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.

INDENTIFICATION 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) ☐☐-☐☐-2019
   b. Birth Time: (00:00) ☐☐:☐☐ (use 24-hour clock)
5. **Infant Sex:** ☐ Male ☐ Female ☐ 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 ☐ White ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Unknown
11. **Prenatal Care:** ☐ Yes ☐ No ☐ 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) ☐ Yes ☐ No ☐ Unknown
    c. If Yes, what was the documented reason for NOT administrating 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 ☐ History of adverse reaction to corticosteroids ☐ Comfort Care ☐ Other ☐ Unknown
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): _____ ☐ Unknown
    - **b. Fetal Antenatal Conditions** ☐ None ☐ IUGR ☐ Non-Reassuring Fetal Status ☐ Anomaly ☐ Other Fetal (describe):_____ ☐ Unknown
    - **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):_____

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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?	☐ 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 ☐ Not Done ☐☐ 5 min ☐ Unknown ☐ Not Done ☐☐ 10 min ☐ Unknown ☐ Not Done

22. Delivery Room Resuscitation

a. Supplemental Oxygen:	☐ Yes	☐ No	☐ Unknown	**e. Epinephrine:**	☐ Yes	☐ No	☐ Unknown
b. CPAP:	☐ Yes	☐ No	☐ Unknown	**f. Cardiac Compressions:**	☐ Yes	☐ No	☐ Unknown
c. Bag/Mask:	☐ Yes	☐ No	☐ Unknown	**g. Nasal Intermittent Positive Pressure (NIPPV)**	☐ Yes	☐ No	☐ Unknown
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) __ __ - __ __ -__ __ __ __ __ __: __ __		

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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