QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS

PLACE OF DELIVERY

DATE OF ADMISSION (for delivery)

MOTHER'S COUNTRY OF BIRTH

SEROLOGY
RPR.....IgG.....
Rubella.....
Blood Group.....
Rh.....
Antibodies No ☐ Yes ☐
Other

INDIGENOUS STATUS
- Aboriginal 1
- Torres Strait Islander 2
- Aborig. & Torres Str. Is. 3
- Neither Aboriginal nor Torres Str. Is. 4

MARITAL STATUS
- Never Married 1
- Married/defacto 2
- Widowed 3
- Divorced 4
- Separated 5

ACCOMMODATION STATUS OF MOTHER
- Public 1
- Private 4

FAMILY NAME

1ST GIVEN NAME

2ND GIVEN NAME

UR No.

DOB

Estimated Date of Birth ☐

USUAL RESIDENCE

POSTCODE ☐☐☐☐ STATE ☐ SLA ☐☐☐☐

PREVIOUS PREGNANCIES

PREVIOUS PREGNANCIES
None ☐1 (go to next section)

Number of **previous pregnancies** resulting in:
- Only livebirths ☐☐
- Only stillbirths ☐☐
- Only abortions/miscarriages/ectopic/hydatiform mole ☐☐
- Livebirth & stillbirth ☐
- Livebirth & abortion/miscarriages/ectopic/hydatiform mole ☐
- Stillbirth & abortion/miscarriages/ectopic/hydatiform mole ☐
- Livebirth, stillbirth & abortion/miscarriages/ectopic/hydatiform mole ☐

TOTAL NUMBER of previous pregnancies ☐☐

METHOD OF DELIVERY OF LAST BIRTH
- Vaginal non-instrumental 10
- Forceps 02
- Vacuum extractor 03
- LSCS 04
- Classical CS 05
- Other (specify)

Number of previous caesareans ☐☐

ANTENATAL TRANSFER No ☐1 Yes ☐2
(include transfers from planned home birth to hospital, from birthing centre to acute care areas etc.)
Reason for transfer

Time of transfer
- prior to onset of labour ☐1
- during labour ☐2

Transferred from

SMOKING
During the first 20 weeks of pregnancy
- Did the mother smoke? No ☐1 Yes ☐2
- If yes, how many cigarettes per day? ☐☐☐
- Was smoking cessation advice offered by a health care provider? No ☐1 Yes ☐2

After 20 weeks of pregnancy
- Did the mother smoke? No ☐1 Yes ☐2
- If yes, how many cigarettes per day? ☐☐☐
- Was smoking cessation advice offered by a health care provider? No ☐1 Yes ☐2

PRESENT PREGNANCY

LMP ☐☐☐☐☐☐☐☐

EDC by US scan/dates/clinical assessment ☐☐☐☐☐☐☐☐

HEIGHT ☐☐☐ cm

WEIGHT ☐☐.☐ kg (self-reported at conception)

TOTAL NUMBER OF VISITS ☐☐

GESTATION AT FIRST ANTENATAL VISIT ☐☐ Weeks

ANTENATAL CARE
You may tick more than one box
- No antenatal care ☐
- Public hospital/clinic midwifery practitioner ☐06
- Public hospital/clinic medical practitioner ☐07
- General practitioner ☐08
- Private medical practitioner ☐03
- Private midwife practitioner ☐04

CURRENT MEDICAL CONDITIONS
You may tick more than one box
- None ☐
- Essential hypertension ☐O100
- Pre-existing diabetes mellitus
  - Type 1 diabetes ☐O240
  - Type 2 insulin treated ☐O2412
  - Type 2 oral hypoglycaemic therapy ☐O2413
  - Type 2 diet/exercise ☐O2414
  - Other (specify) ☐
- Asthma (treated during this pregnancy) ☐J459
- Epilepsy ☐G4090
- Genital herpes (active during this pregnancy) ☐
- Anaemia ☐D649
- Renal condition (specify) ☐
- Cardiac condition (specify) ☐
- Hepatitis B Active ☐B169
- Hepatitis B Carrier ☐Z2251
- Hepatitis C Active ☐B171
- Hepatitis C Carrier ☐Z2252
- Other (specify) ☐

PREGNANCY COMPLICATIONS
You may tick more than one box
- None ☐
- APH (<20 weeks) ☐O209
- APH (<20 weeks or later) due to
  - abruption ☐O459
  - placenta praevia ☐O441
  - other ☐O469
- Gestational diabetes
  - insulin treated ☐O2442
  - oral hypoglycaemic therapy ☐O2443
  - diet/exercise ☐O2444
- Hypertension
  - Gestational (mild) ☐O13
  - Pre eclampsia (moderate) ☐O140
  - Pre eclampsia (severe) ☐O141
  - HELLP ☐O142
- Other (specify) ☐

PROCEDURES AND OPERATIONS
(during pregnancy, labour and delivery)
You may tick more than one box
- None ☐
- Chorionic villus sampling ☐1660300
- Amniocentesis (diagnostic) ☐1660000
- Cordocentesis ☐1660600
- Cervical suture (for cervical incompetence) ☐1651100
- Other (specify) ☐

ULTRASOUNDS
Number of scans ☐☐

Were any of the following performed?
- Nuchal translucency ultrasound No ☐1 Yes ☐2
- Morphology ultrasound scan No ☐1 Yes ☐2
- Assessment for chorionicity scan No ☐1 Yes ☐2

ASSISTED CONCEPTION
Was this pregnancy the result of assisted conception? No ☐1 Yes ☐2

If yes, indicate method/s used
- AIH / AID ☐02
- Ovulation induction ☐03
- IVF ☐04
- GIFT ☐05
- ICSI (intracytoplasmic sperm injection) ☐07
- Donor Egg ☐08
- Other (specify) ☐

LABOUR AND DELIVERY

INTENDED PLACE OF BIRTH AT ONSET OF LABOUR
- Hospital 1
- Birthing centre 2
- Home 4
- Other 8

ACTUAL PLACE OF BIRTH OF BABY
- Hospital 1
- Birthing centre 2
- Home 4
- Other (BBA) 8

ONSET OF LABOUR
Tick one box only
- Spontaneous 1
- Induced 2
- No labour (caesarean section) 3

Methods used to **induce labour** or **augment labour?**
You may tick more than one box
- Artificial rupture of Membranes (ARM) 1
- Oxytocin 2
- Prostaglandins 3
- Other (specify)

If labour induced
Reason for induction

MEMBRANES RUPTURED
____ days ____ hours ____ mins before delivery

LENGTH OF LABOUR

	hours	minutes
• 1st stage		
• 2nd stage		

PRESENTATION AT BIRTH
Tick one box only
- Vertex 1
- Breech 2
- Face 4
- Brow 5
- Transverse/shoulder 7
- Other (specify)

METHOD OF BIRTH
Tick one box only
- Vaginal non-instrumental 10
- Forceps 02
- Vacuum extractor 03
- LSCS 04
- Classical CS 05
- Other (specify)

WATER BIRTH
Was this a **water birth?** No ☐1 Yes ☐2

If **yes**, was the water birth
- Unplanned 1
- Planned 2

REASON FOR FORCEPS/VACUUM

MAIN REASON FOR CAESAREAN

1ST ADDITIONAL REASON FOR CAESAREAN

2ND ADDITIONAL REASON FOR CAESAREAN

Cervical dilation prior to caesarean
- 3cm or less 1
- More than 3cm 2
- Not measured 3

ANTIBIOTICS AT TIME OF CAESAREAN
Tick one box only
- None 1
- Prophylactic antibiotics received 2
- Antibiotics already received 3

PLACENTA/ CORD

NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY
- None ☐
- Heat pack 02
- Birth ball 03
- Massage 04
- Shower 05
- Water Immersion 06
- Aromatherapy 07
- Homeopathy 08
- Acupuncture 09
- TENS 10
- Water Injection 11
- Other (specify)

PRINCIPAL ACCOUCHEUR
Tick one box only
- Obstetrician 1
- Other medical officer 2
- Midwife 3
- Student midwife 4
- Medical student 5
- Other (specify)

DAMAGE TO THE PERINEUM
You may tick more than one box
- None ☐
- Graze/tear – vagina, labia, vulva 02
- Lacerated -1st degree 02
- -2nd degree 03
- -3rd degree 04
- -4th degree 05
- Episiotomy 06

Other genital trauma

Surgical repair of vagina or perineum? No ☐1 Yes ☐2

PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY
- None ☐
- Nitrous oxide 02
- Systemic opioid (incl. narcotic (IM/IV)) 08
- Epidural 04
- Spinal 05
- Combined Spinal-Epidural 10
- Caudal 07
- Other (specify)

LABOUR AND DELIVERY COMPLICATIONS
You may tick more than one box
- None ☐
- Meconium liquor ☐O681
- Fetal distress ☐O689
- Cord prolapse ☐O690
- Cord entanglement with compression ☐O692
- Failure to progress ☐O622
- Prolonged second stage (active) ☐O631
- Precipitate labour/delivery ☐O623
- Retained placenta with manual removal ☐
  - with haemorrhage ☐O720
  - without haemorrhage ☐O730
- Primary PPH (500-999ml) ☐O721
- Primary PPH (1000-1499ml) ☐O721
- Primary PPH (=>1500ml) ☐O721
- Other (specify) ☐

- CTG in labour? No ☐1 Yes ☐2
- FSE in labour? No ☐1 Yes ☐2
- Fetal scalp pH? No ☐1 Yes ☐2
- Fetal scalp pH result → ☐.☐
- Lactate? No ☐1 Yes ☐2
- Lactate result → ☐☐.☐

ANAESTHESIA FOR DELIVERY
- None ☐
- Epidural 04
- Spinal 05
- Combined Spinal-Epidural 10
- General Anaesthetic 06
- Local to perineum 02
- Pudendal 03
- Caudal 07
- Other (specify) ☐

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BABY

For multiple births complete one form per baby

BABY'S UR No.

DATE OF BIRTH

INDIGENOUS STATUS - BABY
Aboriginal 1
Torres Strait Islander 2
Aborig. & Torres Str. Is. 3
Neither Aboriginal nor Torres Str. Isl 4

TIME OF BIRTH ____ hours

BIRTHWEIGHT ____ grams

GESTATION (clinical assessment at birth) ____ weeks ____ days

HEAD CIRCUMFERENCE AT BIRTH ____ . ____ cm

LENGTH AT BIRTH ____ . ____ cm

PLURALITY
Single 1
Twin I 2
Twin II 2
Other (Specify)

SEX
Male 1
Female 2
Indeterm. 3

BIRTH STATUS
Born alive 1
Stillborn 2
– macerated
No 1 Yes 2

APGAR SCORE

	1 min	5 mins
Heart rate		
Respiratory effort		
Muscle tone		
Reflex irritability		
Colour		
TOTAL		

REGULAR RESPIRATIONS ____ minutes

OR At birth
OR Intubated/Ventilated
OR Respirations not established

RESUSCITATION
You may tick more than one box
None 1
Suction (oral, pharyngeal etc) 02
Suction of meconium (oral, pharyngeal etc) 03
Suction of meconium via ETT 04
Facial O_2 05
Bag and mask 06
IPPV via ETT 07
Narcotic antagonist injection 08
External cardiac massage 09
Other (specify-include drugs)

Urine
Meconium

Cord pH?
No 1 Yes 2

Cord pH value ____ . ____

BE ____

VITAMIN K (first dose)
Oral 1
IM 2
None 3

HEPATITIS B IMMUNOGLOBULIN
No 1 Yes 2

HEPATITIS B (birth dose vaccination)
No 1 Yes 2

POSTNATAL DETAILS

BABY
NEONATAL MORBIDITY

None
Jaundice → Diagnosis
Respiratory distress → Diagnosis
Hypo/Hyperglycaemia or Normal → Results
Neonatal abstinence syndrome → Drug name
Infection → Diagnosis
Other (specify) →

NEONATAL TREATMENT
None 1
Oxygen for > 4 hours 02
Phototherapy 03
IV/IM antibiotics 04
IV fluid 05
Mechanical ventilation 06
Blood glucose monitoring 10
CPAP 11
Oro / naso gastric feeding 12
Other treatment

Was baby admitted to ICN/SCN?
No Yes

If yes, how many days was baby admitted to:
• ICN (days) ____
• SCN (days) ____

Main reason for admission to ICN/SCN

CONGENITAL ANOMALY
No 1 Yes 2 Suspected 3
If yes or suspected enter details below or in the Congenital Anomaly section.

DISCHARGE DETAILS

MOTHER
PUERPERIUM COMPLICATIONS
You may tick more than one box
None
Haemorrhoids O872
Wound infection O860
Anaemia O9903
Dehiscence/disruption of wound
Febrile O864
UTI O862
Spinal headache O894
Secondary PPH O722
Other (specify)

THROMBOPROPHYLAXIS FOLLOWING CAESAREAN You may tick more than one box
None
Pharmacological thromboprophylaxis 2
Intermittent Calf Compression 3
TED Stocking 4
Other thromboprophylaxis

PUERPERIUM PROCEDURES AND OPERATIONS
You may tick more than one box
None
Blood Patch 1823300
Blood Transfusion 1370601
D & C 1656400
Other (specify)

Discharged 1
Transferred 2 Place of Transfer
Died 3
Remaining in 4

Date

Early Discharge Program
No 1 Yes 2

BABY
Neonatal Screening

Discharge weight ____ grams

Discharged 1
Transferred 2 Place of transfer
Died 3
Remaining in 4

Date

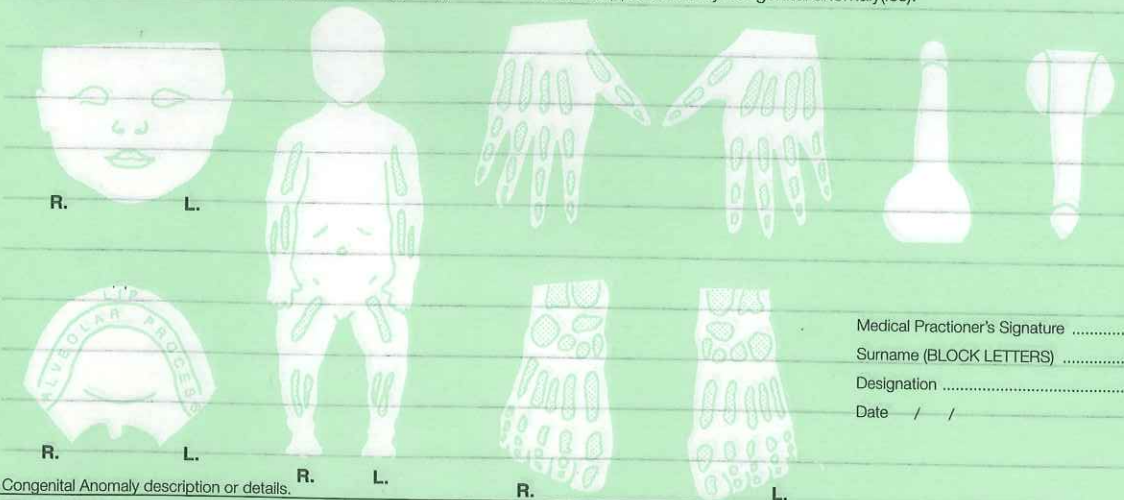
TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE
You may tick more than one box
Breast milk/colostrum 1
Infant formula 2
Water, fruit juice or water-based products 3
Nil by mouth 4

TYPES OF FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE.
You may tick more than one box
Breast milk/colostrum 1
Infant formula 2
Water, fruit juice or water-based products 3
Nil by mouth 4

ALTERNATE FEEDING METHOD
You may tick more than one box
None
Bottle 02
Cup 03
Syringe 04
Other (specify)

CONGENITAL ANOMALY/MORBIDITY DATA

B. Indicate by shading or marking the appropriate diagram(s) the anatomical site(s) affected by congenital anomaly(ies).



Medical Practioner's Signature .....
Surname (BLOCK LETTERS) .....
Designation .....
Date / /

Additional Congenital Anomaly description or details.

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