Delivery Room Death Form for Infants Born in 2017

california perinatal quality care collaborative

Network ID ☐☐☐☐☐ Hospital ID ☐☐☐☐

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

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.

IDENTIFICATION AND DEMOGRAPHICS

1. Birth Weight	☐☐☐☐ Grams		
2. Head Circumference at Birth	☐☐.☐ cm		☐ Unk
3. Best estimate of gestational age *(DO NOT leave days blank)*	☐☐ **a) Weeks**	☐ **b) Days (0-6)**	☐ Unk
4a. Birth Date (*MM/DD*)	☐☐/☐☐ 2017		
4b. Birth Time (00:00 AM/PM)	☐☐:☐☐ ☐ AM ☐ PM `		
5. Infant Sex	☐ Male	☐ Female	☐ Unk
6. Died in Delivery Room *(If YES, Use DRD Form)*	☒ Yes	☐ No	

DELIVERY AND MATERNAL HISTORY

9. Maternal Date of Birth (MM/DD/YY) ☐☐/☐☐/☐☐ ☐ Unk		**Maternal Age** ☐☐ Years ☐ Unk		
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 ☐ American Indian/ Alaska Native	☐ Asian ☐ White	☐ Native Hawaiian/ Pacific Islander ☐ Other ☐ Unk
11. Prenatal Care	☐ Yes	☐ No	☐ Unk	
12. Group B Strep Positive	☐ Yes	☐ No	☐ Not Done	☐ Unk

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CPQCC, Stanford University, MSOB, 1265 Welch Road-X1C55
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13. a) Is there documentation that Antenatal Steroids therapy was initiated before delivery?

☐ Yes ☐ No ☐ Unk

b) Is there documentation in the medical record of reasons for NOT initiating antenatal steroid therapy before delivery?

Note: Starting from 2013, this item is <u>only applicable and OPTIONAL for inborn infants who are <32 weeks gestational age.</u>

☐ Yes ☐ No ☐ Unk

c) If yes, what was the documented reason for NOT administering antenatal steroids?

Note: Starting from 2013, this item is <u>only applicable and OPTIONAL for inborn infants who are <32 weeks gestational age.</u>

☐ Chorioamnionitis ☐ Fetus has anomalies incompatible with life
☐ Other active infection ☐ History of adverse reaction to corticosteroids
☐ Immediate delivery ☐Unknown

14. Spontaneous Labor ☐ Yes ☐ No ☐ Unk

15. a) Multiple Gestation ☐ Yes ☐ No ☐ Unk

b) If Yes to multiple gestation, number of infants delivered including stillbirths ☐ ☐ Unk ☐ NA

c) Birth Order ☐ ☐ Unk ☐ NA

16. Delivery Mode *(Choose only one)* ☐ Spontaneous Vaginal ☐ Operative Vaginal ☐ Cesarean ☐ Unk

17. Antenatal Conditions (*Select all conditions occurring in this pregnancy. If NONE, select the checkbox for "None" in each column***)**

<u>Maternal</u>

☐ None ☐ Diabetes ☐ Other Maternal
☐ Hypertension ☐ Prev. Cesarean ☐ Unk
☐ Chorioamnionitis ☐ Antenatal Magnesium Sulfate ☐ Other *(Specify)*
☐ Other Infection

<u>Fetal</u>

☐ None ☐ Anomaly ☐ Other *(Specify)*
☐ IUGR ☐ Other Fetal
☐ Distress ☐ Unk

<u>Obstetrical</u>

☐ None
☐ Preterm (<37 wks) Labor
☐ Preterm (<37 wks) Premature ROM before onset of labor
☐ Term Premature ROM (≥37 weeks, before onset of labor, not premature gestation)
☐ Prolonged ROM (>18 hrs)
☐ Malpresentation/Breech
☐ Bleeding/Abruption/Previa
☐ Other Obstetrical (describe)
☐ Unk
☐ Other *(Specify)*

18. Indication for Cesarean Section *(Select at least one)*

☐ Not Applicable (No C/S) ☐ Multiple Gestation ☐ Elective ☐ Placental Problems ☐ Unk
☐ Malpresentation/ Breech ☐ Fetal Distress ☐ Dystocia/Failed to Progress ☐ Hypertension ☐ Other *(Specify)*

19. Apgar Scores

☐☐ 1 Min ☐ Unk ☐☐ 5 Min ☐ Unk ☐☐ 10 Min ☐ Unk ☐Not Done

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20. Delivery Room Resuscitation

a) Oxygen	☐ Yes	☐ No	☐ Unk	**d) Endotracheal Tube/Vent**	☐ Yes	☐ No	☐ Unk
b) CPAP	☐ Yes	☐ No	☐ Unk	**e) Epinephrine**	☐ Yes	☐ No	☐ Unk
				f) Cardiac Compressions	☐ Yes	☐ No	☐ Unk
c) Bag/Mask	☐ Yes	☐ No	☐ Unk	**g) Nasal Intermittent Positive Pressure**	☐ Yes	☐ No	☐ Unk

21. Surfactant Use

a) Was Surfactant given in the Delivery Room? ☐ Yes ☐ No ☐Unk

b) Was Surfactant given at any time? ☐ Yes ☐ No ☐Unk

c) Enter age at first dose: ☐☐ Hrs ☐☐ Min ☐Unk ☐ NA

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – CONGENITAL MALFORMATIONS

49. a) Congenital anomalies ☐ Yes ☐ No ☐ Unk

b) Enter up to 5 birth defect codes: ☐☐☐☐☐

Enter birth defect description for codes 100 150 200 300 400 504 601 605 800 900:

____

Notes:

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