

# QUEENSLAND PERINATAL DATA COLLECTION FORM

<b>MOTHER'S DETAILS</b>	PLACE OF DELIVERY <input type="text"/>	DATE OF ADMISSION (for delivery) <input type="text"/>	SURNAME <input type="text"/>	UR No. <input type="text"/>	
	MOTHER'S COUNTRY OF BIRTH <input type="text"/>	SEROLOGY RPR.....IgG..... Rubella..... Hepatitis B..... Blood Group..... Rh..... Antibodies No <input type="checkbox"/> Yes <input type="checkbox"/> Other.....	FIRST NAME <input type="text"/>	DOB <input type="text"/>	
<b>PREVIOUS PREGNANCIES</b>	INDIGENOUS STATUS Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aborig. & Torres Str. Is. <input type="checkbox"/> Neither Aboriginal nor Torres Str. Is. <input type="checkbox"/>	MARITAL STATUS Never Married <input type="checkbox"/> Married/defacto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>	ACCOMMODATION STATUS OF MOTHER Public <input type="checkbox"/> Private <input type="checkbox"/>	USUAL RESIDENCE <input type="text"/>	POSTCODE <input type="text"/> STATE <input type="text"/> SLA <input type="text"/>
	PREVIOUS PREGNANCIES None <input type="checkbox"/> (go to next section)	METHOD OF DELIVERY OF LAST BIRTH 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) <input type="text"/>		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 <input type="text"/>	Time of transfer • prior to onset of labour <input type="checkbox"/> • during labour <input type="checkbox"/>
<b>PRESENT PREGNANCY</b>	LMP <input type="text"/>	NUMBER OF VISITS Less than 2 <input type="checkbox"/> 2 - 4 <input type="checkbox"/> 5 - 7 <input type="checkbox"/> 8 or more <input type="checkbox"/>	GESTATION AT FIRST ANTENATAL VISIT <input type="text"/> Weeks		
	EDC <input type="text"/> by US scan/dates/clinical assessment	HEIGHT <input type="text"/> cm	WEIGHT (self-reported at conception) <input type="text"/> 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) <input type="text"/> Cardiac condition (specify) <input type="text"/> Other (specify) <input type="text"/>
<b>LABOUR AND DELIVERY</b>	INTENDED PLACE OF BIRTH AT ONSET OF LABOUR Hospital <input type="checkbox"/> Birthing centre <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/>	If labour induced Reason for induction <input type="text"/>	WATER BIRTH Was this a water birth? No <input type="checkbox"/> Yes <input type="checkbox"/>	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) <input type="text"/>	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) <input type="text"/>
	ACTUAL PLACE OF BIRTH OF BABY Hospital <input type="checkbox"/> Birthing centre <input type="checkbox"/> Home <input type="checkbox"/> Other (BBA) <input type="checkbox"/>	MEMBRANES RUPTURED _____ days _____ hours _____ mins before delivery	REASON FOR FORCEPS/VACUUM <input type="text"/>	REASON FOR CAESAREAN <input type="text"/>	PERINEUM Please tick the most severe Intact <input type="checkbox"/> Grazes <input type="checkbox"/> Lacerated -1st degree <input type="checkbox"/> -2nd degree <input type="checkbox"/> -3rd degree <input type="checkbox"/> -4th degree <input type="checkbox"/>
ONSET OF LABOUR Tick one box only Spontaneous <input type="checkbox"/> Induced <input type="checkbox"/> No labour (caesarean section) <input type="checkbox"/>	LENGTH OF LABOUR hours minutes • 1st stage <input type="text"/> <input type="text"/> • 2nd stage <input type="text"/> <input type="text"/>	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"/>	PLACENTA / CORD <input type="text"/>	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) <input type="text"/>	Fetal scalp pH result → <input type="text"/> Lactate? No <input type="checkbox"/> Yes <input type="checkbox"/> Lactate result → <input type="text"/>
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) <input type="text"/>	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) <input type="text"/>	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"/> Other (specify) <input type="text"/>	Other genital trauma <input type="text"/>	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) <input type="text"/>	

