2007 DELIVERY ROOM DEATH FORM
FOR INFANTS BORN IN 2007

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 ☐☐☐☐☐ **Hospital No.** ☐☐☐☐

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 *MM/DD* ☐☐ / ☐☐ / 2007

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)** ☐ Total ☐ N/A

c) **Birth Order** ☐ ☐ N/A

16. Mode of Delivery *Choose only one*

☐ Spont. vag. ☐ Op. vag. ☐ Cesarean

17. Antenatal Conditions (Optional <=1500 grams)

*Select all conditions occuring in this pregnancy. If **None**, select checkbox for "None" in each column.*

Maternal	Fetal	Obstetrical
☐ None	☐ None	☐ None
☐ Hypertension	☐ IUGR	☐ Premature ROM
☐ Uterine Infection	☐ Distress	☐ Prolonged ROM(>18hr)
☐ Other Infection	☐ Anomaly	☐ Malpresent./Breech
☐ Diabetes	☐ Other Fetal	☐ Bleed/Abrupt/Previa
☐ Prev. Cesarean	☐ Unk	☐ Other Obstetrical
☐ Other Maternal		☐ Unk
☐ 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) Endotrachael 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** ☐☐☐☐ Hours ☐☐ Minutes (0-59) ☐ N/A

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: _____

Sections of this form include data elements and definitions developed by Vermont Oxford Network

This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.