

Patient name <input style="width: 150px; height: 20px;" type="text"/>					
Hospital record number <input style="width: 150px; height: 20px;" type="text"/>					
Second birth		Third birth			
<p>10 MODE OF BIRTH</p> <input type="checkbox"/> normal vaginal delivery <input type="checkbox"/> forceps <input type="checkbox"/> vaginal breech <input type="checkbox"/> caesarean section <input type="checkbox"/> vacuum extraction <p>15 BABY RESUSCITATION</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (tick all that apply) <input type="checkbox"/> oxygen alone <input type="checkbox"/> bag and mask <input type="checkbox"/> IPPV via ETT <input type="checkbox"/> drugs given <p>16 SKILLED RESUSCITATOR PRESENT AT BIRTH</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unknown <p>17 1 minute APGAR score <input style="width: 30px; height: 20px;" type="text"/></p> <input type="checkbox"/> unknown <p>18 5 minute APGAR score <input style="width: 30px; height: 20px;" type="text"/></p> <input type="checkbox"/> unknown <p>19 BIRTHWEIGHT (grams) <input style="width: 80px; height: 20px;" type="text"/> gms</p> <input type="checkbox"/> unknown <p>20 GESTATIONAL AGE AT BIRTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> weeks</p> <input type="checkbox"/> unknown <p>32 IMMUNISATION OF NEWBORN AGAINST HEPATITIS B</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unknown <p>35 STILLBIRTH</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Cause of death: _____ <p>36 BORN ALIVE BUT DEATH BEFORE DISCHARGE</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Cause of death: _____	<p>10 MODE OF BIRTH</p> <input type="checkbox"/> normal vaginal delivery <input type="checkbox"/> forceps <input type="checkbox"/> vaginal breech <input type="checkbox"/> caesarean section <input type="checkbox"/> vacuum extraction <p>15 BABY RESUSCITATION</p> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (tick all that apply) <input type="checkbox"/> oxygen alone <input type="checkbox"/> bag and mask <input type="checkbox"/> IPPV via ETT <input type="checkbox"/> drugs given <p>16 SKILLED RESUSCITATOR PRESENT AT BIRTH</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unknown <p>17 1 minute APGAR score <input style="width: 30px; height: 20px;" type="text"/></p> <input type="checkbox"/> unknown <p>18 5 minute APGAR score <input style="width: 30px; height: 20px;" type="text"/></p> <input type="checkbox"/> unknown <p>19 BIRTHWEIGHT (grams) <input style="width: 80px; height: 20px;" type="text"/> gms</p> <input type="checkbox"/> unknown <p>20 GESTATIONAL AGE AT BIRTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> weeks</p> <input type="checkbox"/> unknown <p>32 IMMUNISATION OF NEWBORN AGAINST HEPATITIS B</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> unknown <p>35 STILLBIRTH</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Cause of death: _____ <p>36 BORN ALIVE BUT DEATH BEFORE DISCHARGE</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Cause of death: _____				
<input type="checkbox"/> Entered online	Date entered ___ / ___ /2005	Initials	<input type="checkbox"/> Entered online	Date entered ___ / ___ /2005	Initials