



# DELIVERY ROOM DEATH FORM FOR INFANTS BORN IN 2019

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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)	_____ - _____ -2019
b. Birth Time: (00:00)	_____ : _____ (use 24-hour clock)
5. Infant Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <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"/> History of adverse reaction to corticosteroids		
	<input type="checkbox"/> Other active infection <input type="checkbox"/> Comfort Care		
	<input type="checkbox"/> Immediate delivery <input type="checkbox"/> Other		
	<input type="checkbox"/> Fetus has anomalies incompatible with life <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"/> Other Infection <input type="checkbox"/> Antenatal Magnesium Sulfate		
	<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Other (describe): _____		
	<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Prev. Cesarean <input type="checkbox"/> Unknown		
b. Fetal Antenatal Conditions	<input type="checkbox"/> None <input type="checkbox"/> Non-Reassuring Fetal Status <input type="checkbox"/> Other Fetal (describe): _____		
	<input type="checkbox"/> IUGR <input type="checkbox"/> Anomaly <input type="checkbox"/> Unknown		
c. Obstetrical Conditions	<input type="checkbox"/> None <input type="checkbox"/> Prolonged ROM (>18hrs)		
	<input type="checkbox"/> Preterm (<37 wks) Labor <input type="checkbox"/> Malpresentation/Breech		
	<input type="checkbox"/> Preterm (<37 wks) Premature ROM before onset of labor <input type="checkbox"/> Bleeding/Abruption/Placenta Previa		
	<input type="checkbox"/> Term Premature ROM (≥37 wks) before onset of labor, not premature gestation <input type="checkbox"/> Other Obstetrical (describe): _____		

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Not Applicable (No C/S)     | <input type="checkbox"/> Multiple Gestation          | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Elective                    | <input type="checkbox"/> Placental Problems          | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Malpresentation/Breech      | <input type="checkbox"/> Non-Reassuring Fetal Status | <input type="checkbox"/> Unknown                 |
| <input type="checkbox"/> Dystocia/Failed to Progress |  |  |

**DELIVERY ROOM AND FIRST HOUR AFTER BIRTH**

**19. Delayed Cord Clamping**

- a. Was delayed umbilical cord clamping performed?  Yes  No  Unknown
- b. How long was umbilical cord clamping delayed?  30-60 secs  61-120 secs  >120 secs  NA  Unknown
- c. If DCC was not done, reason why (optional)?  Maternal Bleeding  Neonatal Causes  Other (specify): \_\_\_\_\_
- d. Was umbilical cord milking performed?  Yes  No  Unknown
- e. Did breathing begin before umbilical cord clamping?  Yes  No  Unknown

20. a. Apgar Scores:  1min  Unknown  5 min  Unknown  10 min  Unknown
- Not Done  Not Done  Not Done

**22. Delivery Room Resuscitation**

- |                         |   |   |   |
|-------------------------|---|---|---|
| a. Supplemental Oxygen: | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | e. Epinephrine:                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| b. CPAP:                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | f. Cardiac Compressions:                        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| c. Bag/Mask:            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | g. Nasal Intermittent Positive Pressure (NIPPV) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| d. ETT Ventilation      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | h. Laryngeal Mask Airway (LMA)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)  
\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_:\_\_\_\_\_



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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