

QUEENSLAND PERINATAL DATA COLLECTION FORM

MOTHER'S DETAILS	PLACE OF BIRTH <input type="text"/>	DATE OF ADMISSION (for birth) <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 <input type="text"/>	RPR <input type="text"/> igG <input type="text"/>	2ND GIVEN NAME <input type="text"/>	ESTIMATED DATE OF BIRTH <input type="text"/>
	MARITAL STATUS <input type="text"/>	Rubella <input type="text"/>	USUAL RESIDENCE <input type="text"/>	STATE <input type="text"/> POSTCODE <input type="text"/>
	ACCOMODATION STATUS OF MOTHER <input type="text"/>	Blood group <input type="text"/>	ANTENATAL TRANSFER 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)	TIME OF TRANSFER prior to onset of labour <input type="text"/> 1
		Rh <input type="text"/>	Reason for Transfer <input type="text"/>	during labour <input type="text"/> 2
	Antibodies No <input type="checkbox"/> Yes <input type="checkbox"/>	Transferred from <input type="text"/>		
	Other <input type="text"/>			

PREVIOUS PREGNANCIES	PREVIOUS PREGNANCIES None <input type="checkbox"/> 1 (go to next section)	LAST BIRTH METHOD	ANTENATAL SCREENING Was antenatal screening for family violence performed? <input type="text"/>	SMOKING During the first 20 weeks of pregnancy did the mother smoke? <input type="text"/>	ALCOHOL During the first 20 weeks of pregnancy did the mother consume alcohol? <input type="text"/>
	Number of previous pregnancies resulting in:	Vaginal non-instrumental <input type="text"/> 10	Was antenatal screening for illicit drug use performed? <input type="text"/>	If yes, how many cigarettes per day? <input type="text"/>	If yes, how many standard drinks has the mother had on a typical day when drinking? <input type="text"/>
	Only livebirths <input type="text"/>	Forceps <input type="text"/> 02	Was antenatal screening for EPDS performed? <input type="text"/>	Was smoking cessation advice offered by a health care provider? <input type="text"/>	Frequency of alcohol consumption <input type="text"/>
	Only stillbirths <input type="text"/>	Vacuum extractor <input type="text"/> 03	What was the EPDS Score? <input type="text"/>	After 20 weeks of pregnancy did the mother smoke? <input type="text"/>	After 20 weeks of pregnancy did the mother consume alcohol? <input type="text"/>
Only abortions/miscarriages/ectopic/hydatiform mole <input type="text"/>	LSCS <input type="text"/> 04				
Livebirth & stillbirth <input type="text"/>	Classical CS <input type="text"/> 05				
Livebirth & abortion/miscarriage/ectopic/hydatiform mole <input type="text"/>					
Stillbirth & abortion/miscarriage/ectopic/hydatiform mole <input type="text"/>					
Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole <input type="text"/>					
TOTAL NUMBER OF PREVIOUS PREGNANCIES <input type="text"/>	Number of previous caesareans <input type="text"/>				

PRESENT PREGNANCY	ANTENATAL CARE <i>You may tick more than one box</i>	CURRENT MEDICAL CONDITIONS <i>You may tick more than one box</i>	IMMUNISATION Was immunisation for influenza received during this pregnancy? <input type="text"/>	PROCEDURES & OPERATIONS (during pregnancy, labour and birth) <i>You may tick more than one box</i>	ASSISTED CONCEPTION Was this pregnancy the result of assisted conception? <input type="text"/>
	No antenatal care <input type="checkbox"/>	None <input type="checkbox"/>	Gestation Weeks <input type="text"/>	None <input type="checkbox"/>	If yes, indicated method/s used
	Public hospital/clinic midwifery practitioner <input type="checkbox"/> 06	Pre-existing hypertension <input type="checkbox"/> 010	Was immunisation for pertussis received during this pregnancy? <input type="text"/>	Chorionic villus sampling <input type="checkbox"/> 1660300	AIH / AID / IUI <input type="checkbox"/> 02
	Public hospital/clinic medical practitioner <input type="checkbox"/> 07	Diabetes mellitus	Gestation Weeks <input type="text"/>	Amniocentesis (diagnostic) <input type="checkbox"/> 1660000	Ovulation induction <input type="checkbox"/> 03
	General practitioner <input type="checkbox"/> 08	• Type 1 <input type="checkbox"/> 0240		Cordocentesis <input type="checkbox"/> 1660600	IVF <input type="checkbox"/> 04
	Private medical practitioner <input type="checkbox"/> 03	• Type 2 insulin treated <input type="checkbox"/> 02412		Cervical suture (for cervical incompetence) <input type="checkbox"/> 1651100	GIFT <input type="checkbox"/> 05
	Private midwife practitioner <input type="checkbox"/> 04	• Type 2 oral hypoglycaemic therapy <input type="checkbox"/> 02413		Other (specify) <input type="text"/>	ICSI (intracytoplasmic sperm injection) <input type="checkbox"/> 07
	TOTAL NUMBER OF VISITS <input type="text"/>	• Type 2 diet/exercise <input type="checkbox"/> 02414		ULTRASOUNDS Number of Scans <input type="text"/>	Donor egg <input type="checkbox"/> 08
	GESTATION AT FIRST ANTENATAL VISIT <input type="text"/> weeks	Other (specify) <input type="text"/>		WERE ANY OF THE FOLLOWING PERFORMED?	Frozen embryo transfer/embryo transfer <input type="checkbox"/> 09
	LMP <input type="text"/>	Asthma (treated during this pregnancy) <input type="checkbox"/> J459		Nuchal translucency ultrasound <input type="checkbox"/>	Other (specify) <input type="text"/>
EDC <input type="text"/>	Epilepsy <input type="checkbox"/> G4090		Morphology ultrasound scan <input type="checkbox"/>	Primary Maternity Model of Care <input type="text"/>	
by US scan/dates/clinical assessment	Genital herpes (active during this pregnancy) <input type="checkbox"/>		Assessment for chorionicity scan <input type="text"/>	Maternity Model of Care at onset of labour <input type="text"/>	
HEIGHT <input type="text"/> cm	Anaemia <input type="checkbox"/> D649				
WEIGHT <input type="text"/> kg (self reported at conception)	Renal condition (specify) <input type="text"/>				
	Cardiac condition (specify) <input type="text"/>				
	Hepatitis B Active <input type="checkbox"/> B169				
	Hepatitis B Carrier <input type="checkbox"/> B181				
	Hepatitis C Active <input type="checkbox"/> B171				
	Hepatitis C Carrier <input type="checkbox"/> B182				
	Other (specify) <input type="text"/>				

LABOUR AND BIRTH	INTENDED PLACE OF BIRTH AT ONSET OF LABOUR <input type="text"/>	METHODS USED TO INDUCE LABOUR OR AUGMENT LABOUR? <i>You may tick more than one box</i>	MEMBRANES RUPTURED <input type="text"/> days <input type="text"/> hours <input type="text"/> mins	REASON FOR FORCEPS/VACUUM <input type="text"/>	NON-PHARMACOLOGICAL ANALGESIA DURING LABOUR/BIRTH	PRINCIPAL ACCOUCHEUR <input type="text"/>
	OTHER (SPECIFY) <input type="text"/>	Artificial rupture of Membranes (ARM) <input type="checkbox"/> 1	before birth	MAIN REASON FOR CAESAREAN <input type="text"/>	None <input type="checkbox"/>	Other (specify) <input type="text"/>
	ACTUAL PLACE OF BIRTH OF BABY <input type="text"/>	Oxytocin <input type="checkbox"/> 2	LENGTH OF LABOUR	1 st ADDITIONAL REASON FOR CAESAREAN <input type="text"/>	Heat Pack <input type="checkbox"/> 02	DAMAGE TO THE PERINEUM <i>You may tick more than one box</i>
	OTHER (BBA) <input type="text"/>	Prostaglandins <input type="checkbox"/> 3	• 1st Stage <input type="text"/> hours <input type="text"/> mins	2 nd ADDITIONAL REASON FOR CAESAREAN <input type="text"/>	Birth Ball <input type="checkbox"/> 03	None <input type="checkbox"/>
	ONSET OF LABOUR <input type="text"/>	Mechanical Cervical Dilatation <input type="checkbox"/> 6	• 2nd Stage <input type="text"/> hours <input type="text"/> mins	Cervical dilation prior to caesarean <input type="text"/>	Massage <input type="checkbox"/> 04	Graze/tear vagina, labia, vulva <input type="checkbox"/> 02
		Antiprogesterone <input type="checkbox"/> 7	PRESENTATION AT BIRTH	ANTIBIOTICS RECEIVED AT TIME OF CAESAREAN <input type="text"/>	Shower <input type="checkbox"/> 05	Lacerated 1st degree <input type="checkbox"/> 02
		Other (specify) <input type="text"/>	Other (specify) <input type="text"/>	PLACENTA / CORD <input type="text"/>	Water Immersion <input type="checkbox"/> 06	2nd degree <input type="checkbox"/> 03
		IF LABOUR INDUCED	METHOD OF BIRTH <input type="text"/>		Aromatherapy <input type="checkbox"/> 07	3rd degree <input type="checkbox"/> 04
		MAIN reason for induction <input type="text"/>			Homeopathy <input type="checkbox"/> 08	4th degree <input type="checkbox"/> 05
		1 st Additional reason for induction <input type="text"/>			Acupuncture <input type="checkbox"/> 09	Episiotomy <input type="checkbox"/> 06
	2 nd Additional reason for induction <input type="text"/>			Water Injection <input type="checkbox"/> 11	Other genital trauma <input type="text"/>	
		WATER BIRTH		Other (specify) <input type="text"/>	Surgical repair of vagina or perineum? <input type="text"/>	
		Was this a water birth? <input type="checkbox"/>				
		If yes, was the water birth <input type="text"/>				

LABOUR AND BIRTH (continued)

PHARMACOLOGICAL ANALGESIA DURING LABOUR/BIRTH

None, Nitrous oxide, Systemic opioid (incl. narcotic (IM/IV)), Epidural, Spinal, Combined Spinal-Epidural, Caudal, Other (specify)

LABOUR AND BIRTH COMPLICATIONS

None, Meconium liquor, Fetal distress, Cord prolapse, Cord entanglement with compression, Failure to progress, Prolonged second stage (active), Precipitate labour/birth

Retained placenta with manual removal, with haemorrhage, without haemorrhage, Primary PPH (500-999ml), Primary PPH (1000-1499ml), Primary PPH (>= 1500ml), Other (specify)

CTG in labour?, FSE in labour?, Fetal scalp pH?, Fetal Scalp pH result, Lactate?, Lactate Result

ANAESTHESIA FOR OPERATIVE/ INSTRUMENTAL BIRTH

None, Epidural, Spinal, Combined Spinal-Epidural General anaesthetic, Local to perineum, Pudendal, Caudal, Other (specify)

BABY

For multiple births complete one form per baby

BABY'S UR NO.

DATE OF BIRTH

INDIGENOUS STATUS - BABY

TIME OF BIRTH

BIRTHWEIGHT

GESTATION (clinical assessment at birth)

HEAD CIRCUMFERENCE AT BIRTH

LENGTH AT BIRTH

PLURALITY

Other (specify)

SEX

BIRTH STATUS

-macerated

APGAR SCORE

1 min 5min

Heart rate

Respiratory effort

Muscle tone

Reflex irritability

Colour

TOTAL

REGULAR RESPIRATIONS

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

CPAP ventilation

Intubation

Narcotic antagonist injection

External cardiac massage

Other (specify-include drugs)

Urine

Meconium

Arterial Cord pH?

Arterial Cord pH result

BE

VITAMIN K (first dose)

HEPATITIS B (birth dose vaccination)

HEPATITIS B IMMUNOGLOBULIN

POSTNATAL DETAILS

BABY

NEONATAL MORBIDITY

None, Jaundice, Respiratory distress, Hypo/Hyperglycaemia or Normal, Neonatal abstinence syndrome, Infection, 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?

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

Main reason for admission to ICN/SCN

CONGENITAL ANOMALY

If yes or suspected enter details below or in the Congenital Anomaly section, Position, Status, Was CA diagnosed antenatally?

DISCHARGE DETAILS

MOTHER PUERPERIUM COMPLICATIONS

None, Haemorrhoids, Wound Infection, Anaemia, Dehiscence/disruption of wound, Febrile, UTI, Spinal Headache, Secondary PPH, Other (specify)

PUERPERIUM PROCEDURES AND OPERATIONS

None, Blood Patch, Blood Transfusion, D & C, Other (specify)

MOTHER'S DISCHARGE DETAILS

Discharged, Transferred, Place of Transfer, Died, Remaining in, Date, Early Discharge Program

BABY NEONATAL SCREENING

Discharge weight, Discharged, Transferred, Place of Transfer, Died, Remaining in, Date

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

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

Breast milk/colostrum, Infant Formula, Water, fruit juice or water based products, Nil By Mouth

ALTERNATE FEEDING METHOD

None, Bottle, Cup, Syringe, Other

OFFICE USE ONLY