**DELIVERY ROOM DEATH FORM FOR INFANTS BORN IN 2021**

**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  
   - Unknown
   - Not Done
3. **Best Estimate of Gestational Age:** ____ ____ a) Weeks (15-46) ____ ____ b) Days (0-6)  
   - Unknown
4. **a. Birth Date:** (MM-DD) ____ ____ - ____ ____ -2021  
   **b. Birth Time:** (00:00) ____ ____ : ____ ____ (use 24-hour clock)
5. **Infant Sex:**  
   - Male
   - Female
   - Undetermined
   - Unknown
6. **Died in Delivery Room:** ❑ Yes

## MATERNAL HISTORY

9. **a. Maternal Date of Birth:** (MM/DD/YY) ____ ____ / ____ ____ / ____ ____  
   **b. Maternal Age:** ____ ____ years  
   - Unknown
10. **Maternal Race/Ethnicity:** (answer both parts a. and b.)  
    - **a. Is the Mother of Hispanic Origin?**  
      - Yes
      - No
      - Unknown
    - **b. Maternal Race** (check only one)  
      - Black
      - Native Hawaiian/Pacific Islander
      - Asian
      - American Indian/Alaska Native
      - White
      - Other
      - Unknown
11. **Prenatal Care:**  
    - Yes
    - No
    - Not Done
    - Unknown
12. **Group B Strep Positive:**  
    - Yes
    - No
    - Not Done
    - Unknown
13. **a. Is there documentation that Antenatal Steroids therapy was initiated before delivery?**  
    - Yes
    - No
    - Unknown
   **b. Is there documentation in the medical record of reason for NOT initiating antenatal steroid therapy before delivery?**  
    - Yes
    - No
    - Unknown
   **c. If Yes, what was the documented reason for NOT administering antenatal steroids?**  
    - Chorioamnionitis
    - Other active infection
    - Immediate delivery
    - Fetus has anomalies incompatible with life
14. **Spontaneous Labor**  
   - Yes
   - No
   - Unknown
15. **a. Multiple Gestation**  
   - Yes
   - No
   - Unknown
   **b. If Yes, to multiple gestation enter number of infants delivered including stillborn**  
   - Unknown
   - NA
16. **Delivery Mode** (check only one)  
   - Spontaneous Vaginal
   - Operative Vaginal
   - Cesarean
   - Unknown
17. **Antenatal Conditions** (select ALL conditions occurring in this pregnancy)  
   **a. Maternal Antenatal Conditions**  
   - None
   - Hypertension
   - Chorioamnionitis
   - Other Infection
   - Diabetes
   - Prev. Cesarean
   - Antenatal Magnesium Sulfate
   - Other (describe): __________
   **b. Fetal Antenatal Conditions**  
   - None
   - IUGR
   - Non-Reassuring Fetal Status
   - Anomaly
   - Other Fetal (describe): __________
   **c. Obstetrical Conditions**  
   - None
   - Preterm (<37 wks) Labor
   - Preterm (<37 wks) Premature ROM before onset of labor
   - Term Premature ROM (≥37 wks) before onset of labor, not premature gestation
   - Prolonged ROM (>18hrs)
   - Malpresentation/Breech
   - Bleeding/Abruption/Previa
   - Other Obstetrical (describe): __________
**INDICATIONS FOR CESAREAN SECTION**

<table>
<thead>
<tr>
<th>Indications</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable (No C/S)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Malpresentation/Breech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dystocia/Failed to Progress</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Multiple Gestation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placental Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Reassuring Fetal Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (describe): ______________</td>
<td></td>
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</tr>
</tbody>
</table>

**APGAR SCORES**

<table>
<thead>
<tr>
<th>Apgar Scores</th>
<th>1min</th>
<th>Unknown</th>
<th>5min</th>
<th>Unknown</th>
<th>10min</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**DELIVERY ROOM RESUSCITATION**

<table>
<thead>
<tr>
<th>Supplemental Oxygen:</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP:</td>
<td></td>
<td></td>
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<tr>
<td>PPV via Bag/Mask:</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
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<tr>
<td>ETT Ventilation</td>
<td></td>
<td></td>
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<tr>
<td>Laryngeal Mask Airway (LMA)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Epinephrine:</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Cardiac Compressions:</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Nasal Intermittent Positive Pressure (NIPPV)</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**SURFACTANT TREATMENT**

<table>
<thead>
<tr>
<th>Surfactant given in the Delivery Room?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surfactant given at any time?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter age at first dose:</th>
<th>___ ___ hours ___ ___ mins</th>
<th>Unknown</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM)</td>
<td>___ ___ - ___ ___ - ___ ___ ___ ___: ___</td>
<td></td>
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<th>NETWORK ID:</th>
<th>HOSPITAL ID:</th>
</tr>
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</table>

## CONGENTIAL INFECTIONS / ANOMALIES

42. **Congenital Infection**
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

   If Yes, specify up to 3 pathogens:
   1. ______________
   2. ______________
   3. ______________

   Enter a description for pathogen code 8888 (other):

52.

   a. **Congenital Anomalies**
      - [ ] Yes
      - [ ] No
      - [ ] Unknown

   b. If Yes, enter up to 5 congenital anomaly codes:
      1. ____________
      2. ____________
      3. ____________
      4. ____________
      5. ____________

   Enter a congenital anomaly description for codes 100, 150, 200, 300, 400, 504, 601, 605, 800 and 900:

## NOTES

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