

# Guidelines for Completion of the Notification of Case Attended Health Act (Notification by Midwife) Regulations Form No.2



**Ms Frances Downey**

BSc (Nursing), Postgrad Dip Midwifery, BSW  
Project Officer, Maternal & Child Health Unit  
Information Collection & Management

**Ms Vivien Gee**

BAppSc. (Nursing, Admin), RN, RM, CHN  
Manager, Maternal & Child Health Unit  
Information Collection & Management

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## 1 Introduction

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This document has been produced as a reference guide for clinical midwives in the completion of the '*Notification of Case Attended*' Health Act (Notification by Midwife) Regulations Form 2 on using either a paper based or electronic system.

These guidelines will also act as a reference for other health professionals required to complete the form, in the absence of an attending midwife. In addition, these guidelines provide definition of data items for users to fully comprehend the basis on which information is recorded. In the remainder of this document, the Notification of Case Attended Form 2 will be referred to as the Midwives' Form 2.

These guidelines aim to improve the consistency and standardisation of definition of terms for data provision. Health care professionals interested in obtaining additional or specific statistics from the Midwives' Notification System, or requiring additional copies of these Guidelines are asked to contact:

Ms Vivien Gee  
Manager, Maternal and Child Health Unit  
Health Data Collections  
Information Collection and Management  
Department of Health WA  
189 Royal Street  
East Perth WA 6004

Telephone: (08) 9222 4262  
Email: [vivien.gee@health.wa.gov.au](mailto:vivien.gee@health.wa.gov.au)

## 2 The Midwives' Notification System

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### 2.1 Objectives

The objectives of the Midwives' Notification System are to

- Provide notification and summary of all births in the state to the Commissioner of Health.
- Monitor maternal and neonatal events.
- Facilitate the provision of postnatal and child health services.
- Assist in the planning of obstetric and neonatal services.
- Assist with ongoing research in the areas of obstetrics and maternity services.
- Provide a continuing source of information for ongoing education in clinical practice.
- Provide Western Australian (WA) perinatal data for inclusion in national perinatal statistical reports.

### 2.2 Overview

The Midwives' Notification System was introduced in WA in 1974. Ongoing reviews of collected data items have been possible since the computerisation of records in 1980.

It is a requirement under the *Health Act 1911*(Section 335) that the midwife in attendance at any birth complete a 'Notification of Case Attended' Form 2. This form has been prescribed in the Health Act as (Notifications by Midwives) Regulations 1994 and is known as Form 2 of Schedule 1.

Data from the Midwives' Notification System is used to compile annual reports of perinatal statistics and perinatal, infant and maternal mortality in WA. These statistics provide the basis of planning by the Department of Health for matters such as obstetric facilities, neonatal care units and community child

health centres. In WA, epidemiological research into issues of low birthweight babies, gestational differences and congenital malformations is recognised worldwide and these studies rely to a large extent on a complete and valid data base from the WA Midwives' Notification System.

Many additional data requests are received from external organisations and individuals for studies aimed at improving the health of confined women and their newborn babies. Data requests are encouraged and, subject to confidentiality guidelines, relevant subjects of data are extracted from the Midwives' Notification System files.

### **3 Notification of Case Attended Regulations Form 2**

A Midwives' Form 2 or computerised record is to be completed for every baby born, either stillborn or liveborn, of 400 grams or more birthweight and/or 20 weeks or more gestation occurring in WA. The midwife in attendance usually completes the form.

In the absence of an attending midwife, the medical officer is asked to complete a Midwives' Form 2. If there is no midwife or medical officer in attendance when the birth event occurs, the first qualified midwife or medical officer to attend the mother and baby should complete a Midwives' Form 2.

The Midwives' Form 2 is a three-part form on NCR (No Carbon Required) paper. For this reason, care should be taken to avoid unintentional marking of duplicate and triplicate copies. Dependent on the hospital, this form may be in an electronic format. Only one copy needs to be completed (i.e. either a paper or an electronic form not - NOT BOTH)

The paper copies comprise:

- The 'Health Department Copy' - The original form printed on green paper. This is forwarded to Information Collection and Management at the Department of Health, WA when details of the discharge of the baby from hospital of birth have been completed.
- The 'Medical Records Copy' - A blue paper form that is retained in the hospital medical records, except in the case of midwives in private practice attending births outside hospital, where it is kept as an individual record.
- The 'Child Health Copy' - A white paper form which is forwarded within 48 hours of birth also to Information Collection and Management at the Department of Health, WA so that it may be redirected to the appropriate community health nurse to facilitate continuity of care of mother and baby(s).

Please note that multiple births require a separate Midwives' Form 2 for each baby with the same identifying maternal demographic information.

### 3.1 General Instructions

- 1 When filling in the paper form please use ballpoint pen and place on a firm surface to ensure legibility of all three copies.
- 2 Answer ALL questions.
- 3 If a particular item of information is not available then record as 'Unknown' in a text field or '9999' in a numeric field.
- 4 When text is required please PRINT, preferably with the use of block letters.
- 5 Abbreviations should be limited to those in common use to avoid miscoding of information.

- 6 Addressograph labels may be used, but please ensure that one is placed on each copy of the paper form.
- 7 Wherever possible insert home or contact telephone numbers to facilitate continuity of care by child health nurses.
- 8 Where there are more boxes provided than necessary, please 'right adjust' your response.

*e.g. birthweight of baby - 975 grams*

0	9	7	5
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- 9 For all dates, eight boxes are provided, two for each day, two for each month and four for each year. If only month and year are known, leave boxes for days blank.

*e.g. mother's date of birth - 6 June 1975*

0	6	0	6	1	9	7	5
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- 10 Some questions allow for more than one response. Of these, although numbered for data entry purposes, you are only required to 'tick' the appropriate box(s) and where not applicable please leave blank.

*e.g. 'Complications of Pregnancy' section*

Items not listed in tick boxes should be recorded as text under the appropriate headings.

- 11 The Midwives' Form 2 should be forwarded to the Department of Health WA as soon as possible. Prompt notification is especially important at the end of the calendar year to enable closure of the data file.

Data cannot be analysed until the file is closed and late receipt of forms could result in delayed provision of reports.

## 3.2 Sections of the Midwives' Form 2

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### 3.2.1 Demographic Information

**Surname** - The legal surname should always be given. If an alias or assumed name is used, this should be indicated in brackets in same space following the legal surname.

**Forenames** - No anglicised versions of forenames are to be given, e.g. Maria-Mary; Marguiretta-Margaret.

**Address of Usual Residence** - The usual residential address of the mother should be recorded for population statistical purposes. If the mother normally resides in country areas or overseas and is temporarily resident in another place at the time of the delivery, her usual address should be recorded. However, if applicable, a temporary address should additionally be noted to assist child health nurses with earlier contact. It is preferable that a full address be provided rather than a post office or road mail box number.

**Post Code** - The usual residential postcode should be inserted as four digits.

**Maiden Name** - This should be the mother's surname at her birth. If the mother has never married or changed her name by deed poll, record that name.

**Telephone Number** - Inclusion of home or contact telephone numbers at usual place of residence are valuable to child health nurses. For women intending to reside temporarily at other than their usual address, please record an additional contact number.

**Unit Record Number** - This is the number allocated by the hospital to each patient. If there are more boxes provided than are necessary, 'right adjust' your response e.g. Unit Record No. 17234

0	0	0	1	7	2	3	4
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**Mother's Date of Birth** - Record the date as an 8 digit numeric field i.e. ddmmyyyy.

**Marital Status** - This refers to the current social status of the mother, which is not necessarily her legal status. If the mother is single, but living in a defacto relationship then for the purpose of this form, record married/defacto. Defacto relationships in this context may be identified as where the mother and her partner live at the same residential address.

**Ethnic Origin** - Refers only to mother's ethnic origin, not that of the baby or the father of the baby.

- **Caucasian** - Includes all people of Caucasoid (European) heritage e.g. Maltese, Lebanese, Italian, etc.
- **Aboriginal/TSI** - Includes persons of Australian Aboriginal and/or Torres Strait Islander (Australoid) heritage.
- **Other** - Includes any racial group other than Caucasian or Aboriginal/TSI, e.g. Asian, Indian, African, Polynesian, etc. Please identify in text in the space provided on paper form.

**Height** - Record the mother's height in centimetres.

**Hospital** - This refers to the establishment or hospital where the baby was born.

- **Hospital** - Record the name of the hospital.
- **Home** - If a planned homebirth, record 'Homebirth'.
- **B.B.A.** - If an intended hospital birth but born before arrival, record B.B.A. and name of admitting hospital.

## 3.2.2 Pregnancy Details

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### 3.2.2.1 Previous Pregnancies

This section EXCLUDES the present pregnancy but includes the total number of:

- Previous Pregnancies - Record the total number of known previous pregnancies of any gestation regardless of outcome e.g. livebirth, stillbirth, termination or spontaneous abortion.
- Previous Children - Now Living - Should include all children born to the mother, including any child given up for adoption, known to be alive.
- Previous Children - Born Alive, Now Dead - Include all children (born alive to this woman) that are no longer living.
- Previous Children - Stillborn - Includes all babies (born to this woman) of 400 grams or more birthweight and/or 20 weeks or more gestation, which showed no sign of life at birth.

### 3.2.2.2 This Pregnancy

***Date of Last Menstrual Period (LMP)*** - This date should be recorded in the appropriate boxes. If the date is unknown, indicate with 'Unknown' and leave the coding boxes blank. If the mother has had a recent previous pregnancy and not had a menstrual period prior to this, then record as unknown and record as 'Not Certain'.

***This Date*** - Certain/Not Certain - Indicate in the appropriate tick box which is applicable.

***Expected Due Date*** - Record date directly into coding boxes. If date is unknown then leave boxes blank and record 'Unknown' under the question. Assessments by either clinical acumen or ultrasound are acceptable.

**Complications** - Tick appropriate listed complications or record in text (in the space provided) any other complication that has occurred during the current pregnancy.

The following definitions should be used when completing the Midwives' Form 2.

**Threatened Abortion (under 20' weeks)** - Uterine bleeding in pregnancy before the 20th week.

**Urinary Tract Infection** - Confirmed by bacteriological culture of urine.

**Pre-Eclampsia** - The development of hypertension with either proteinuria, oedema, or both, induced by pregnancy after the 24th week. It is a specific disease of pregnancy.

**Pregnancy Induced Hypertension** - Is defined by the Perinatal and Infant Mortality Committee as:

'A rise in the systolic blood pressure to 140 mm Hg or more and/or a rise in the diastolic blood pressure to 90 mm Hg or more in a woman who has been normotensive before the 24th week of pregnancy with or without proteinuria'.

**Essential Hypertension** - A diastolic blood pressure of 90 mm Hg or more recorded on at least two occasions before 24 weeks of pregnancy and not due to any identifiable aetiological factor. This should be recorded in medical conditions in text.

**Eclampsia** - The occurrence of convulsions, not caused by any coincidental neurological disease. If this condition occurs, record in text.

**Superimposed Pre-eclampsia or Eclampsia** - The development of pre-eclampsia in a woman with chronic hypertension. If this condition occurs, record in text.

***Antepartum Haemorrhage (APH) - Placenta Praevia*** -

Antepartum haemorrhage resulting from the placenta being located over or very near to the internal cervical os.

***AntePartum Haemorrhage (APH) - Abruptio*** - Antepartum haemorrhage resulting from the placenta becoming totally or partially detached from the uterine wall whilst the fetus is still in utero. Abruptio without antepartum haemorrhage (APH) should be recorded under 'other' in text.

***Antepartum Haemorrhage (APH) - Other*** - Antepartum haemorrhage resulting from causes other than placenta praevia or placental abruption.

***Prelabour Rupture of Membranes*** - Rupture of the membranes at any time before the onset of labour irrespective of gestation at the time of membrane rupture.

***Gestational Diabetes*** - Diabetes in pregnancy as confirmed by clinical investigations (e.g. Glucose Tolerance Test). Pre-existing diabetes is to be marked in the 'Medical Conditions' section.

***Other*** - If there are other complications of pregnancy that are not listed with a tick box but which have occurred, please record in text in space provided. For example:

Intrauterine growth restriction (IUGR)

Genital herpes

Intrauterine death

Anaemia - haemoglobin less than 11 grams/100ml

Oligohydramnios

Polyhydramnios

Hyperemesis Gravidarum, etc.

**Medical conditions** - Any current medical condition relevant to pregnancy, or maternal congenital abnormality or carrier trait (e.g. Thalassaemia) should be recorded. Care should be taken to ensure that any of the following medical conditions are recorded:

Essential Hypertension

Pre-existing diabetes

Asthma

Genital Herpes

Epilepsy

Malignant neoplasms

Renal disease

Thyroid disease

### 3.2.3 Midwife Details

The Midwife completing the form must clearly PRINT their name and Nurses Board of WA registration number in the provided spaces. If a Doctor completes the form, their current medical registration number should be recorded.

### 3.2.4 Labour Details

As an attempt to standardise and improve the quality of information collected, please use the following definitions to complete Midwives' Form 2.

**Onset of Labour** - There must be at least one response indicated in this question.

1) **Spontaneous** - Contractions commence spontaneously.

Spontaneous rupture of membranes by itself does NOT constitute spontaneous onset of labour.

- 2) **Induction** - Is either a medical and/or surgical procedure performed for the purpose of stimulating and establishing labour in a woman who has not commenced labour spontaneously.
- 3) **No Labour** - Indicates the absence of labour (e.g. where there is an elective caesarean section or a failed induction followed by an emergency caesarean section).

### ***Augmentation of Labour***

The labour is augmented when, following spontaneous onset of labour, medical and/or surgical interventions (e.g. Syntocinon Infusion and A.R.M.) are used to assist progress.

More than one method of augmentation can be indicated on the Midwives' Form 2.

### ***Induction of Labour***

More than one method of induction can be indicated on the Midwives' Form 2.

***Failed Induction*** - Occurs when an induction procedure, either medical and/or surgical, fails to establish labour. If an induction has failed, perhaps at another hospital then record 'Failed Induction' in text under 'Complications of Labour and Delivery'.

***Analgesia*** - This question refers to analgesia during labour only. A response must be recorded, however, more than one response is permitted.

***Duration of Labour - Hours of Established Labour*** - Time is recorded in four figures for the hours and minutes of the first and second stages of labour.

e.g. Time of First Stage = 5 hours and 25 minutes

0	5	2	5
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e.g. Time of Second Stage = 1 hour and 5 minutes

0	1	0	5
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**First Stage of Labour** - Commences when uterine contractions of sufficient frequency, intensity and duration bring about demonstrable effacement and dilation of the cervix. Although the differential diagnosis between false and true labour is difficult at times, it can usually be made on the basis of the following features.

***Contractions of True Labour***

- Occur at regular intervals
- Occur at gradually shorter intervals
- Gradually increase in intensity
- Cause discomfort in the back and abdomen
- Cause cervical dilation
- Are not stopped by analgesia

***Contractions of False Labour***

- Occur at irregular intervals
- Remain at long intervals
- Do not increase in intensity
- Cause discomfort chiefly in the lower abdomen
- Do not cause cervical dilatation
- Are usually stopped by analgesia

**Second Stage of Labour** - Begins when dilatation of the cervix is complete and ends with delivery of the infant. For those women who have either an elective caesarean section or failed induction resulting in an emergency caesarean section, please record the hours of first stage of labour as closely as possible and record the second stage as 0000.

Generally, it is not appropriate to calculate the hours of established labour from the time of admission to hospital.

### 3.2.5 Delivery Details

**Anaesthesia** - The question refers to anaesthesia during delivery only. A response must be recorded, however, more than one response is permitted.

**Local Anaesthesia to Perineum** - Includes local anaesthetic infiltration for an episiotomy.

**Epidural/Caudal** - Includes lumbar epidural and caudal anaesthetics.

Please Note: If an epidural/caudal block is recorded for analgesia during labour, it is usually recorded for anaesthesia during delivery also.

**Spinal** - Refers to spinal anaesthetic. Often performed in combination with an epidural. In this case, indicate both epidural and spinal responses.

**General** - Refers to anaesthetic that renders the patient completely unconscious and unaware of pain or other sensations for a period of time.

**Other** - Includes nerve blocks.

**Complications of Labour Delivery** - Tick the appropriate listed complication or record any other complication that has occurred in text in the space provided. Ensure the indications for caesarean section are included in this question.

The following definitions should be used when completing the Midwives Form 2.

**Precipitate Delivery** - Is a term to describe any rapid delivery deleterious to condition of the mother or baby.

**Precipitate Labour** - Is rapid labour and delivery where the total duration is less than two hours. If this occurs please record in text.

**Fetal Distress** - Identified by any means including a fresh meconium staining of the liquor in the first stage of labour, abnormalities of the fetal heart rate, etc.

***Prolapsed Cord*** - The cord prolapses between the presenting part and the pelvic inlet.

***Cord Tight Around Neck*** - Record only if the cord required clamping and cutting prior to delivery of the shoulders.

Any other cord complications should be recorded under 'Other' in text (e.g. vasa praevia).

***Cephalopelvic Disproportion*** - When the fetal head is disproportionately large for the mother's pelvis, sufficient to create problems with delivery.

***Other***- If there are other complications of labour or delivery that are not listed with a tick box, please record text in the space provided.

Other complications that should be recorded include:

***Post-Partum Haemorrhage*** - Bleeding from the genital tract after delivery of 500mls of blood or more.

***Maternal Distress*** - Physical and psychological distress with a lowered pain threshold. Signs may include dehydration, ketoacidosis or rise in pulse or temperature.

***Prolonged Labour*** - Where the total of first and second stages of labour exceed 24 hours.

***Eclampsia*** - The occurrence of convulsions, not caused by any coincidental neurological disease.

***Prolonged Rupture of Membranes*** - Either artificial or spontaneous rupture of membranes occurring more than 24 hours before delivery.

***Perineal Lacerations*** - Specify whether first, second or third degree of severity.

***Retained Placenta*** - A third stage lasting more than 30 minutes.

Complications that contribute to intervention in labour should be recorded e.g.

***Delay in 2nd Stage Labour*** - Vacuum extraction.

***Fetal Distress*** - Emergency caesarean section.

***Deep Transverse Arrest*** - Forceps rotation and delivery.

### 3.2.6 Baby's Details

***Adoption*** - Indicate in appropriate box if the baby is for adoption. Should the mother change her mind about the child for adoption whilst in hospital, please indicate on the green copy of Midwives' Form 2.

***Born Before Arrival*** - Indicate if baby was born before arrival at the intended place of birth.

For babies born before arrival (B.B.A.), the first midwife to attend the mother and baby should complete the Midwives' Form 2 with as much information as possible.

***Birth Date*** - Record the date of birth of the baby as an 8 digit numeric field i.e. ddmmyyyy.

***Birth Time*** - Should be recorded using the twenty-four hour clock. Four boxes are provided, two for hours and two for minutes. e.g. 3.05 in the afternoon should be recorded as

1	5	0	5
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For babies born at midnight, please record 2400.

***Plurality*** - Refers to the number of fetuses or babies resulting from the pregnancy. On this basis, pregnancy may be classified as singleton or multiple and the outcome will be a single baby, twins, triplets, etc.

**Singleton Birth** - Is the expulsion or extraction of one baby (live or stillborn) from the mother.

**Multiple Births** - Is the expulsion or extraction of more than one baby (live and/or stillborn) from the mother.

Each baby of a multiple birth is individually identified by recording its order of birth.

Please remember that all multiple births must have a Midwives' Form 2 completed for each baby (e.g. twins require 2 forms, triplets require 3 forms).

**Presentation** - There can be only one response indicated in this question. For a multiple pregnancy with differing presentations, please record the presentation of each fetus on the individual form completed for that baby.

**Vertex** - Presentation is when the occipital fontanelle is the presenting part.

**Breech** - Presentation includes breech with extended legs, breech with flexed legs, footling and knee presentations.

**Face** - Baby's face is the presenting part

**Brow** - Baby's brow is the presenting part

**Other** - Presentations include chin presentation (mentum), shoulder presentation, etc.

**Method of Birth** - This question must have at least one response recorded. It is possible to have a combination of several types of delivery (e.g. failed vacuum and emergency caesarean section).

**Spontaneous** - Any spontaneous delivery that is achieved solely by the mother's expulsive efforts. This includes any spontaneous breech delivery.

**Vacuum** - The attachment of traction by suction to the fetal scalp.

**Forceps** - Used for traction and/or rotation.

**Breech Manoeuvre** - For the purpose of this form the following methods of breech delivery through the vagina are included.

- 1) Assisted Breech Delivery - The baby is delivered spontaneously as far as the umbilicus, but the remainder of the body is assisted by the obstetrician or accoucheur.
- 2) Breech Extraction - The entire body of the baby is extracted by the obstetrician.

If forceps are applied to the after-coming head of a breech delivery, then record forceps as well as breech delivery.

However, if a

**Spontaneous Breech Delivery** - Occurs where the baby is expelled spontaneously without any traction or assistance other than support; this should be recorded as a normal delivery with a breech presentation.

**Caesarean Section** - Is defined as delivery of the fetus through an incision in the abdominal wall (laparotomy) and the uterine wall (hysterotomy).

**Elective Caesarean Section** - A planned procedure performed

- 1) Prior to onset of labour and before spontaneous rupture of membranes, and
- 2) Without any procedure to induce labour

**Emergency (Non-Elective) Caesarean Section** - Is undertaken at short notice for a complication either

- 1) Before the onset of labour (e.g. life threatening A.P.H).
- 2) During labour whether that labour is spontaneous or induced labour (e.g. fetal distress).

If the woman is booked for an elective caesarean section and either goes into spontaneous labour or has a spontaneous rupture of membranes and the caesarean section is performed in

advance of the elective caesarean section, then for the purpose of this form, emergency caesarean section should be recorded.

**Sex** - Record the sex of the baby in the appropriate box. If the sex of the baby is indeterminate, record in text.

**Condition** - Refers to the condition of baby at birth, either alive (liveborn) or dead (stillborn).

The following definitions must be used when completing the Midwives' Form 2.

**Liveborn** - Is the complete expulsion or extraction from the mother of a product of conception, irrespective of duration of pregnancy, which after separation shows sign of life.

**Stillborn** - Is the complete expulsion or extraction from the mother of a product of conception, of at least 20 weeks gestation or 400 grams in weight, which, after separation, did not show any sign of life.

**Birthweight** - All babies should be weighed to the nearest five grams. This is usually obtained within the first hour of birth. If the birthweight is less than 1000 grams then right adjust the response e.g. a birthweight of 975 grams should be recorded as

0	9	7	5
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**Length** - All babies should be measured to the nearest centimetre from crown to heel. For cases where a measurement is midway between two numbers, please round up e.g. 51.5 cm should be recorded as 52 cm.

**Head Circumference** - This is the measurement to the nearest centimetre with the tape just above the eyebrows anteriorly and at the maximum point of the occiput posteriorly. For cases where a measurement is midway between two numbers, please round up e.g. 35.5 cm should be recorded as 36 cm.

**Time to Establish Unassisted Regular Breathing** - Record to the nearest minute the time taken to establish and maintain spontaneous respirations. If a baby takes less than one minute to establish unassisted breathing, please record as 01 on the Midwives' Form 2. If a baby is intubated AND ventilated, and accurate assessment of time is not possible, then record as 98. For stillbirths and neonatal deaths that do not establish spontaneous respirations and are not intubated, record as 00.

**Resuscitation** - If the infant was intubated or if oxygen only was administered then tick the appropriate box. For cases where there are more than one type of resuscitation used, please record the most invasive.

**Apgar Scores** - At one minute and five minutes are recorded on the Midwives' Form 2. The scoring system is a numerical scoring system used to evaluate the baby at birth and is based on:

Heart Rate

Respiratory Effort

Muscle Tone

Reflex Irritability

Colour

If the score is a single digit score then 'right adjust' the response e.g. Apgar score 7 should be recorded as

0	7
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If the baby is stillborn then record Apgar score as 00.

If Apgar score unknown record as 99.

Please Note: For Born Before Arrival (BBA) cases, Apgar scores cannot be guessed - record as 99.

**Estimated Gestation** - Gestational age at delivery may be estimated by clinical examination of the baby using the following summary chart as a guide.

**Estimation of Gestational Age of the Newborn**

Gestational Age			
Site	< 36 weeks	37-38 weeks	39 + weeks
Sole creases	Anterior transverse crease only	Occasional creases anterior two thirds	Sole covered with creases
Breast module diameter	2 mm	4 mm	7 mm
Scalp hair	Fine and fuzzy	Fine and fuzzy	Coarse and silky
Ear lobe	Pliable, no cartilage	Some cartilage	Stiffened by thick cartilage
For males, testes and scrotum	Testes in lower inguinal canal scrotum small with few rugae	Intermediate	Testes pendulous scrotum full with extensive rugae (except undescended)

A more definitive estimate could be made utilizing the complete Dubowitz Score which may be found in most obstetric texts.

For example:

Pritchard, J., MacDonald, P., & Gant, N. (1985). *Williams Obstetrics* (17th ed.). Norwalk: Appleton-Century-Crofts.

This only applies to livebirths. The gestation of stillbirths is based on the duration of pregnancy, which may be different from the gestation of the fetus at the time of fetal death (e.g. if the fetus dies in utero at 32 weeks gestation and is not delivered until 36 weeks gestation then the estimated gestation should be recorded as 36 weeks).

**Birth Defects** - When a congenital anomaly or malformation is recorded on the Midwives' Form 2 then it provides a source of

notification to the Birth Defects Registry of Western Australia. Malformations should be described in detail and multiple anomalies identified and listed whenever possible.

However, when a late diagnosis or a more specific diagnosis of the congenital malformation is made after completion of the Midwives' Form 2 it is necessary to notify the Birth Defects Registry of Western Australia directly. This enables the Register staff to update records. Any duplication of notification is easily handled by the Register staff.

The Register defines a congenital malformation as any defect probably of developmental origin in either liveborn or stillborn babies. Therefore, the following defects are included in the Register: Structural (e.g. spina bifida), Genetic/and Chromosomal (e.g. Down's Syndrome) and Biochemical (e.g. Glucose 6-phosphate dehydrogenase deficiency).

Most minor malformations are excluded unless they are disfiguring or require treatment. The following list identifies those minor malformations that should be **excluded**.

If in doubt, please record malformation and allow Birth Defects Registry staff to exclude.

***Birth Defects Registry of Western Australia (Exclusions)***

- Blocked Tear Duct
- Broncho-pulmonary Dysplasia
- Clicky Hips
- Congenital Pneumonia
- Delayed Milestones
- Epigastric Hernia
- Epilepsy
- Failure to Thrive
- Hydrocele Testis
- Hypoglycaemia

***Birth Defects Registry of Western Australia (Exclusions)  
continued..,***

Intrauterine Growth Restriction

Imperforate Hymen

Inguinal Hernia

Intussusception

Labial Adhesion or Fusion

Large Fontanelles

Raynaud's Disease

Single Palmar Crease

Small Anomalies of Ear

Strabismus

Tachycardia

Umbilical Hernia

Wide Suture Lines

Low Birthweight

Meconium Ileus

Mental Retardation

Mongolian Blue Spot

Motor Impairment

Birthmarks:

Naevus (<4 cm)

Angioma (<4 cm)

Haemangioma (<4 cm)

Lymphangioma (<4 cm)

Oesophageal Reflux

Paroxysmal Atrial Tachycardia

Persistent Fetal Circulation

***Birth Defects Registry of Western Australia (Exclusions)  
continued..,***

Pilonidal Sinus

Positional or Postural Foot Deformities

Sacral Dimple/Sinus

Skin Tag

Small Anomalies of Toe

Submucous Retention Cyst

Tongue Tie, even if surgery

Webbing 2nd and 3rd Toes

Undescended Testes - unless treated

The following list of malformations is not complete but if identified, should be recorded on the Midwives' Form 2.

***Birth Defects Registry of Western Australia (Inclusions)***

***Nervous System***

Anencephaly

Spina bifida

Encephalocele

Congenital Hydrocephalus

Microcephaly

Cysts

***Skin***

Cystic Hygroma

Birthmarks

Haemangiomas

Naevi

*(Please state size, site and whether multiple or not for the above three malformations)*

***Eye***

Absence of Eye

Microphthalmia

Congenital Glaucoma

Congenital Cataract

***Genital System***

Undescended Testis

*(requiring treatment)*

Hypospadias

Indeterminate Sex

***Birth Defects Registry of Western Australia (Inclusions)***  
***continued..,***

***Cardiovascular System***

Congenital Heart Defects

*(please specify)*

Coarctation of the Aorta

Patent Ductus Arteriosus

Dextrocardia

***Gastro-Intestinal System***

Cleft Lip and/or Palate

Tracheo-Oesophageal Fistula

Pyloric Stenosis

Intestinal Atresia

Hirschsprung's Disease

Ectopic Anus

Imperforate Anus

***Urinary System***

Cystic Kidney

Absent Kidney

Ectopic Kidney

Double Ureter

Vesico-Ureteric Reflux

***Blood***

Thalassaemia

Sickle Cell Anaemia

Haemophilia

***Respiratory System***

Pulmonary Hypoplasia

Diaphragmatic Hernia

Undescended Testis

*(requiring treatment)*

Hypospadias

Indeterminate Sex

***Metabolic Disorders - Inborn***

Errors of Metabolism

Phenylketonuria

Cystic Fibrosis

Congenital Hypothyroidism

Adreno-Genital Syndrome

Glycogen Storage Disorder

Lipid Storage Disorder

Albinism

***Chromosomal Anomalies***

Downs Syndrome

Trisomy 13

Trisomy 18

Turner's Syndrome

Klinefelter's Syndrome

Cri-du-chat Syndrome

***Musculo-Skeletal System***

Congenital Dislocation of Hip

Talipes *(requiring plasters or surgery)*

Polydactyly

Syndactyly

Absence of Limbs

*(complete of partial)*

Craniosostenosis

Osteogenesis Imperfecta

Exomphalos

***Congenital Infections***

Rubella

Toxoplasmosis

Cytomegalovirus

Herpes

Syphilis

**Birth Trauma** - Describe the site, type and cause of trauma if possible (e.g. fractured skull, cephalhaematoma, nerve palsy, etc.)

### 3.2.7 Baby's Separation Details

This section is completed, when using the paper based system, on the green copy and the blue copy of the Midwives' Form 2 on discharge, transfer or death of the baby. (The white third copy should have already been forwarded to the Health Department of WA within 48 hours of birth).

**Separation Date** - Record the appropriate date of discharge, transfer or death.

**Mode of Separation** - Refers to whether the baby was discharged home, died or transferred.

If transferred to another hospital, then the name of that hospital should be recorded in text in the space provided.

**Special Care** - Any baby who is admitted to an intensive or special care nursery (Level 3 or 2) must have the number of whole days in special care recorded on Midwives' Form 2.

N.B. Special care facilities are defined in the Hospital Morbidity Data System Reference Manual, July 2005, which may be found on [www.health.wa.gov.au/publications/hmds.cfm](http://www.health.wa.gov.au/publications/hmds.cfm)

## 4 Follow-up Information

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The Midwives' Form 2s are checked for completeness and accuracy when received at the Health Department. Incomplete or incorrect forms are set aside for follow-up. Photocopies of Midwives' Forms 2 with follow-up forms are returned when necessary to the hospital where confinement occurred. The midwife who initially completed the Midwives' Form 2 should normally provide the required additional information, but in the case of baby separation details this is often not possible.

Birth information provided by Midwives' on Notification of Case Attended forms is not amended/completed by clerical staff of this office without further consultation with the midwife concerned.



# Delivering a Healthy WA



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