



DELIVERY ROOM DEATH FORM FOR INFANTS BORN IN 2020

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NETWORK ID:

HOSPITAL ID:

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 <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done
3. Best Estimate of Gestational Age:	___ ___ a) Weeks (15-46) ___ ___ b) Days (0-6) <input type="checkbox"/> Unknown
4. a. Birth Date: (MM-DD)	___ ___ - ___ ___ -2020
b. Birth Time: (00:00)	___ ___ : ___ ___ (use 24-hour clock)
5. Infant Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined <input type="checkbox"/> Unknown
6. Died in Delivery Room:	<input checked="" type="checkbox"/> Yes

MATERNAL HISTORY

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



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18. Indications for Cesarean Section (select at least one)

- Not Applicable (No C/S), Elective, Malpresentation/Breech, Dystocia/Failed to Progress, Multiple Gestation, Placental Problems, Non-Reassuring Fetal Status, Hypertension, Other (describe):, Unknown

DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

19. Delayed Cord Clamping

- a. Was delayed umbilical cord clamping performed? b. How long was umbilical cord clamping delayed? c. If DCC was not done, reason why (optional)? d. Was umbilical cord milking performed? e. Did breathing begin before umbilical cord clamping?

- 20. a. Apgar Scores: [][] 1min, [][] 5 min, [][] 10 min, [][][] 1min, [][][] 5 min, [][][] 10 min, [][][] 1min, [][][] 5 min, [][][] 10 min

22. Delivery Room Resuscitation

- a. Supplemental Oxygen, b. CPAP, c. PPV via Bag/Mask, d. ETT Ventilation, e. Epinephrine, f. Cardiac Compressions, g. Nasal Intermittent Positive Pressure (NIPPV), h. Laryngeal Mask Airway (LMA)

23. Surfactant Treatment

- a. Was Surfactant given in the Delivery Room? b. Was Surfactant given at any time? c. Enter age at first dose: _____ hours _____ mins [] Unknown [] NA or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM)



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CONGENITAL 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