QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS

PLACE OF DELIVERY _____ DATE OF ADMISSION (for delivery) ☐☐/☐☐/☐☐☐☐

MOTHER'S COUNTRY OF BIRTH _____

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

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

FAMILY NAME _____ UR No. ☐☐☐☐☐☐☐

1ST GIVEN NAME _____ DOB ☐☐/☐☐/☐☐☐☐

2ND GIVEN NAME _____ Estimated Date of Birth ☐

USUAL RESIDENCE _____

STATE ☐☐☐ POSTCODE ☐☐☐☐

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 _____

Transferred from _____

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

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 SCREENING
- Was antenatal screening for domestic violence performed? No ☐ 1 Yes ☐ 2
- Was antenatal screening for alcohol use performed? No ☐ 1 Yes ☐ 2
- Was antenatal screening for illicit drug use performed? No ☐ 1 Yes ☐ 2
- Was antenatal screening for Edinburgh Depression Score performed? No ☐ 1 Yes ☐ 2 What was the EDS score? ☐☐

IMMUNISATION
- Was immunisation for influenza received during this pregnancy? No ☐ 1 Yes ☐ 2 Gestation Weeks ☐☐
- Was immunisation for pertussis received during this pregnancy? No ☐ 1 Yes ☐ 2 Gestation Weeks ☐☐

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 ☐☐/☐☐/☐☐☐☐ TOTAL NUMBER OF VISITS ☐☐

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

HEIGHT ☐☐☐ cm

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

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 ☐
- Pre-existing hypertension ☐ O10
- 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 (diagostic) ☐ 1660000
- Cordocentesis ☐ 1660600
- Cervical suture (for cervical incompetence) ☐ 1651100
- Other (specify) ☐

ULTRASOUNDS
Number of scans ☐☐

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
- Frozen embryo transfer/ embryo transfer ☐ 09
- Other (specify) ☐

GESTATION AT FIRST ANTENATAL VISIT ☐☐ Weeks

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

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
- Mechanical Cervical Dilatation ☐ 6
- Antiprogestogen ☐ 7
- Other (specify) ☐

If labour induced
MAIN REASON FOR INDUCTION _____

1ST ADDITIONAL REASON FOR INDUCTION _____

2ND ADDITIONAL 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 opiod (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 ☐ O629
- 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 p H 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 ____ weeks ____ days
(clinical assessment at birth)

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
- Other 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)

HEPATITIS B IMMUNOGLOBULIN No 1 Yes 2

Urine

Meconium

Cord pH? No 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
- 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.

Was anomaly diagnosed antenatally? No 1 Yes 2

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)

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

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

BABY
Neonatal Screening

Discharge weight ____ grams

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

Date

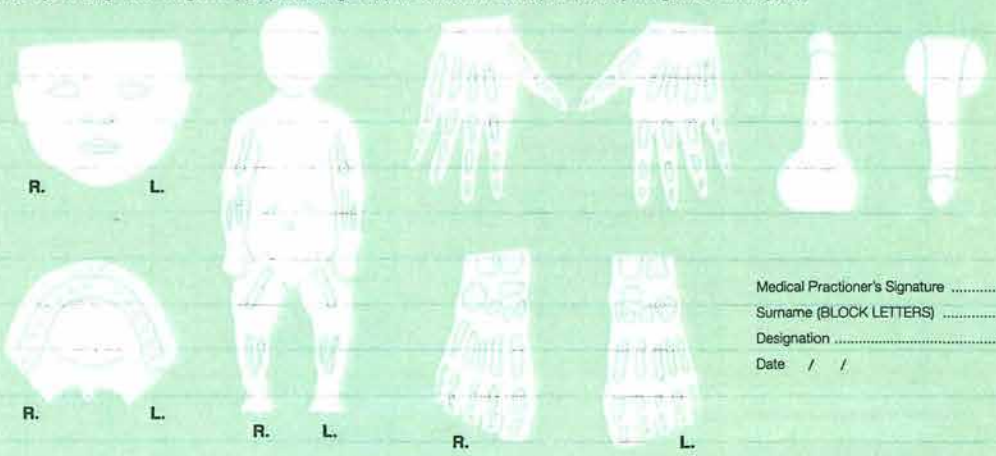
TYPES OF FLUID BABY RECEIVED AT ANY TIME FROM BIRTH TO DISCHARGE
You may tick more than one box
- Breast milk/colostrum 1
- Infant formula 2
- Water, fruit juice or water-based products 3
- Nil by mouth 4

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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