's Last Name Suffix:	The legal name (suffix) of the child as provided by the parents.	"KIDSUFFX" SHALL be populated using HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.05 Person Name	/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD']/following-sibling::subject/name	
BFED	Y	N	Child: Infant being breastfed?	Information on whether the infant was being breast-fed during the period between birth and discharge from the hospital.	If 7.04 Problem Code is value set (Infant being breastfed at discharge) THEN BFED SHALL be "Y".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Breastfed Infant Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.41
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	IF NOT Problem Code CONTAINS ValueSet(MCH HBS Neonatal Death Value Set) THEN "ILIV" SHALL = 'Y' ELSE 'N'	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Neonatal Death Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				known, indicate the known status.			
IREC NUM	Y	N	Child: Newborn Medical Record Number	The medical record number assignedto the newborn.	"IRECNUM" **SHALL** = Child's newborn medical record number	Metadata Entry: Child's newborn medical record number recordTarget/patientRole[1]/id	
ISEX	Y	N	Child: (infant) Sex -	The sex of the infant.	IF Coded Physical Exam Result Type CONTAINS ValueSet(MCH HBS Gender Observation Value Set) AND Result Value CONTAINS ValueSet(MCH HBS Male Gender Value Set) THEN "ISEX" SHALL ='M' ELSE IF Coded Physical Exam Result Type CONTAINS ValueSet(MCH HBS Gender Observation Value Set) AND Result Value CONTAINS ValueSet(MCH HBS Female Gender Value Set) THEN "ISEX" SHALL ='F' ELSE THEN "ISEX" SHALL ='N'	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Type 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Gender Observation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.183
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Male Gender Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42
							MCH HBS Female Gender Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
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.	If Child's dischargeDisposition Code CONTAINS ValueSet (Discharge Transfer) and (effectiveTime (High) – Child's date of birth) <= 24 hours THEN ITRAN **SHALL** = "Y" ELSE ITRAN **SHALL** = "N"	Child's Encounter 2.16.840.1.113883.10.20.1.21 dischargeDispositionCode	MCH HBS Discharge Transfer Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44
						Child's Encounter 2.16.840.1.113883.10.20.1.21 effectiveTime	
						/ClinicalDocument/component/structuredBody/component/section/template	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Id[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD']/following-sibling::birthTime	
FTRAN	Y	N	Child: Infant transferred within 24 hours of delivery/name the facility		Need Encounter Attribute 'Referred to Facility' If Infant Record Discharge Disposition CONTAINS ValueSet (Discharge Transfer) and (Encounter Date/Time (High) – Person Date of Birth) <= 24 hours THEN FTRAN **SHALL** = Referred to Facility	Child's Encounter 2.16.840.1.113883.10.20.1.21 Discharge Disposition	MCH HBS Discharge Transfer Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.44
						Child's Encounter 2.16.840.1.113883.10.20.1.21 Encounter Date/Time	
						/ClinicalDocument/component/structuredBody/component/section/templateId[@root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4']/following-sibling::subject/relatedSubject/code[@code='NCHILD']/following-sibling::birthTime	
						Child's Encounter 2.16.840.1.113883.10.20.1.21 Referred To Facility	
TB	Y	N	Child: Time of Birth	The infant's time of birth.	"TB" **SHALL** = Time part of Child's date of birth	Metadata Entry: Child's date 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 craniorachisch	IF (Problem Code CONTAINS ValueSet (MCH HBS Anencephaly of the Newborn Value Set THEN "ANEN" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Anencephaly of the Newborn Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.53

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				isis (anencephaly with a contiguous spine defect).			
CCHD	Y	Y	Congenital anomalies of the Newborn: Cyanotic congenital heart disease	Congenital heart defects that cause cyanosis.	IF (Problem Code CONTAINS ValueSet (MCH HBS Cyanotic Congenital Heart Disease Value Set) THEN "CCHD" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Cyanotic Congenital Heart Disease Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.54
CDH	Y	Y	Congenital anomalies of the Newborn:- Congenital diaphragmatic hernia	Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.	If (Problem Code CONTAINS ValueSet (MCH HSB Congenital Diaphragmatic Hernia Value Set)THEN "CDH" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HSB Congenital Diaphragmatic Hernia Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.55
CDIC	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype confirmed	Suspected chromosomal disorder karyotype confirmed	If ((Problem Code CONTAINS ValueSet (MCH HBS Karyotype Confirmed Value Set) AND ((Problem Code CONTAINS ValueSet (MCH HBS Suspected Chromosomal Disorder Value Set)) THEN "CDIC" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Karyotype Confirmed Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56 MCH HBS Suspected Chromosomal Disorder Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
CDIS	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal Disorder	Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by	IF (NOT(Problem Code CONTAINS ValueSet (MCH HBS Karyotype Confirmed Value Set) AND (Problem Code CONTAINS ValueSet (Suspected chromosomal disorder)) THEN "CDIS" **SHALL** = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Suspected Chromosomal Disorder Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				detectable defects in chromosome structure.			
CDIP	Y	Y	Congenital anomalies of the Newborn: Suspected chromosomal disorder karyotype pending	Suspected chromosomal disorder karyotype pending.	If (Problem Code CONTAINS ValueSet (MCH HBS Suspected Chromosomal Disorder) AND Procedure Contains (MCH HBS Karyotype Determination Value Set) AND act classCode='ACT' moodCode='INT' AND NOT Result Type (MCH HBS Karyotype Result Value Set) THEN "CDIP" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Suspected Chromosomal Disorder 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.57
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Karyotype Determination Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Karyotype Result Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59
CL	Y	Y	Congenital anomalies of the Newborn: Cleft Lip with or without Cleft Palate	Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.	IF (Problem Code CONTAINS ValueSet (MCH HBS Cleft Lip with/without Cleft Palate Value Set)) "CL" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Cleft Lip with/without Cleft Palate Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.58
CP	Y	Y	Congenital anomalies of	Cleft palate refers to	IF (Problem Code CONTAINS	Newborn Delivery Information	MCH HSB Cleft Lip without Cleft

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			the Newborn: Cleft Palate alone	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.	ValueSet (MCH HSB Cleft Lip without Cleft Palate Value Set)) THEN "~~CL~~CP" **SHALL** = "Y" ELSE "N".	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	Palate Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.60
DOWC	Y	Y	Congenital anomalies of the Newborn: Down Karyotype confirmed	Down Karyotype confirmed	IF ((Problem Code CONTAINS ValueSet (MCH HBS Karyotype Confirmed Value Set) AND (Problem Code CONTAINS ValueSet (MCH HSB Downs Syndrome Value Set)) THEN "DOWC" **SHALL** = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Karyotype Confirmed Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.56 MCH HSB Downs Syndrome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
DOWN	Y	Y	Congenital anomalies of the Newborn: Down Syndrome	Down Syndrome: Trisomy 21	IF (Problem Code CONTAINS ValueSet (MCH HSB Downs Syndrome Value Set)) THEN "DOWN" SHALL = "Y" ELSE "N"	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HSB Downs Syndrome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61
DOWP	Y	Y	Congenital anomalies of the Newborn: Down Karyotype pending	Down Karyotype pending	IF (Problem Code CONTAINS ValueSet (Down Karyotype pending) AND Procedure Contains (MCH HBS Karyotype	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code	MCH HSB Downs Syndrome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.61

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Determination Value Set) AND act classCode='ACT' moodCode='INT' AND NOT Result Type (MCH HBS Karyotype Result Value Set) THEN "~~DOWC~~DOWP" **SHALL** = "Y" ELSE "N"	1.3.6.1.4.1.19376.1.5.3.1.3.6	
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure Date/Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Karyotype Determination Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.154
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Karyotype Result Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.59
GAST	Y	Y	Congenital anomalies of the Newborn: Gastroschisis	An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.	IF (Problem Code CONTAINS ValueSet (MCH HBS Gastroschisis of the Newborn Value Set)) THEN "GAST" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Gastroschisis of the Newborn Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.62
HYPO	Y	Y	Congenital anomalies of the Newborn: Hypospadias	Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus	If (Problem Code CONTAINS ValueSet (MCH HBS Hypospadias Value Set)) THEN "HYPO" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code	MCH HBS Hypospadias Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.63

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.		1.3.6.1.4.1.19376.1.5.3.1.3.6	
LIMB	Y	Y	Congenital anomalies of the Newborn: Limb reduction defect	Limb reduction defect: (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.	IF (Problem Code CONTAINS ValueSet (MCH HSB Limb Reduction Defect Value Set) THEN "LIMB" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HSB Limb Reduction Defect Value Set 6.1.4.1.19376.1.7.3.1.1.13.8.64
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	IF (Problem Code CONTAINS ValueSet (MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set) THEN "~~ANEN~~MNSB" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Meningomyelocele/Spina Bifida of the Newborn Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.65

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).			
OMPH	Y	Y	Congenital anomalies of the Newborn: Omphalocele	A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.	IF (Problem Code CONTAINS ValueSet (MCH HBS Omphalocele of the Newborn Value Set) THEN "OMPH" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Omphalocele of the Newborn Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.66
NOA5	Y	Y	Congenital	None of the	This SHALL require		

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
5			anomalies of the Newborn: None of the anomalies listed above	listed congenital anomalies of the newborn or fetus.	data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	
DNA55	Y	Y	Congenital anomalies of the Newborn: Unknown	If the data are not available when the abnormal conditions of the newborn are provided, the pending flag is set. The item will appear on the final review screen for entry before information is sent to vital records.	IF ((ANEN = "N") OR (MNSB = "N") OR (CCHD = "N") OR (CDH = "N") OR (OMPF = "N") OR (GAST = "N") OR (LIMB = "N") OR (CL = "N") OR (CP = "N") OR (DOWN = "N") OR (DOWC = "N") OR (DOWP = "N") OR (CDIS = "N") OR (CDIC = "N") OR (CDIP = "N") OR (HYPO = "N")), THEN "DNA55" **SHALL** = "1", ELSE "DNA55" **SHALL** = "0".	See ANEN, MNSB, CCHD, CDH, OMPF, GAST, LIMB, CL, CP, DOWN, DOWC, DOWP, CDIS, CDIC, CDIP, HYPO	
YLLB	Y	Y	Date of last live birth:	The year of birth of the last live-born infant.	Pregnancy History Pregnancy Observation Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set), THEN (IF Result Value NOT NULL THEN "YLLB" SHALL = the Year part of Result Value WHERE Result Value is expressed as Date AND WHERE the Year is represented using 4-digits ELSE "YLLB" SHALL = '8888') ELSE "YLLB" SHALL = '9999'	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HSB Date of Last Live Birth Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67
							MCH HBS Number of Live Births Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					IF NOT Pregnancy History Coded Results Section Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set), THEN "YLLB" SHALL = '9999' IF Pregnancy History Coded Results Section Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set) AND Result Type='ValueSet (MCH HBS Number of Live Births Value Set) AND Result Value = '0', THEN "YLLB" SHALL = '8888' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.		
MLLB	Y	Y	Date of last live birth:	The month of birth of the last live-born infant.	IF Pregnancy Pregnancy Observation Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set), THEN (IF Result Value NOT NULL THEN "MLLB" SHALL = the Month part of	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HSB Date of Last Live Birth Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.67 MCH HBS Number of Live Births Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Result Value WHERE Result Value is expressed as Date AND WHERE the Month is represented using 2-digits ELSE "MLLB" SHALL = '88') ELSE "YLLB" SHALL = '99' IF NOT Pregnancy History Coded Results Section Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set), THEN "MLLB" SHALL = '99' IF Pregnancy History Coded Results Section Result Type = ValueSet (MCH HSB Date of Last Live Birth Value Set) AND Result Type='ValueSet MCH HBS Number of Live Births Value Set) AND Result Value = '0', "MLLB" SHALL = '88' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
DLMP_DY	Y	Y	Date last Normal Menses began:	The date the mother's last normal	IF Pregnancy History Pregnancy Observation Result	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	MCH HBS Date of Last Menses Value Set

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				menstrual period began.	Type = ValueSet (MCH HBS Date of Last Menses Value Set), THEN "~~CM_DLNM~~ DLMP_DY" SHALL = Day part of Result Value WHERE Result Value is expressed as Date NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
DLMP_MO	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.	IF Pregnancy History Pregnancy Observation Result Type = ValueSet (MCH HBS Date of Last Menses Value Set), THEN "~~CM_DLNM~~ DLMP_MO" SHALL = Month part of Result Value WHERE Result Value is expressed as Date	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Date of Last Menses Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
DLMP_YR	Y	Y	Date last Normal Menses began:	The date the mother's last normal menstrual period began.	IF Pregnancy History Pregnancy Observation Result Type = ValueSet (MCH HBS Date of Last Menses Value Set), THEN "~~CM_DLNM~~DLMP_YR" SHALL = Year part of Result Value WHERE Result Value is expressed as Date	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Date of Last Menses Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.69
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
						Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
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 Pregnancy History Pregnancy Observation Result Type = ValueSet (MCH HBS Date of Last Other Pregnancy Outcome Value Set), THEN (IF Result Value NOT NULL THEN "YOPO" SHALL = the Year part of Result Value WHERE Result Value is expressed as Date AND WHERE the Year is represented using 4-digits ELSE YOPO" SHALL = '8888') ELSE "YOPO" SHALL = '9999' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Date of Last Other Pregnancy Outcome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
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	IF Pregnancy History Pregnancy Observation Result Type = ValueSet (MCH HBS Date of Last Other Pregnancy Outcome Value Set), THEN (IF Result Value NOT NULL THEN "MOPO" SHALL = the Month part of Result Value WHERE Result Value is expressed as Date AND WHERE	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Date of Last Other Pregnancy Outcome Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.70
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				pregnancy.	the Month is represented using 2-digits ELSE MOPO" SHALL = '88') ELSE "MOPO" SHALL = '99' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	13.5	
ADDRESS_D	Y	Y	Facility Address		"Facility Address" SHALL be populated using the Child's facility address	Metadata Entry: Child's facility address ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/addr	
FNAME	Y	Y	Facility Name (if Not institution, give street and number)	The name of the facility where the delivery took place.	"FNAME" SHALL be populated using the Child's Facility Name	ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/name	
FNPI	Y	Y	Facility National Provider Identifier	National Provider Identifier.	"FNPI" SHALL be populated using the Child Facility's NPI Id	ClinicalDocument/component/structuredBody/component/section[templateId[@root=2.16.840.1.113883.10.20.1.21]]/ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/id	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
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.	IF (Problem Code CONTAINS ValueSet (MCH HBS Clamydia Value Set)) THEN "CHAM" **SHALL** = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Chlamydia Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.93
						Prenatal Events 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2 Active Problems Problem Status 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Problem Status Active 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.119
GON	Y	Y	Infections present and treated during this pregnancy: Gonorrhea	Gonorrhea: A positive test/culture for Neisseria gonorrhoeae. 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	IF (Problem Code CONTAINS ValueSet (MCH HBS Gonorrhea Value Set) THEN "GON" **SHALL** = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Gonorrhea Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.94

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				diagnosis is not present in the available record.			
HEPB	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis B	Hepatitis B (HBV, serum hepatitis): A positive test for the hepatitis B virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	IF (Problem Code CONTAINS ValueSet (MCH HBS Hepatitis B Value Set)THEN "HEPB" **SHALL** = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Hepatitis B Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.96
HEPC	Y	~~Y~~N	Infections present and treated during this pregnancy: Hepatitis C	Hepatitis C (non-A, non-B hepatitis (HCV)): A positive test for the hepatitis C virus. Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy	IF (Problem Code CONTAINS ValueSet (MCH HBS Hepatitis C Value Set)) THEN "HEPC" **SHALL** = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Hepatitis C Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.97

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	IF (Problem Code CONTAINS ValueSet (MCH HBS Syphilis Value Set)) THEN "SYPH" **SHALL** ="Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Syphilis Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.98
NOA02	Y	Y	Infections present and treated during this pregnancy: None of the above	None of the listed infections were present and treated during this pregnancy.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
AINT	Y	Y	Maternal Morbidity: - Admission to Intensive care [unit]	Admission to intensive care unit: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care. Serious complications experienced by the mother associated with labor and delivery.	IF (Mother's facility location CONTAINS ValueSet (MCH HBS Facility Location ICU Value Set) AND (procedure date/time (low) <=Mother's Facility Location effectiveTime (low) <= procedure date/time (high) WHERE Procedure ID CONTAINS (MCH HBS Delivery Value Set)) THEN "AINT" SHALL be "Y" ELSE "N".	Mother's Metadata Entry: Mother's facility location	MCH HBS Facility Location ICU Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.2
						Mother's Metadata Entry: Mother's facility location effectiveTime	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Date/Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	
MTR	Y	Y	Maternal Morbidity: Maternal Transfusion	Maternal transfusion: Includes infusion of whole blood or packed red blood cells within the period specified. Serious complications experienced by the mother associated with labor and delivery.	IF (Procedure ID CONTAINS ValueSet (MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set) THEN "MTR" **SHALL** be "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Transfusion Whole Blood or Packed Red Blood Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.99
PLAC	Y	Y	Maternal Morbidity: [Third or fourth degree] perineal	Third or fourth degree perineal laceration: 3rd	IF (Problem Code CONTAINS ValueSet (MCH HBS Third Degree	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	MCH HBS Third Degree Perineal Laceration Value Set

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			laceration	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.	Perineal Laceration Value Set) OR (MCH HBS Fourth Degree Perineal Laceration Value Set) THEN "PLAC" **SHALL** be "Y" ELSE "N"	Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.100 MCH HBS Fourth Degree Perineal Laceration Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.101
RUT	Y	Y	Maternal Morbidity: Ruptured Uterus	Ruptured Uterus: Tearing of the uterine wall. Serious complications experienced by the mother associated with labor and delivery.	IF (Problem Code CONTAINS ValueSet (MCH HBS Ruptured Uterus Value Set) THEN "RUT" **SHALL** be "Y" ELSE "N"	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Ruptured Uterus Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.102
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	IF (Problem Code CONTAINS ValueSet(MCH HBS Unplanned Hysterectomy)) THEN "UHYS" **SHALL** be "Y" ELSE "N" NOTE: The SNOMED-CT codes associated with this value set are still pending. Until such	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Unplanned Hysterectomy 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.103

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				procedure. Serious complications experienced by the mother associated with labor and delivery.	time as these codes are available, this attribute will require data entry.		
UOPR	Y	Y	Maternal Morbidity: Unplanned operat[ing]ion [room procedure following delivery]	Unplanned operating room procedure following delivery: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations. Serious complications experienced by the mother associated with labor and delivery.	IF (Procedure ID CONTAINS ValueSet (MCH HBS Unplanned Operation Value Set) AND (Mother's facility location CONTAINS ValueSet (MCH Facility Location OR Value Set) AND (Mother's facility location effectiveTime (low) > Procedure Date/Time (high) WHERE Procedure ID CONTAINS (MCH HBS Delivery Value Set)) "UOPR" **SHALL** be "Y" ELSE "N" NOTE: The SNOMED-CT codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Mother's Metadata Entry: Mother's facility location	MCH Facility Location OR Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.104
						Mother's Metadata Entry: Mother's facility location effectiveTime	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
							MCH HBS Unplanned Operation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.105
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure Date/Time 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	
NOA05	Y	Y	Maternal Morbidity:None of the above	None of the listed serious complications experienced by the mother associated with labor and delivery.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PRES	Y	Y	Method of Delivery: Fetal presentation [at birth]: Cephalic	The physical process by which the complete delivery of the fetus was affected. Fetal presentation at birth - Cephalic: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP); Breech: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech; Other: Any other presentation not listed above.	IF (Problem Code CONTAINS ValueSet (MCH HBS Fetal Presentation at Birth-Cephalic Value Set) THEN "PRES" **SHALL** = "1" ELSE IF (Problem Code CONTAINS ValueSet (MCH HBS Fetal Presentation at Birth-Breech Value Set) THEN "PRES" **SHALL** = "2" ELSE IF (Problem Code CONTAINS ValueSet (MCH HBS Fetal Presentation at Birth-Other Value Set) THEN "PRES" **SHALL** = "3" ELSE "PRES" **SHALL** = "9" NOTE: The SNOMED-CT codes associated with the MCH HBS Fetal Presentation at Birth-Other Value Set are still pending enumeration. Until such time as these codes are available, this attribute will require data entry.	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Fetal Presentation at Birth- Breech Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.108 MCH HBS Fetal Presentation at Birth- Cephalic Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.109 MCH HBS Fetal Presentation at Birth- Other Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.110
ROUT	Y	Y	Method of Delivery: [Final]Route and method of delivery	The physical process by which the complete delivery of the fetus was affected. Includes: Vaginal/spontaneous:	IF (Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set) THEN "ROUT" SHALL = "1" ELSE IF Procedure Code	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Route and Method of Delivery - Spontaneous Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.111 MCH HBS Route and Method of

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Forceps Delivery Value Set THEN "ROUT" SHALL = "2" ELSE IF Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set) THEN "ROUT" SHALL = "3" ELSE IF Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set) THEN "ROUT" SHALL = "4" ELSE "ROUT" **SHALL** = "9".		Delivery - Forceps Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.112 MCH HBS Route and Method of Delivery - Vacuum Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.113 MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
TLAB	Y	Y	Method of Delivery: Trial of labor attempted	If cesarean, indicate if a trial of labor was attempted (labor was	Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery -	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and	MCH HBS Route and Method of Delivery - Trial of Labor Value Set 1.3.6.1.4.1.19376.

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				allowed, augmented, or induced with plans for a vaginal delivery).	Cesarean Delivery Value Set) THEN (IF (Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Trial of Labor Value Set) THEN "TLAB" **SHALL** be "Y" ELSE IF Procedure Code CONTAINS ValueSet (MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set) THEN "TLAB" SHALL = "X" ELSE IF =NULL THEN "U") ELSE "N".	Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	1.7.3.1.1.13.8.115 MCH HBS Route and Method of Delivery - Scheduled Cesarean Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.116 MCH HBS Route and Method of Delivery - Cesarean Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.114
MARE	Y	Y	Mother: Has the mother ever been married?	Indicates if the mother has ever been married.	IF (Mother's Metadata Entry : Marital Status CONTAINS ValueSet (MCH HBS Married Value Set) OR ValueSet (MCH HBS Previously Married Value Set) THEN "MARE" **SHALL** = 'Y' ELSE IF Mother's Metadata Entry Marital Status CONTAINS ValueSet (MCH HBS Never Married Value Set) THEN "MARE" **SHALL** = 'N' ELSE "MARE" **SHALL** = 'U'	Mother's Metadata Entry: Marital Status	MCH HBS Married Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.170 MCH HBS Never Married Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.171 MCH HBS Previously Married Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.172
MFNAME	Y	Y	Mother's Current Legal Name: First Name	The current legal first name of the mother.	"MFNAME" **SHALL** be populated using Mother's Metadata Entry: Mother's Name using the First Name part of Mother's	Mother's Metadata Entry: Mother's Name	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Name		
MMNAME	Y	Y	Mother's Current Legal Name: Middle Name	The current legal middle name of the mother.	"MMNAME" **SHALL** be populated using Mother's Metadata Entry: Mother's Name using the Middle Name part of part of Mother's Name	Mother's Metadata Entry: Mother's Name	
MLNAME	Y	Y	Mother's Current Legal Name: Last Name	The current legal last name of the mother.	"MLNAME" **SHALL** be populated using Mother's Metadata Entry: Mother's Name using the Last Name part of part of Mother's Name	Mother's Metadata Entry: Mother's Name	
MSUFF	Y	Y	Mother's Current Legal Name: suffix	The current legal name suffix of the mother.	"MSUFF" **SHALL** be populated using Mother's Metadata Entry: Mother's Name the Last Name Suffix part of part of Mother's Name	Mother's Metadata Entry: Mother's Name	
HFT	Y	Y	Mother's Height: Feet	Mother's height feet	IF (Mother's) Coded Physical Exam Result Type CONTAINS ValueSet (MCH HBS Measured Height Value Set), THEN "HFT" **SHALL** = feet part of Result Value WHERE Result Value Units are expressed in Feet and Inches ELSE IF Prenatal Events Coded Results Section Result Type CONTAINS ValueSet (MCH HBS Stated Height	(Mother's) Coded Physical Exam Result Type 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Measured Height Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.117 MCH HBS Stated Height Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.179
						(Mother's) Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
						(Mother's) Coded Physical Exam Result Value Units 1.3.6.1.4.1.19376.1.5.3.1.	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Value Set), THEN "HFT" **SHALL** = feet part of Result Value WHERE Result Value Units are expressed in Feet and Inches	1.9.15.1	
HIN	Y	Y	Mother's Height: Inches	Mother's height inches	IF Mother's Coded Physical Exam Result Type CONTAINS ValueSet (MCH HBS Measured Height Value Set), THEN "~~HFT~~HIN" **SHALL** = Inches part of Result Value WHERE Result Value Units are expressed in Feet and Inches ELSE IF Prenatal Events Coded Results Section Result Type CONTAINS ValueSet (MCH HBS Stated Height Value Set), THEN "HFT" **SHALL** = Inches part of Result Value WHERE Result Value Units are expressed in Feet and Inches	(Mother's) Coded Physical Exam Result Type 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Measured Height Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.117
							MCH HBS Stated Height Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.179
						(Mother's) Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
						(Mother's) Coded Physical Exam Result Value Units 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	
MRECNUM	Y	Y	Mother's medical record number	The mother's medical record number for this facility admission	"MRECNUM" **SHALL** be populated using Mother's Metadata Entry: Mother's Person ID using Mother's Person ID Where Person ID represents the Mother's Medical Record Number	/ClinicalDocument/recordTarget/patientRole/patient/id	
PWGT	Y	Y	Mother's pre-pregnancy weight	The mother's prepregnancy weight	IF Mother's Coded Results: Result Type CONTAINS ValueSet (Mother's Pre-pregnancy	(Mother's) Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.	MCH HBS Pre-Pregnancy Weight Value Set 1.3.6.1.4.1.19376.

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					weight), THEN "PWGT" **SHALL** = Result Value	3.28	1.7.3.1.1.13.8.118
						(Mother's) Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
NFACL	Y	Y	Mother: If Mother transferred for maternal medical or fetal indications for delivery, enter name of facility mother transferred from.	Indicates the name of the facility the mother was transferred from if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	IF Admission Source is value set (MCH HBS Transfer In Value Set) and Problem Code is value set (MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery), THEN **NFACL SHALL** = Referring Facility Name ELSE **NFACL SHALL** = NULL NOTE: Codes for transfer for maternal or fetal indications are not currently available. Until such time as these codes are available, this attribute will require data entry.	Mother's Encounter 2.16.840.1.113883.10.20.1.21 Referring Facility Name	
						Mother's Encounter 2.16.840.1.113883.10.20.1.21 Admission Source	MCH HBS Transfer In Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176
TRAN	Y	Y	Mother transferred for maternal medical or fetal indications for delivery?	Indicates if the mother was transferred from another facility. Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	If Admission Source is value set (Mother transferred) and 7.04 Problem Code is value set (MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set), THEN **"TRAN" SHALL** = "Y" ELSE IF 16.06 NOT NULL, THEN TRAN **SHALL** = "N" ELSE TRAN **SHALL** = "U".	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Transferred for Maternal Medical or Fetal Indications for Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.176
						Mother's Encounter 2.16.840.1.113883.10.20.1.21 Admission Source	MCH HBS Transfer In Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.177

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
DWGT	Y	Y	Mother's weight at delivery	The mother's weight at the time of delivery.	(Mother's) Coded Physical Exam Results Result Type CONTAINS ValueSet (MCH HBS Mother's Delivery Weight Value Set), THEN "DWGT" **SHALL** = Result Value NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	(Mother's) Coded Physical Exam Result Type	MCH HBS Mother's Delivery Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.120
						(Mother's) Coded Physical Exam Result Value	
POPO	Y	Y	Number of other pregnancy outcomes	Total number of other pregnancy outcomes that did not result in a live birth. Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	IF Pregnancy History Pregnancy Observation Coded Results Section Result Type CONTAINS ValueSet (Previous other pregnancy outcomes), THEN "~~POBO~~POPO" **SHALL** = Result Value NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Previous Other Pregnancy Outcomes Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.121
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
PLBD	Y	Y	Number of previous live births now dead (do not include	The total number of previous live-born infants	IF Pregnancy History Pregnancy Observation Coded Results Section	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4	MCH HBS Number of Previous Live Births Now Dead

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			this child)	now dead.	Result Type CONTAINS ValueSet (Number of Previous Live Births now Dead), THEN "PLBD" **SHALL** = Result Value NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.122
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
PLBL	Y	Y	Number of previous live births now living (do not include this child)	The total number of previous live-born infants now living.	IF Pregnancy History Pregnancy Observation Coded Results Section Result Type CONTAINS ValueSet (Number of Previous Live Births now Living), THEN "PLBL" **SHALL** = Result Value	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Number of Previous Live Births Now Living Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.123
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value 1.3.6.1.4.19376.1.5.3.1.4.13.5	
OWGEST	Y	Y	Obstetric Estimate of Gestation	The best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of g**estation** This estimate of gestation should be determined by	IF Pregnancy History Pregnancy Observation Coded Results Section Result Type CONTAINS ValueSet (Obstetric Estimate of Gestation), THEN "OWGEST" **SHALL** = Result Value	Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Type 1.3.6.1.4.19376.1.5.3.1.4.13.5	MCH HBS Obstetric Estimate of Gestation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.124
						Pregnancy History 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 Pregnancy Observation Result Value	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred.		1.3.6.1.4.19376.1.5.3.1.4.13.5	
CERV	Y	N	Obstetric procedures: Cervical cerclage	Cervical cerclage: Circumferential banding or suture of the cervix to prevent or treat dilation. Includes: MacDonald's suture; Shirodkar procedure; and Abdominal cerclage via laparotomy. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Procedures and Interventions Section Procedure ID CONTAINS ValueSet (MCH HBS Cervical Cerclage Value Set), THEN "CERV" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Cervical Cerclage Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125
ECVF	Y	N	Obstetric procedures: Failed External cephalic Version	Failed External cephalic version: Failed attempt to convert a fetus from a nonvertex to a	IF Labor and Delivery Procedures and Interventions Section Procedure ID CONTAINS ValueSet (MCH HBS External Cephalic Version	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.	MCH HBS External Cephalic Version Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	Value Set) as Intent and Negation=TURE, THEN "ECVF" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	1.13.2.11	
ECVS	Y	N	Obstetric procedures: Successful External cephalic version	Successful External cephalic version: Successful conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. Obstetric procedures: Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	IF Labor and Delivery Procedures and Interventions Section Procedure ID CONTAINS ValueSet (MCH HBS External Cephalic Version Value Set), THEN "ECVS" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS External Cephalic Version Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127
TOC	Y	N	Obstetric procedures: Tocolysis	Tocolysis: Administration of any agent	IF Labor and Delivery Procedures and Interventions	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3	MCH HBS Tocolysis Value Set

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	Section Procedure ID CONTAINS ValueSet (MCH HBS Tocolysis Value Set), THEN "TOC" **SHALL** = 'Y' ELSE IF Procedure Code = NULL THEN 'U' ELSE 'N'	Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128
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.	This SHALL require data entry and SHALL NOT be a result of a default from the other attributes in the list	Data Entry Required	MCH HBS Cervical Cerclage Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.125 MCH HBS Failed External Cephalic VersionValue 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.126 MCH HBS External Cephalic VersionValue Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.127 MCH HBS Tocolysis Value

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
							Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.128
PROM	Y	N	Onset of labor: Premature Rupture	Premature Rupture of the Membranes (prolonged≥12 hours): Spontaneous tearing of the amniotic sac, (natural breaking of the "bag of waters"), 12 hours or more before labor begins. Serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Active Problems Problem Code CONTAINS ValueSet (MCH HBS Premature Rupture Value Set), THEN "PROM" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PROM" SHALL = 'U" ELSE "PROM" SHALL = 'N'	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Premature Rupture Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129
PRIC	Y	N	Onset of labor: Precipitous Labor	Precipitous labor (<3hours): Labor that progresses rapidly and lasts for less than 3 hours. Serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Active Problems Problem Code CONTAINS ValueSet (MCH HBS Precipitous Labor Value Set), THEN "PRIC" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PRIC" SHALL = 'U" ELSE "PRIC" SHALL = 'N'	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Precipitous Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130
PROL	Y	N	Onset of labor: Prolonged Labor	Prolonged labor (≥ 20 hours): Labor that progresses slowly and lasts for 20 hours or more. Serious complications	IF Labor and Delivery Active Problems Problem Code CONTAINS ValueSet (MCH HBS Prolonged Labor Value Set), THEN "PROL" **SHALL** = 'Y' ELSE	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Prolonged Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				experienced by the mother associated with labor and delivery.	IF Problem Code = 'NULL' THEN "PROL" SHALL = 'U" ELSE "PROL" SHALL = 'N'		
NOA05	Y	N	Onset of labor: None of the above	None of the listed serious complications experienced by the mother associated with labor and delivery.	IF Labor and Delivery Active Problems Problem Code NOT (CONTAINS ValueSet (MCH HBS Premature Rupture Value Set) OR ValueSet(MCH HBS Precipitous Labor Value Set) OR ValueSet(MCH HBS Prolonged Labor Value Set) THEN "NOA05" **SHALL** = "Y" ELSE IF Problem Code = 'NULL' THEN "NOA05" SHALL = 'U" ELSE "N".	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Premature Rupture Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.129 MCH HBS Precipitous Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.130 MCH HBS Prolonged Labor Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.131
SFN	Y	Y	Place where birth occurred: State Facility Number		IF Newborn Delivery Information Coded Results Result Type CONTAINS ValueSet(MCH HBS Birthplace Value Set) THEN "SFN" SHALL = Facility ID part of Result Value	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
FLOC	Y	Y	Place where birth occurred: Facility City/Town		"FLOC" SHALL = City/Town part of Metadata Entry: Birth Place taken from the newborn's	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					record	Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
CNAME	Y	Y	Place where birth occurred: County Name		"CNAME" SHALL = County name part of Metadata Entry: Birth Place taken from the newborn's record	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
CNTYO	Y	Y	Place where birth occurred: County Code		"CNTYO" SHALL = County Code part of Metadata Entry: Birth Place taken from the newborn's record	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Birthplace Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.184
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
BPLACE	Y	N	Place where birth occurred: Birth Place		This may be identified through the Newborn Delivery Information by either SNOMED observations or Coded results from LOINC. NOTE: The full set of LOINC or SNOMED codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4	
PLUR	Y	Y	Plurality	The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age or if the fetuses were delivered at different dates in the pregnancy. ("Reabsorbed" fetuses, those which are not "delivered" (expulsed or extracted from the mother) should not be counted.)	IF Labor and Delivery Coded Results Section Result Type CONTAINS ValueSet (Birth Plurality of Delivery), THEN "PLUR" SHALL = Result Value	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Birth Plurality of Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.132
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
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	IF History of Surgical Procedures Procedure ID CONTAINS ValueSet (MCH HBS First Prenatal Care Visit Value Set) THEN (IF Procedure	History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure ID	MCH HBS First Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						History of Surgical	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				pregnant woman for the pregnancy.	Date/Time NOT NULL THEN "~~DOLP~~DOFP_MO" SHALL = the Month part of Procedure Date/TimeWHERE the Month is represented using 2-digits ELSE ~~DOLP~~DOFP_MO" SHALL = '88') ELSE "~~DOLP~~DOFP_MO" SHALL = '99'	Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure Date/Time	
DOFP_DY	Y	Y	Date of first prenatal care visit: Day	The day a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	IF History of Surgical Procedures Procedure ID CONTAINS ValueSet (MCH HBS First Prenatal Care Visit Value Set THEN (IF Procedure Date/Time NOT NULL THEN "DOFP_DY" SHALL CONTAINS the Day part of Procedure Date/Time WHERE the Day is represented using 2-digits ELSE DOFP_DY" SHALL = '88') ELSE "DOFP_DY" SHALL = '99'	History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure ID	MCH HBS First Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure Date/Time	
DOFP_YR	Y	Y	Date of first prenatal care visit: Year	The year a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy.	IF History of Surgical Procedures Procedure ID CONTAINS ValueSet (MCH HBS First Prenatal Care Visit Value Set), THEN (IF Procedure Date/Time NOT NULL THEN "DOFP_YR" SHALL = the Year part of Procedure Date/Time WHERE	History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure ID	MCH HBS First Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.133
						History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedure Date/Time	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					the Year is represented using 4-digits ELSE DOFP_YR" SHALL = '8888') ELSE "DOFP_YR" SHALL = '9999'		
DOLP _MO	Y	Y	Prenatal care visits: Date of last prenatal care visit: Month	The month of the last prenatal care visit recorded in the records.	IF Coded Results Result Type CONTAINS ValueSet (MCH HBS Last Prenatal Care Visit Value Set), THEN (IF Result Value NOT NULL THEN "DOLP_MO" SHALL = the Month part of Result Value WHERE Result Value is expressed as Date AND WHERE the Month is represented using 2-digits for the MAX Result Date/Time ELSE DOLP_MO" SHALL = '88') ELSE "DOLP_MO" SHALL = '99' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Last Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
						Coded Results Result Date/Time 1.3.6.1.4.1.19376.1.5.3.1.3.28	
DOLP _DY	Y	Y	Prenatal care visits: Date of last prenatal care visit: Day	The day of the last prenatal care visit recorded in the records.	IF Coded Results Result Type CONTAINS ValueSet (MCH HBS Last Prenatal Care Visit Value Set), THEN (IF Result Value NOT NULL THEN "DOLP_DY" SHALL = the Day	Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Last Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					part of Result Value WHERE Result Value is expressed as Date AND WHERE the Day is represented using 2-digits for the MAX Result Date/Time ELSE DOLP_DY" SHALL = '88') ELSE "DOLP_DY" SHALL = '99' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.		
DOLP _YR	Y	Y	Prenatal care visits: Date of last prenatal care visit: Year	The year of the last prenatal care visit recorded in the records.	IF Coded Results Result Type CONTAINS ValueSet (MCH HBS Last Prenatal Care Visit Value Set), THEN (IF Result Value NOT NULL THEN "DOLP_DY" SHALL = the Year part of Result Value WHERE Result Value is expressed as Date AND WHERE the Year is represented using 4-digits for the MAX Result Date/Time ELSE DOLP_YR" SHALL = '8888') ELSE "DOLP_YR" SHALL = '9999' NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are	Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Last Prenatal Care Visit Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.134
						Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					available, this attribute will require data entry.		
NPREV	Y	Y	Prenatal care visits: Total number of prenatal visits for this pregnancy	The total number of visits recorded in the record.	IF Coded Results Result Type CONTAINS ValueSet (MCH HBS Number Prenatal Care Visits Value Set), THEN "NPREV" **SHALL** = Result Value NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Number Prenatal Care Visits Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.135
						Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
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]);	NOTE: The US-Specific codes associated with this value set are not yet mapped to the form data from HITSP selected ANSI X12 Values. Until such time as these codes are mapped, this attribute will require implementation-specific mapping.	Payers 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7 Coverage Entry 1.3.6.1.4.1.19376.1.5.3.1.4.17	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				Unknown			
PDIAB	Y	Y	Risk factors in this pregnancy: Prepregnancy Diabetes	Prepregnancy Diabetes (diagnosis of glucose intolerance requiring treatment before this pregnancy).	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Prepregnancy Diabetes Value Set), THEN "PDIAB" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PDIAB" SHALL = 'U" ELSE "PDIAB" SHALL = 'N'	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Prepregnancy Diabetes Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.136
GDIAB	Y	Y	Risk factors in this pregnancy: Gestational Diabetes	Gestational Diabetes (diagnosis of glucose intolerance requiring treatment during this pregnancy).	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Gestational Diabetes Value Set), THEN "GDIAB" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "GDIAB" SHALL = 'U" ELSE "GDIAB" SHALL = 'N'	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Gestational Diabetes Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.137
PHYPE	Y	Y	Risk factors in this pregnancy: Prepregnancy Hypertension	Prepregnancy (Chronic) Hypertension (Elevation of blood pressure above normal for age, gender, and.physiological condition with diagnosis prior to the onset of this pregnancy. Does not include getational (pregnancy induced) hypertension (PIH).)	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Prepregnancy Hypertension Value Set) AND NOT Problem Code CONTAINS (MCH HBS Gestational Hypertension Value Set) THEN "PHYPE" SHALL = 'Y' ELSE IF Problem Code = 'NULL' THEN "PHYPE" SHALL = 'U" ELSE "PHYPE" SHALL = 'N'	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Prepregnancy Hypertension Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138 MCH HBS Gestational Hypertension Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
GHYPE	Y	Y	Risk factors in this pregnancy: Gestational Hypertension	Gestational Hypertension (Elevation of blood pressure above normal for age, gender, and.physiological condition with diagnosis in this pregnancy (pregnancy-induced hypertensio or preeclampsia).	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Gestational Hypertension Value Set)AND NOT Problem Code CONTAINS (MCH HBS Gestational Hypertension Value Set) THEN “GHYPE” SHALL = ‘Y’ ELSE IF Problem Code = ‘NULL’ THEN “GHYPE” SHALL = ‘U” ELSE “GHYPE” SHALL = ‘N’	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Gestational Hypertension Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.139 MCH HBS Prepregnancy Hypertension Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.138
EHYPE	Y	Y	Risk factors in this pregnancy: Eclampsia	Eclampsia Hypertension (Elevation of blood pressure above normal for age, gender, and physiological condition with proteinuria with generalized seizures or coma. May include pathologic edema.	IF History of Past Illness Problem Code CONTAINS ValueSet (Eclampsia), THEN “EHYPE” SHALL = ‘Y’ ELSE IF Problem Code = ‘NULL’ THEN “EHYPE” SHALL = ‘U” ELSE “EHYPE” SHALL = ‘N’	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Eclampsia Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.140
PPB	Y	Y	Risk factors in this pregnancy: Previous preterm births	History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Preterm Birth Value Set)THEN “PPB” **SHALL** = ‘Y’ ELSE IF Problem Code = ‘NULL’ THEN “PPB” SHALL = ‘U” ELSE “PPB” SHALL = ‘N’	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Preterm BirthValue Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.141

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
PPO	Y	Y	Risk factors in this pregnancy: Poor pregnancy outcomes	History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: Perinatal death (including fetal and neonatal deaths); Small for gestational age; Intrauterine-growth-restricted birth.	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Poor Pregnancy Outcome – History Value Set)THEN "PPO" **SHALL** = 'Y' ELSE IF 7.04 Problem Code = 'NULL' THEN "PPO" SHALL = 'U" ELSE "PPO" SHALL = 'N'	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Poor Pregnancy Outcome – History Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.142
INFT	Y	Y	Risk factors in this pregnancy: Infertility treatment	Any assisted reproductive treatment used to initiate the pregnancy. Includes: Drugs (such as Clomid, Pergonal); Artificial insemination; Technical procedures (such as in-vitro fertilization).	IF History of Surgical Procedures Procedure Code CONTAINS ValueSet (MCH HBS Infertility Treatment Value Set)THEN "INFT" **SHALL** = 'Y' ELSE IF Procedure Code = 'NULL' THEN "INFT" SHALL = 'U" ELSE "INFT" SHALL = 'N'	History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Infertility Treatment Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.143
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	IF Admission Medication History Medications AdministeredSection Coded Product Name CONTAINS ValueSet (MCH HBS Fertility Enhancing Drugs)THEN "INFT_DRG" **SHALL** = 'Y' ELSE IF History of Surgical	Admission Medication History 1.3.6.1.4.1.19376.1.5.3.1.3.20 Medications Administered Coded Product Name 1.3.6.1.4.1.19376.1.5.3.1.3.21	MCH HBS Fertility Enhancing Drugs 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.144
						History of Surgical Procedures	MCH HBS Artificial or

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				insemination or intrauterine insemination used to initiate the pregnancy.	Procedures Procedure Code CONTAINS (MCH HBS Artificial or Intrauterine Value Set) THEN "INFT_DRG" SHALL = 'Y' ELSE (IF (Coded Product Name = 'NULL') AND (Procedure Code = 'NULL') THEN "INFT_DRG" SHALL = 'U") ELSE "INFT_DRG" SHALL = 'N'	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	Intrauterine Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.145
INFT_ART	Y	Y	Risk factors in this pregnancy: Infertility: Asst. Rep. Technology	Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer GIFT)) Any assisted reproductive technology (ART/technical procedures (e.g., IVF, GIFT, ZIFT)) used to initiate the pregnancy.	IF History of Surgical Procedures Procedure Code CONTAINS ValueSet (MCH HBS Assistive Reproductive Technology Value Set)THEN "INFT_ART" **SHALL** = 'Y' ELSE IF Procedure Code = 'NULL' THEN "INFT_ART" SHALL = 'U" ELSE "INFT_ART" SHALL = 'N'	History of Surgical Procedures 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Assistive Reproductive Technology Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.146
PCES	Y	Y	Risk factors in this pregnancy: Previous cesarean	Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	IF History of Past Illness Problem Code CONTAINS ValueSet (MCH HBS Previous Cesarean Value Set)THEN "PCES" **SHALL** = 'Y' ELSE IF Problem Code = 'NULL' THEN "PCES" SHALL = 'U" ELSE "PCES" SHALL = 'N'	History of Past Illness 1.3.6.1.4.1.19376.1.5.3.1.3.8 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Previous Cesarean Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.147
NPCE	Y	Y	Risk factors in this pregnancy:	Number of previous	IF History of Past Illness Result Type	History of Past Illness	MCH Number of Previous

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
S			Number of previous cesareans	deliveries extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls.	CONTAINS ValueSet (MCH MCH Number of Previous Cesareans Value Set), THEN "NPCES" **SHALL** = Result Value NOTE: The LOINC codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry.	1.3.6.1.4.1.19376.1.5.3.1.3.8 Coded Results Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	Cesareans Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.148
						History of Past Illness Coded Results Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
NOA01	Y	Y	Risk factors in this pregnancy: None of the above	The patient had none of the listed risk factors in this pregnancy.	This attribute SHALL NOT be determined by default. If there are no other risk factors identified through other attributes, the form manager SHALL require data entry to assure the accuracy of the data.		
SORD	Y	Y	Set Order	Order this infant was delivered in the set.	If Labor and Delivery Event Outcome Multiple Birth ='Y' THEN "SORD" **SHALL** be populated using Birth Order AND using '99' where not known ELSE IF Multiple Birth ='N' "SORD" **SHALL** = '88'	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Multiple Birth Indication Event Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7	
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Birth Order Event Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FSEX	Y	N	Child: (infant) Sex -	The sex of the infant.	IF Coded Physical Exam Result Type CONTAINS ValueSet(MCH HBS Gender Observation Value Set) AND Result Value CONTAINS ValueSet(MCH HBS Male Gender Value Set) THEN "FSEX" SHALL ='M' ELSE IF Coded Physical Exam Result Type CONTAINS ValueSet(MCH HBS Gender Observation Value Set) AND Result Value CONTAINS ValueSet(MCH HBS Female Gender Value Set) THEN "FSEX" SHALL ='F' ELSE THEN "FSEX" SHALL ='N'	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Type 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Gender Observation Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.183
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Coded Physical Exam Result Value 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1	MCH HBS Male Gender Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.42
							MCH HBS Female Gender Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.43
FDOD_YR	N	Y		Date of Delivery (Fetus) Year	IF Procedure ID CONTAINS ValueSet (MCH HBS Delivery Value Set) THEN "FDOD_YR" **SHALL** = Year part of Procedure Date/Time	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
FDOD_MO	N	Y		Date of Delivery (Fetus) Month	IF Procedure ID CONTAINS ValueSet (MCH HBS Delivery Value Set) THEN "FDOD_MO" **SHALL** = Month part of Procedure Date/Time	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
FDOD_DY	N	Y		Date of Delivery	IF Procedure ID CONTAINS	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.	MCH HBS Delivery Value

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				(Fetus) Day	ValueSet (MCH HBS Delivery Value Set) THEN "FDOD_DYYR" **SHALL** = Day part of Procedure Date/Time	1.21.2.3 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.14
ETIME	N	Y	Estimated Time of Fetal Death	Item to indicate when the fetus died with respect to labor and assessment.	IF Child's Coded Events Outcome Result Type CONTAINS ValueSet (MCH HBS Time of Death Value Set), THEN "ETIME" **SHALL** = Result Value WHERE Result Value is the Time of Death of the Fetus NOTE: The full set of LOINC or SNOMED codes associated with this value set are still pending. Until such time as these codes are available, this attribute will require data entry	Child's Coded Events Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Time of Death Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.149
						Child's Coded Events Outcome 1.3.6.1.4.1.19376.1.7.3.1.1.13.7 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
LIVEB	Y	N	Not single birth - specify number of infants in this delivery born alive.	Specify the number of infants in this delivery born alive	IF Labor and Delivery Result Type CONTAINS ValueSet (MCH HBS Number of Live Births Value Set), THEN **SHALL** = Result Value	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Number of Live Births Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
FDTH	N	Y	Number of fetal deaths	Specify the number of fetal deaths in this delivery	IF Labor and Delivery Result Type CONTAINS ValueSet (MCH HBS Number of Fetal Deaths This Delivery Value Set), THEN **SHALL** = Result Value	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Number of Fetal Deaths This Delivery Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.164
						Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
HYST	N	Y	Method of Delivery: Hysterotomy/Hysterectomy?	Hysterotomy/ Hysterectomy was the physical process by which the complete delivery of the fetus was effected. Hysterotomy: Incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy: Surgical removal of the uterus. May be performed abdominally or vaginally.	IF Labor and Delivery Active Problems CONTAINS ValueSet (MCH HBS Hysterotomy/ Hysterectomy Value Set), THEN "HYST" **SHALL** = Result Value	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Hysterotomy/ Hysterectomy Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.150
TD	N	Y	Time of delivery	Hour and minute fetus was delivered.	IF Labor and Delivery Result Type CONTAINS ValueSet (MCH HBS Delivery Value	Labor and Delivery 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 Procedures and	MCH HBS Delivery Value Set 1.3.6.1.4.1.19376.

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					Set), THEN "TD" **SHALL** = Result Value	Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	1.7.3.1.1.13.8.14
AUTOP	N	Y	Was an autopsy performed?	Information on whether or not an autopsy was performed	IF (Procedure ID CONTAINS ValueSet (MCH HBS Fetal Autopsy Value Set) THEN "AUTOP" **SHALL** = "Y" ELSE "N".	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Procedures and Interventions Procedure ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	MCH HBS Fetal Autopsy Value Set
FWO	N	Y	Weight of Fetus (in ounces)	Fetus' weight in ounces.	IF Newborn Delivery Information Result Type CONTAINS ValueSet (MCH HBS Fetus Weight Value Set) THEN "FWO" **SHALL** = Result Value WHERE units are specified in Ounces	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Fetus Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
FWG	N	Y	Weight of Fetus (grams preferred, specify unit)	Fetus' weight in grams.	IF Newborn Delivery Information Result Type CONTAINS ValueSet (MCH HBS Fetus Weight Value Set) THEN	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Type 1.3.6.1.4.1.19376.1.5.3.1.	MCH HBS Fetus Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
					"FWG" **SHALL** = Result Value WHERE units are specified in Grams	3.28	
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
FWP	N	Y	Weight of Fetus (in pounds)	Fetus' weight in pounds.	IF Newborn Delivery Information Result Type CONTAINS ValueSet (MCH HBS Fetus Weight Value Set) THEN "FWP" **SHALL** = Result Value WHERE units are specified in pounds	Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Type 1.3.6.1.4.1.19376.1.5.3.1.3.28	MCH HBS Fetus Weight Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.68
						Newborn Delivery Information 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 Result Value 1.3.6.1.4.1.19376.1.5.3.1.3.28	
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	IF (Problem Code CONTAINS ValueSet (MCH HBS Listeria Value Set)) THEN THEN "LM" SHALL = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Listeria Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.165

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				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.	IF (Problem Code CONTAINS ValueSet (MCH HBS Group B Streptococcus Value Set)) THEN THEN "GBS" SHALL = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Group B Streptococcus Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.166
CMV	N	Y	Infections present and	Cytomegalovirus (CMV): A	IF (Problem Code CONTAINS	Coded History of Infection Section	MCH HBS Cytomegalovirus

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
			treated during this pregnancy: Cytomeglovirus	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.	ValueSet (MCH HBS Cytomegalovirus Value Set)) THEN THEN "CMV" SHALL = "Y" ELSE "N".	1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.167
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	IF (Problem Code CONTAINS ValueSet (MCH HBS Parvovirus Value Set)) THEN THEN "B19" SHALL = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Parvovirus Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.168

US Attribute code	Used in Birth	Used in Fetal Death	Form Data Element	Definition	Derivation Rule	LDS Source	Value sets
				diagnosis is not present in the available record			
TOXO	N	Y	Infections present and treated during this pregnancy: Toxoplasmosis	Toxoplasmosis : A diagnosis of or positive test for Toxoplasma gondii.	IF (Problem Code CONTAINS ValueSet (MCH HBS Toxoplasmosis Value Set)) THEN THEN "TOXO" SHALL = "Y" ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code 1.3.6.1.4.1.19376.1.5.3.1.3.6	MCH HBS Toxoplasmosis Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169
Other Infection	Y	Y	Infections present and treated during this pregnancy: Other	Specify other infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment that are not included in the current list of infections. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	For Birth: IF NOT (TOXO OR B19 OR CMV OR LM OR GBS OR CHAM OR GON OR HEPB OR HEPC OR SYPH) Then 'Y' ELSE "N". For Fetal Death: IF NOT (TOXO OR B19 OR CMV OR LM OR GBS OR CHAM OR GON OR HEPB OR HEPC OR SYPH) Then Problem Code ELSE "N".	Coded History of Infection Section 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 Active Problems Problem Code	MCH HBS Other Pregnancy Infection Value Set 1.3.6.1.4.1.19376.1.7.3.1.1.13.8.169

The EHR mapping associated with the attributes described in Table 5.X.2-1 are provided by this specification. Until such time as permissible by the jurisdiction, the attributes included in Table 5.X.2-2 SHALL require manual entry to assure the accuracy of the certificate data.

Table 5.X.2-2 Attributes Requiring Direct Data Entry

US Attribute code	Used in Birth	Used in Fetal	Form Data Element	Definition	Derivation Rule	LDS Source
AUTOPF	N	Y	Were autopsy or histological placental examination results used in determining the cause of fetal death?	Information on whether the findings of the autopsy or histological placental examination were used in completing the medical portion of the fetal death report.	Data Entry Required	Data Entry Required
HISTOP	N	Y	Was a Histological Placental Examination performed?	Information on whether or not a histological placental examination was performed	Data Entry Required	Data Entry Required
	N	Y	Initiating Cause/Condition: Maternal Condition/Diseases (Specify)	The initiating cause/condition (18a) is for reporting a single condition that most likely began the sequence of events resulting in the death of the fetus.	Data Entry Required	Not Available from EHR
COD18a1	N	Y	Rupture of membranes prior to onset of labor	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a2	N	Y	Abruptio placenta	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a3	N	Y	Placental insufficiency	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a4	N	Y	Prolapsed cord	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a5	N	Y	Chorioamnionitis	Yes/No Response	Data Entry Required	Not Available from EHR

US Attribute code	Used in Birth	Used in Fetal	Form Data Element	Definition	Derivation Rule	LDS Source
COD18a6	N	Y	Other complications of placenta, cord or membranes	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a7	N	Y	Unknown	Yes/No Response	Data Entry Required	Not Available from EHR
COD18a8	N	Y	Maternal conditions/diseases	Literal responses	Data Entry Required	Not Available from EHR
COD18a9	N	Y	Other complications of placenta, cord, or membranes listed	Literal responses	Data Entry Required	Not Available from EHR
COD18a10	N	Y	Other obstetrical or pregnancy complications	Literal responses	Data Entry Required	Not Available from EHR
COD18a11	N	Y	Fetal anomaly	Literal responses	Data Entry Required	Not Available from EHR
COD18a12	N	Y	Fetal injury	Literal responses	Data Entry Required	Not Available from EHR
COD18a13	N	Y	Fetal infection	Literal responses	Data Entry Required	Not Available from EHR
COD18a14	N	Y	Other fetal conditions/disorders	Literal responses	Data Entry Required	Not Available from EHR

US Attribute code	Used in Birth	Used in Fetal	Form Data Element	Definition	Derivation Rule	LDS Source
	N	Y	Other Significant Causes or Conditions: Maternal Condition/Diseases (Specify)	Contributing cause	Data Entry required	Not Available from EHR
COD18b1	N	Y	Rupture of membranes prior to onset of labor	Yes/No Response	Data Entry required	Not Available from EHR
COD18b2	N	Y	Abruptio placenta	Yes/No Response	Data Entry required	Not Available from EHR
COD18b3	N	Y	Placental insufficiency	Yes/No Response	Data Entry required	Not Available from EHR
COD18b4	N	Y	Prolapsed cord	Yes/No Response	Data Entry required	Not Available from EHR
COD18b5	N	Y	Chorioamnionitis	Yes/No Response	Data Entry required	Not Available from EHR
COD18b6	N	Y	Othercomplication of placenta, cord, or membranes	Yes/No Response	Data Entry required	Not Available from EHR
COD18b7	N	Y	Unknown	Yes/No Response	Data Entry required	Not Available from EHR
COD18b8	N	Y	Maternal conditions/diseases	Literal responses	Data Entry required	Not Available from EHR

US Attribute code	Used in Birth	Used in Fetal	Form Data Element	Definition	Derivation Rule	LDS Source
COD18b9	N	Y	Other complications of placenta, cord, or membranes	Literal responses	Data Entry required	Not Available from EHR
COD18b10	N	Y	Other obstetrical or pregnancy complications	Literal responses	Data Entry required	Not Available from EHR
COD18b11	N	Y	Fetal anomaly	Literal responses	Data Entry required	Not Available from EHR
COD18b12	N	Y	Fetal injury	Literal responses	Data Entry required	Not Available from EHR
COD18b13	N	Y	Fetal infection	Literal responses	Data Entry required	Not Available from EHR
COD18b14	N	Y	Other fetal conditions/disorders	Literal responses	Data Entry required	Not Available from EHR