Any 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
4. a. Birth Date: (MM-DD) ___ ___ - ___ ___ -2022
   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 □ Asian □ Native Hawaiian/Pacific Islander □ 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? (This item is only applicable and optional for inborn infants who are <34 weeks GA)
       □ History of adverse reaction to corticosteroids
       □ Comfort Care
       □ Other □ Unknown
    c. If Yes, what was the documented reason for NOT administering antenatal steroids? (This item is only applicable and optional for inborn infants who are <34 weeks GA)
       □ 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
    c. Birth Order: □ 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 □ 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): __________
**DELIVERY ROOM DEATH FORM FOR INFANTS BORN IN 2022**

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

**NETWORK ID:**

**HOSPITAL ID:**

<table>
<thead>
<tr>
<th>Indications for Cesarean Section (select at least one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Not Applicable (No C/S)</td>
</tr>
<tr>
<td>☐ Elective</td>
</tr>
<tr>
<td>☐ Malpresentation/Breech</td>
</tr>
<tr>
<td>☐ Dystocia/Failed to Progress</td>
</tr>
<tr>
<td>☐ Other (describe): ____________</td>
</tr>
</tbody>
</table>

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**DELIVERY ROOM AND FIRST HOUR AFTER BIRTH**

<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>Not Done</td>
<td>Not Done</td>
<td>Not Done</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. **Delivery Room Resuscitation**

   a. Supplemental Oxygen: ☐ Yes ☐ No ☐ Unknown
e. Epinephrine: ☐ Yes ☐ No ☐ Unknown
   b. Nasal CPAP: ☐ Yes ☐ No ☐ Unknown
   f. Cardiac Compressions: ☐ Yes ☐ No ☐ Unknown
c. PPV via Bag/Mask: ☐ Yes ☐ No ☐ Unknown
   g. Noninvasive Ventilation
   d. ETT Ventilation ☐ Yes ☐ No ☐ Unknown
   h. Laryngeal Mask Airway (LMA) ☐ Yes ☐ No ☐ Unknown

23. **Surfactant Treatment**

   a. Was Surfactant given in the Delivery Room? ☐ Yes ☐ No ☐ Unknown
   b. Was Surfactant given at any time? ☐ Yes ☐ No ☐ Unknown
   c. Enter age at first dose: _____ _____ hours _____ _____ mins ☐ Unknown ☐ NA
      or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM)
      _____ _____ " _____ _____ " = _____ _____ : _____ _____
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:
   Code 1. __________ Code 2. __________ Code 3. __________ Code 4. __________ Code 5. __________
   Enter a congenital anomaly description for codes 100, 150, 200, 300, 400, 504, 601, 605, 800 and 900:

NOTES