



2008 DELIVERY ROOM DEATH FORM

FOR INFANTS BORN IN 2008

Any eligible inborn infant who dies in the delivery room or at any other location in your hospital within 12 hours after birth and prior to admission to the NICU is defined as a "Delivery Room Death". These locations may include the mother's room, resuscitation rooms, or any location other than the NICU in your hospital. Outborn infants and infants who are admitted to the NICU should not be classified as Delivery Room Deaths.

Network ID

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Hospital No.

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1. Birth weight

Grams

2. Head Circumference at Birth

cm

3. Best Estimate of Gestational Age

a) Weeks b) Days (0-6) *Do NOT leave days blank*

4. Date of Birth / / **2008**

MM/DD

5. Sex Male Female Unk

6. Died in Delivery Room Yes No

If No, use Admission/Discharge Form

7 - 8. Not Applicable

9. Maternal Age

Years

10. Maternal Race/Ethnicity *Answer both Parts a and b*

a) Is Mother of Hispanic Origin? Yes No Unk

b) Maternal Race *Choose only one*

Black Asian or Pacific Islander

White Other

Native American Unk

11. Prenatal Care Yes No

12. Group B Strep Positive Yes No N/A

13. Antenatal Steroids Yes No

14. Spontaneous Labor Yes No

15. a) Multiple Births Yes No

b) If Yes, total number of infants delivered. (Count live born and still infants) N/A

Total

c) Birth Order N/A

16. Mode of Delivery *Choose only one*

Spont. vag. Op. vag. Cesarean

17. Antenatal Conditions (Mandatory for all eligible CPQCC infants)

Select all conditions occurring in this pregnancy. If None, select None

Maternal	Fetal	Obstetrical
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Hypertension	<input type="checkbox"/> IUGR	<input type="checkbox"/> Premature ROM
<input type="checkbox"/> Uterine Infection	<input type="checkbox"/> Distress	<input type="checkbox"/> Prolonged ROM(>18hr)
<input type="checkbox"/> Other Infection	<input type="checkbox"/> Anomaly	<input type="checkbox"/> Malpresent./Breech
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other Fetal	<input type="checkbox"/> Bleed/Abrupt/Previa
<input type="checkbox"/> Prev. Cesarean	<input type="checkbox"/> Unk	<input type="checkbox"/> Other Obstetrical
<input type="checkbox"/> Other Maternal		<input type="checkbox"/> Unk
<input type="checkbox"/> Unk		

If Other, specify: *If Other, specify:* *If Other, specify:*

18. Indications for Cesarean Section
(Optional <=1500 grams) *Select at least one*

Not Applicable (No C/S) Elective

Malpresentation/Breech Dystocia/Failed to progress

Multiple gestation Placental Problems

Fetal distress Hypertension

Other (specify) Unk

If Other, specify: _____

19. Apgar Scores

1 min 5 min 10 min Not Done

20. Delivery Room Resuscitation

a) Oxygen: Yes No

b) CPAP: Yes No

c) Bag/Mask: Yes No

d) Endotracheal tube vent: Yes No

e) Epinephrine: Yes No

f) Cardiac compression: Yes No

21. Surfactant Treatment

a) Surfactant given in Delivery Room Yes No

b) Surfactant given at Any Time Yes No

Part b must be Yes if Part a is answered Yes

c) If Yes, enter Age at First Dose N/A

Hours Minutes (0-59)

22 - 48. Not Applicable

49. a) Major Birth Defects / Congenital Anomalies Yes No

b) If Yes, Enter up to 5 Birth Defect Codes. See Manual for Codes.

Birth Defect 1 Birth Defect 2 Birth Defect 3

Birth Defect 4 Birth Defect 5

For codes 100, 150, 200, 300, 400, 504, 601, 605, 800, & 900, describe: _____