



# 2009 DELIVERY ROOM DEATH FORM

## FOR INFANTS BORN IN 2009

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

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Grams

2. Head Circumference at Birth

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cm

3. Best Estimate of Gestational Age

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a) Weeks

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b) Days (0-6)

Do NOT leave days blank

4. Date of Birth

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MM/DD / 2009

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

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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)

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Total

c) Birth Order

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N/A

16. Mode of Delivery *Choose only one*

Spont. vag.  
  Op. vag.  
  Cesarean  
  Unk

17. Antenatal Conditions (Optional <= 1500 grams)

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

Maternal

Fetal

Obstetrical

None  
 Hypertension  
 Chorioamnionitis  
 Uterine Infection  
 Other Infection  
 Diabetes  
 Prev. Cesarean  
 Other Maternal  
 Unk

None  
 IUGR  
 Distress  
 Anomaly  
 Other Fetal  
 Unk

None  
 Premature ROM  
 Prolonged ROM(>18hr)  
 Malpresent./Breech  
 Bleed/Abrupt/Previa  
 Other Obstetrical  
 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

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1 min

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5 min

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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

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Hours

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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.

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Birth Defect 1

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Birth Defect 2

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Birth Defect 3

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Birth Defect 4

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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.**