

QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS	PLACE OF DELIVERY: _____ DATE OF ADMISSION (for delivery): _____ FAMILY NAME: _____ UR No: _____ MOTHER'S COUNTRY OF BIRTH: _____ SEROLOGY: _____ 1ST GIVEN NAME: _____ DOB: _____ INDIGENOUS STATUS: _____ MARITAL STATUS: _____ ACCOMMODATION STATUS OF MOTHER: _____ Rubella: _____ Blood Group: _____ Rh: _____ Antibodies No <input type="checkbox"/> Yes <input type="checkbox"/> Other: _____ USUAL RESIDENCE: _____ POSTCODE: _____ STATE: _____ SLA: _____
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PREVIOUS PREGNANCIES	PREVIOUS PREGNANCIES: None <input type="checkbox"/> (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: _____ Forceps: _____ Vacuum extractor: _____ LSCS: _____ Classical CS: _____ Other (specify): _____ Number of previous caesareans: _____	ANTENATAL TRANSFER: No <input type="checkbox"/> Yes <input type="checkbox"/> (include transfers from planned home birth to hospital, from birthing centre to acute care areas etc.) Reason for transfer: _____ Transferred from: _____ Time of transfer: • prior to onset of labour <input type="checkbox"/> • during labour <input type="checkbox"/>
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PRESENT PREGNANCY	LMP: _____ TOTAL NUMBER OF VISITS: _____ EDC by US scan/dates/clinical assessment: _____ HEIGHT: _____ cm WEIGHT (self-reported at conception): _____ kg ANTENATAL CARE: You may tick more than one box No antenatal care: <input type="checkbox"/> Public hospital/clinic midwifery practitioner: <input type="checkbox"/> Public hospital/clinic medical practitioner: <input type="checkbox"/> General practitioner: <input type="checkbox"/> Private medical practitioner: <input type="checkbox"/> Private midwife practitioner: <input type="checkbox"/>	CURRENT MEDICAL CONDITIONS: You may tick more than one box None: <input type="checkbox"/> Essential hypertension: <input type="checkbox"/> Pre-existing diabetes mellitus • insulin treated: <input type="checkbox"/> • oral hypoglycaemic therapy: <input type="checkbox"/> • other: <input type="checkbox"/> Asthma (treated during this pregnancy): <input type="checkbox"/> Epilepsy: <input type="checkbox"/> Genital herpes (active during this pregnancy): <input type="checkbox"/> Anaemia: <input type="checkbox"/> Renal condition (specify): _____ Cardiac condition (specify): _____ Hepatitis B Active: <input type="checkbox"/> Hepatitis B Carrier: <input type="checkbox"/> Hepatitis C Active: <input type="checkbox"/> Hepatitis C Carrier: <input type="checkbox"/> Other (specify): _____	PREGNANCY COMPLICATIONS: You may tick more than one box None: <input type="checkbox"/> APH (<20 weeks): <input type="checkbox"/> APH (20 weeks or later) due to: • abruption: <input type="checkbox"/> • placenta praevia: <input type="checkbox"/> • other: <input type="checkbox"/> Gestational diabetes: • insulin treated: <input type="checkbox"/> • oral hypoglycaemic therapy: <input type="checkbox"/> • other: <input type="checkbox"/> PIH/PE: • mild: <input type="checkbox"/> • moderate: <input type="checkbox"/> • severe: <input type="checkbox"/> Other (specify): _____	PROCEDURES AND OPERATIONS (during pregnancy, labour and delivery): You may tick more than one box None: <input type="checkbox"/> Chorionic villus sampling: <input type="checkbox"/> Amniocentesis (diagnostic): <input type="checkbox"/> Cordocentesis: <input type="checkbox"/> Cervical suture (for cervical incompetence): <input type="checkbox"/> Other (specify): _____ ULTRASOUNDS: Number of scans: _____ Were any of the following performed? Nuchal translucency ultrasound: No <input type="checkbox"/> Yes <input type="checkbox"/> Morphology ultrasound scan: No <input type="checkbox"/> Yes <input type="checkbox"/> Assessment for chorionicity scan: No <input type="checkbox"/> Yes <input type="checkbox"/>	ASSISTED CONCEPTION: Was this pregnancy the result of assisted conception? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, indicate method/s used: AIH / AID: <input type="checkbox"/> Ovulation induction: <input type="checkbox"/> IVF: <input type="checkbox"/> GIFT: <input type="checkbox"/> ICSI (intracytoplasmic sperm injection): <input type="checkbox"/> Other (specify): _____
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LABOUR AND DELIVERY	INTENDED PLACE OF BIRTH AT ONSET OF LABOUR: Hospital: <input type="checkbox"/> Birthing centre: <input type="checkbox"/> Home: <input type="checkbox"/> Other: _____ ACTUAL PLACE OF BIRTH OF BABY: Hospital: <input type="checkbox"/> Birthing centre: <input type="checkbox"/> Home: <input type="checkbox"/> Other (BBA): _____ ONSET OF LABOUR: Tick one box only Spontaneous: <input type="checkbox"/> Induced: <input type="checkbox"/> No labour (caesarean section): <input type="checkbox"/> Methods used to induce labour or augment labour? You may tick more than one box Artificial rupture of Membranes (ARM): <input type="checkbox"/> Oxytocin: <input type="checkbox"/> Prostaglandins: <input type="checkbox"/> Other (specify): _____ If labour induced: Reason for induction: _____ If yes, was the water birth: Unplanned <input type="checkbox"/> Planned <input type="checkbox"/>	MEMBRANES RUPTURED: _____ days _____ hours _____ mins before delivery LENGTH OF LABOUR: hours _____ minutes _____ • 1st stage: _____ • 2nd stage: _____ PRESENTATION AT BIRTH: Tick one box only Vertex: <input type="checkbox"/> Breech: <input type="checkbox"/> Face: <input type="checkbox"/> Brow: <input type="checkbox"/> Transverse/shoulder: <input type="checkbox"/> Other (specify): _____ METHOD OF BIRTH: Tick one box only Vaginal non-instrumental: <input type="checkbox"/> Forceps: <input type="checkbox"/> Vacuum extractor: <input type="checkbox"/> LSCS: <input type="checkbox"/> Classical CS: <input type="checkbox"/> Other (specify): _____ WATER BIRTH: Was this a water birth? No <input type="checkbox"/> Yes <input type="checkbox"/>	REASON FOR FORCEPS/VACUUM: _____ REASON FOR CAESAREAN: _____ Cervical dilation prior to caesarean: 3cm or less: <input type="checkbox"/> More than 3cm: <input type="checkbox"/> Not measured: <input type="checkbox"/> ANTIBIOTICS AT TIME OF CAESAREAN: Tick one box only None: <input type="checkbox"/> Prophylactic antibiotics received: <input type="checkbox"/> Antibiotics already received: <input type="checkbox"/> PLACENTA / CORD: _____ NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY: None: <input type="checkbox"/> Heat pack: <input type="checkbox"/> Birth ball: <input type="checkbox"/> Massage: <input type="checkbox"/> Shower: <input type="checkbox"/> Water Immersion: <input type="checkbox"/> Aromatherapy: <input type="checkbox"/> Homeopathy: <input type="checkbox"/> Acupuncture: <input type="checkbox"/> TENS: <input type="checkbox"/> Water Injection: <input type="checkbox"/> Other (specify): _____	PRINCIPAL ACCOUCHEUR: Tick one box only Obstetrician: <input type="checkbox"/> Other medical officer: <input type="checkbox"/> Midwife: <input type="checkbox"/> Student midwife: <input type="checkbox"/> Medical student: <input type="checkbox"/> Other (specify): _____ DAMAGE TO THE PERINEUM: You may tick more than one box None: <input type="checkbox"/> Graze/tear - vagina, labia, vulva: <input type="checkbox"/> Lacerated: -1st degree: <input type="checkbox"/> -2nd degree: <input type="checkbox"/> -3rd degree: <input type="checkbox"/> -4th degree: <input type="checkbox"/> Episiotomy: <input type="checkbox"/> Other genital trauma: _____ Surgical repair of vagina or perineum? No <input type="checkbox"/> Yes <input type="checkbox"/> PHARMACOLOGICAL ANALGESIA DURING LABOUR/DELIVERY: None: <input type="checkbox"/> Nitrous oxide: <input type="checkbox"/> Systemic opioid (incl. narcotic (IM/IV)): <input type="checkbox"/> Epidural: <input type="checkbox"/> Spinal: <input type="checkbox"/> Combined Spinal-Epidural: <input type="checkbox"/> Caudal: <input type="checkbox"/> Other (specify): _____	LABOUR AND DELIVERY COMPLICATIONS: You may tick more than one box None: <input type="checkbox"/> Meconium liquor: <input type="checkbox"/> Fetal distress: <input type="checkbox"/> Cord prolapse: <input type="checkbox"/> Cord entanglement with compression: <input type="checkbox"/> Failure to progress: <input type="checkbox"/> Prolonged second stage (active): <input type="checkbox"/> Precipitate labour/delivery: <input type="checkbox"/> Retained placenta with manual removal: • with haemorrhage: <input type="checkbox"/> • without haemorrhage: <input type="checkbox"/> Primary PPH (500-999ml): <input type="checkbox"/> Primary PPH (>=1000ml): <input type="checkbox"/> Other (specify): _____ CTG in labour? No <input type="checkbox"/> Yes <input type="checkbox"/> FSE in labour? No <input type="checkbox"/> Yes <input type="checkbox"/> Fetal scalp pH? No <input type="checkbox"/> Yes <input type="checkbox"/> Fetal scalp pH result: _____ Lactate? No <input type="checkbox"/> Yes <input type="checkbox"/> Lactate result: _____ ANAESTHESIA FOR DELIVERY: None: <input type="checkbox"/> Epidural: <input type="checkbox"/> Spinal: <input type="checkbox"/> Combined Spinal-Epidural: <input type="checkbox"/> General Anaesthetic: <input type="checkbox"/> Local to perineum: <input type="checkbox"/> Pudendal: <input type="checkbox"/> Caudal: <input type="checkbox"/> 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

Torres Strait Islander

Aborig. & Torres Str. Is.

Neither Aboriginal nor Torres Str. Isl

TIME OF BIRTH hours

BIRTHWEIGHT grams

GESTATION (clinical assessment at birth) weeks days

HEAD CIRCUMFERENCE AT BIRTH cm

LENGTH AT BIRTH cm

PLURALITY

Single

Twin I

Twin II

Other (Specify)

SEX

Male

Female

Indeterm.

BIRTH STATUS

Born alive

Stillborn

- macerated

No Yes

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

Suction (oral, pharyngeal etc)

Suction of meconium (oral, pharyngeal etc)

Suction of meconium via ETT

Facial O₂

Bag and mask

IPPV via ETT

Narcotic antagonist injection

External cardiac massage

Other (specify-include drugs)

HEPATITIS B IMMUNOGLOBULIN

No Yes

Urine

Meconium

Cord pH? No Yes

Cord pH value

BE

VITAMIN K (first dose) Oral IM None

HEPATITIS B (birth dose vaccination) No Yes

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

Oxygen for > 4 hours

Phototherapy

IV/IM antibiotics

IV fluid

Mechanical ventilation

Blood glucose monitoring

CPAP

Oro / naso gastric feeding

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 Yes Suspected

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

Wound infection

Anaemia

Dehiscence/disruption of wound

Febrile

UTI

Spinal headache

Secondary PPH

Other (specify)

THROMBOPROPHYLAXIS FOLLOWING CAESAREAN

You may tick more than one box

None

Pharmacological thromboprophylaxis

Intermittent Calf Compression

TED Stocking

Other thromboprophylaxis

PUERPERIUM PROCEDURES AND OPERATIONS

You may tick more than one box

None

Blood Patch

Blood Transfusion

D & C

Other (specify)

Discharged

Transferred Place of Transfer

Died

Remaining in

Date

Early Discharge Program No Yes

BABY Neonatal Screening

Discharge weight grams

Discharged

Transferred Place of transfer

Died

Remaining in

Date

TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE

You may tick more than one box

Breast milk/colostrum

Infant formula

Water, fruit juice or water-based products

Nil by mouth

TYPES OF FLUID BABY RECEIVED IN THE 24 HOURS PRIOR TO DISCHARGE.

You may tick more than one box

Breast milk/colostrum

Infant formula

Water, fruit juice or water-based products

Nil by mouth

ALTERNATE FEEDING METHOD

You may tick more than one box

None

Bottle

Cup

Syringe

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 Practitioner's Signature

Surname (BLOCK LETTERS)

Designation

Date / /

Additional Congenital Anomaly description or details.

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