

QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS	PLACE OF DELIVERY <input type="text"/>	DATE OF ADMISSION (for delivery) <input type="text"/>	FAMILY NAME <input type="text"/>	UR No. <input type="text"/>
	MOTHER'S COUNTRY OF BIRTH <input type="text"/>	SEROLOGY	1ST GIVEN NAME <input type="text"/>	DOB <input type="text"/>
	INDIGENOUS STATUS	ACCOMMODATION STATUS OF MOTHER	2ND GIVEN NAME <input type="text"/>	Estimated Date of Birth <input type="text"/>
	Aboriginal <input type="checkbox"/> 1 Torres Strait Islander <input type="checkbox"/> 2 Aborig. & Torres Str. Is. <input type="checkbox"/> 3 Neither Aboriginal nor Torres Str. Is. <input type="checkbox"/> 4	Never Married <input type="checkbox"/> 1 Married/defacto <input type="checkbox"/> 2 Widowed <input type="checkbox"/> 3 Divorced <input type="checkbox"/> 4 Separated <input type="checkbox"/> 5	Public <input type="checkbox"/> 1 Private <input type="checkbox"/> 4	Usual Residence <input type="text"/>

PREVIOUS PREGNANCIES	PREVIOUS PREGNANCIES	METHOD OF DELIVERY OF LAST BIRTH	ANTENATAL TRANSFER	Time of transfer
	None <input type="checkbox"/> 1 (go to next section)	Vaginal non-instrumental <input type="checkbox"/> 10 Forceps <input type="checkbox"/> 02 Vacuum extractor <input type="checkbox"/> 03 LSCS <input type="checkbox"/> 04 Classical CS <input type="checkbox"/> 05 Other (specify) <input type="text"/>	No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 (include transfers from planned home birth to hospital, from birthing centre to acute care areas etc.)	prior to onset of labour <input type="checkbox"/> 1 during labour <input type="checkbox"/> 2
	Number of previous pregnancies resulting in:	Number of previous caesareans <input type="text"/>	Reason for transfer <input type="text"/>	
	Only livebirths <input type="checkbox"/>		Transferred from <input type="text"/>	

PRESENT PREGNANCY	LMP <input type="text"/>	TOTAL NUMBER OF VISITS <input type="text"/>	GESTATION AT FIRST ANTENATAL VISIT <input type="text"/> Weeks
	EDC by US scan/dates/clinical assessment <input type="text"/>	CURRENT MEDICAL CONDITIONS	PREGNANCY COMPLICATIONS
	HEIGHT <input type="text"/> cm	None <input type="checkbox"/> O100 Essential hypertension <input type="checkbox"/> Pre-existing diabetes mellitus <input type="checkbox"/> • Type 1 diabetes <input type="checkbox"/> O240 • Type 2 insulin treated <input type="checkbox"/> O2412 • Type 2 oral hypoglycaemic therapy <input type="checkbox"/> O2413 • Type 2 diet/exercise <input type="checkbox"/> O2414 • Other (specify) <input type="text"/>	None <input type="checkbox"/> O209 APH (<20 weeks) <input type="checkbox"/> APH (<20 weeks or later) due to <input type="checkbox"/> • abruptio <input type="checkbox"/> O459 • placenta praevia <input type="checkbox"/> O441 • other <input type="checkbox"/> O469
	WEIGHT (self-reported at conception) <input type="text"/> kg	Asthma (treated during this pregnancy) <input type="checkbox"/> J459 Epilepsy <input type="checkbox"/> G4090 Genital herpes (active during this pregnancy) <input type="checkbox"/> Anaemia (specify) <input type="text"/> D649 Cardiac condition (specify) <input type="text"/> Hepatitis B Active <input type="checkbox"/> B169 Hepatitis B Carrier <input type="checkbox"/> Z2251 Hepatitis C Active <input type="checkbox"/> B171 Hepatitis C Carrier <input type="checkbox"/> Z2252 Other (specify) <input type="text"/>	Gestational diabetes <input type="checkbox"/> • insulin treated <input type="checkbox"/> O2442 • oral hypoglycaemic therapy <input type="checkbox"/> O2443 • diet/exercise <input type="checkbox"/> O2444 Hypertension <input type="checkbox"/> • Gestational (mild) <input type="checkbox"/> O13 • Pre eclampsia (moderate) <input type="checkbox"/> O140 • Pre eclampsia (severe) <input type="checkbox"/> O141 • HELLP <input type="checkbox"/> O142 Other (specify) <input type="text"/>

LABOUR AND DELIVERY	INTENDED PLACE OF BIRTH AT ONSET OF LABOUR	MEMBRANES RUPTURED	REASON FOR FORCEPS/VACUUM	PRINCIPAL ACCOUCHEUR	LABOUR AND DELIVERY COMPLICATIONS
	Hospital <input type="checkbox"/> 1 Birthing centre <input type="checkbox"/> 2 Home <input type="checkbox"/> 4 Other <input type="checkbox"/> 8	_____ days _____ hours _____ mins before delivery	1ST ADDITIONAL REASON FOR CAESAREAN <input type="text"/> 2ND ADDITIONAL REASON FOR CAESAREAN <input type="text"/>	Obstetrician <input type="checkbox"/> 1 Other medical officer <input type="checkbox"/> 2 Midwife <input type="checkbox"/> 3 Student midwife <input type="checkbox"/> 4 Medical student <input type="checkbox"/> 5 Other (specify) <input type="text"/>	None <input type="checkbox"/> Meconium liquor <input type="checkbox"/> O681 Fetal distress <input type="checkbox"/> O689 Cord prolapse <input type="checkbox"/> O690 Cord entanglement with compression <input type="checkbox"/> O692 Failure to progress <input type="checkbox"/> O622 Prolonged second stage (active) <input type="checkbox"/> O631 Precipitate labour/delivery <input type="checkbox"/> O623
	ACTUAL PLACE OF BIRTH OF BABY	LENGTH OF LABOUR	ANTIBIOTICS AT TIME OF CAESAREAN	DAMAGE TO THE PERINEUM	Retained placenta with manual removal <input type="checkbox"/>
	Hospital <input type="checkbox"/> 1 Birthing centre <input type="checkbox"/> 2 Home <input type="checkbox"/> 4 Other (BBA) <input type="checkbox"/> 8	• 1st stage _____ hours _____ minutes • 2nd stage _____ hours _____ minutes	None <input type="checkbox"/> 1 Prophylactic antibiotics received <input type="checkbox"/> 2 Antibiotics already received <input type="checkbox"/> 3	None <input type="checkbox"/> 01 Graze/tear - vagina, labia, vulva <input type="checkbox"/> 02 Lacerated <input type="checkbox"/> 03 -1st degree <input type="checkbox"/> 02 -2nd degree <input type="checkbox"/> 03 -3rd degree <input type="checkbox"/> 04 -4th degree <input type="checkbox"/> 05 Episiotomy <input type="checkbox"/> 06 Other genital trauma <input type="text"/>	• with haemorrhage <input type="checkbox"/> O720 • without haemorrhage <input type="checkbox"/> O730 Primary PPH (500-999ml) <input type="checkbox"/> O721 Primary PPH (1000-1499ml) <input type="checkbox"/> O721 Primary PPH (>=1500ml) <input type="checkbox"/> O721 Other (specify) <input type="text"/>

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 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 O₂ 05

Bag and mask 06

IPPV via ETT 07

Narcotic antagonist injection 08

External cardiac massage 09

Other (specify-include drugs)

HEPATITIS B IMMUNOGLOBULIN

No 1 Yes 2

Urine

Meconium

Cord pH? 1 Yes 2

Cord pH value

BE

VITAMIN K (first dose)

Oral 1

IM 2

None 3

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

I/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 0872

Wound infection 0860

Anaemia 09903

Dehiscence/disruption of wound

Febrile 0864

UTI 0862

Spinal headache 0894

Secondary PPH 0722

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

Died 3

Remaining in 4

Date

Early Discharge Program

No 1 Yes 2

BABY Neonatal Screening

Discharge weight grams

Discharged 1

Transferred 2

Died 3

Remaining in 4

Date

Place of transfer

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

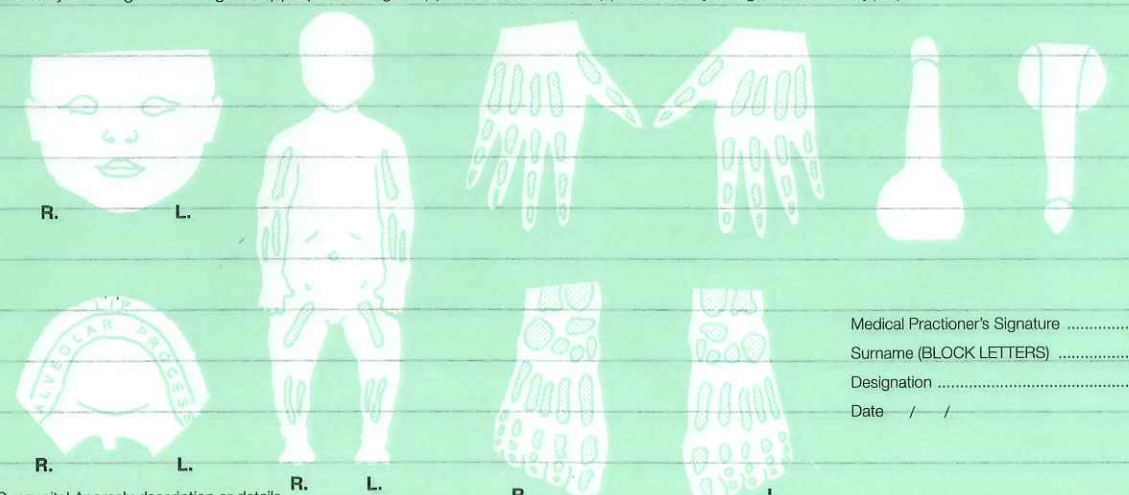
Cup 03

Syringe

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).



R. L.

R. L.

R. L.

R. L.

Medical Practitioner's Signature

Surname (BLOCK LETTERS)

Designation

Date / /

Additional Congenital Anomaly description or details.

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