

<p>Patient Name <input style="width: 200px;" type="text"/></p> <p>Hospital Record Number <input style="width: 200px;" type="text"/></p> <p>1 DATE OF ADMISSION <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Unknown D D M M Y Y</p> <p>2 MOTHER'S DATE OF BIRTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3 PREVIOUS PREGNANCIES ≥22 WEEKS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>4 MOTHER'S WEIGHT <input style="width: 80px;" type="text"/> kgs at gestational age <input type="text"/> <input type="text"/> weeks <input type="checkbox"/> Unknown</p> <p>5 MOTHER'S HEIGHT <input style="width: 80px;" type="text"/> cms <input type="checkbox"/> Unknown</p>	<p>6 PRETERM PRELABOUR RUPTURE OF THE MEMBRANES <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, antibiotics given: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify drugs given: (tick ALL that apply) <input type="checkbox"/> amoxicillin / ampicillin <input type="checkbox"/> erythromycin <input type="checkbox"/> gentamycin <input type="checkbox"/> other, please specify _____</p> <p>7 BABY BREECH PRESENTATION >37 WEEKS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, ECV offered: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, ECV performed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>8 SHAVING OF THE PUBIC HAIR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>9 ENEMA USE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>10 LABOUR INDUCED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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11 SUPPORT DURING LABOUR - First Stage
Who provided support and how much time did they spend with the mother:

	all / most of the time	some / little of the time	none of the time	unknown
skilled birth attendant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
husband _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mother _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other family member _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stranger _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
friend _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
doula _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
childbirth educator _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUPPORT DURING LABOUR - Second Stage
Who provided support and how much time did they spend with the mother:

	all / most of the time	some / little of the time	none of the time	unknown
skilled birth attendant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
husband _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mother _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other family member _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stranger _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
friend _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
doula _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
childbirth educator _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>12 MODE OF BIRTH</p> <p><input type="checkbox"/> normal vaginal delivery <input type="checkbox"/> forceps</p> <p><input type="checkbox"/> vaginal breech <input type="checkbox"/> caesarean section</p> <p><input type="checkbox"/> vacuum extraction</p> <p>13 EPISIOTOMY PERFORMED</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>14 LEVEL OF PERINEAL TRAUMA</p> <p><input type="checkbox"/> None <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 4</p> <p><input type="checkbox"/> Level 1 <input type="checkbox"/> Level 3 <input type="checkbox"/> Unknown</p> <p>15 PERINEUM SUTURED</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, suture material used was: (tick ALL that apply)</p> <p><input type="checkbox"/> polyglycolic acid <input type="checkbox"/> plain or chromic catgut</p> <p><input type="checkbox"/> silk <input type="checkbox"/> other _____ <input type="checkbox"/> unknown</p> <p>Technique used for skin closure: (tick ALL that apply)</p> <p><input type="checkbox"/> continuous <input type="checkbox"/> interrupted <input type="checkbox"/> unknown</p> <p>16 IF CAESAREAN SECTION</p> <p>What was the main indication for caesarean: (tick ONE only)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> breech presentation</td> <td><input type="checkbox"/> CPD cephalopelvic disproportion</td> </tr> <tr> <td><input type="checkbox"/> fetal distress</td> <td><input type="checkbox"/> previous caesarean</td> </tr> <tr> <td><input type="checkbox"/> placenta praevia</td> <td><input type="checkbox"/> failed induction</td> </tr> <tr> <td><input type="checkbox"/> eclampsia / pre-eclampsia</td> <td><input type="checkbox"/> maternal request</td> </tr> <tr> <td><input type="checkbox"/> malpresentation (other than breech)</td> <td><input type="checkbox"/> multiple pregnancy</td> </tr> <tr> <td><input type="checkbox"/> placental abruption</td> <td><input type="checkbox"/> other _____</td> </tr> </table> <p>Were antibiotics given at caesarean:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, when were the antibiotics administered:</p> <p><input type="checkbox"/> before operation</p> <p><input type="checkbox"/> after cord clamped</p> <p><input type="checkbox"/> only post-operatively <input type="checkbox"/> unknown</p> <p>If antibiotics given, specify drugs: (tick ALL that apply)</p> <p><input type="checkbox"/> ampicillin <input type="checkbox"/> gentamycin</p> <p><input type="checkbox"/> cephalosporin <input type="checkbox"/> other _____</p> <p>Antibiotic dosage:</p> <p><input type="checkbox"/> single <input type="checkbox"/> multiple <input type="checkbox"/> unknown</p>	<input type="checkbox"/> breech presentation	<input type="checkbox"/> CPD cephalopelvic disproportion	<input type="checkbox"/> fetal distress	<input type="checkbox"/> previous caesarean	<input type="checkbox"/> placenta praevia	<input type="checkbox"/> failed induction	<input type="checkbox"/> eclampsia / pre-eclampsia	<input type="checkbox"/> maternal request	<input type="checkbox"/> malpresentation (other than breech)	<input type="checkbox"/> multiple pregnancy	<input type="checkbox"/> placental abruption	<input type="checkbox"/> other _____	<p>17 BABY RESUSCITATION</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, (tick ALL that apply)</p> <p><input type="checkbox"/> bag and mask <input type="checkbox"/> IPPV via ETT</p> <p><input type="checkbox"/> drugs given</p> <p>If bag and mask or IPPV via ETT, what type of gas was used:</p> <p><input type="checkbox"/> air alone <input type="checkbox"/> oxygen / air mix</p> <p><input type="checkbox"/> oxygen alone</p> <p>18 SKILLED RESUSCITATOR PRESENT AT BIRTH</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>19 1 minute APGAR score</p> <p><input style="width: 50px;" type="text"/> <input type="checkbox"/> Unknown</p> <p>20 5 minute APGAR score</p> <p><input style="width: 50px;" type="text"/> <input type="checkbox"/> Unknown</p> <p>21 BIRTHWEIGHT (grams)</p> <p><input style="width: 100px;" type="text"/> gms <input type="checkbox"/> Unknown</p> <p>22 GESTATIONAL AGE AT BIRTH</p> <p><input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (completed weeks) <input type="checkbox"/> Unknown</p> <p>If GA <37 weeks, please complete Preterm Form</p> <p>23 ESTIMATED MATERNAL BLOOD LOSS</p> <p><input style="width: 80px;" type="text"/> mls <input type="checkbox"/> unknown</p> <p>24 PROPHYLACTIC OXYTOCIC DRUG GIVEN FOR 3rd STAGE</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, when given:</p> <p><input type="checkbox"/> anterior shoulder <input type="checkbox"/> after placental delivery</p> <p><input type="checkbox"/> after birth <input type="checkbox"/> other _____</p> <p>Specify drug given:</p> <p><input type="checkbox"/> ergometrine <input type="checkbox"/> misoprostol</p> <p><input type="checkbox"/> oxytocin / syntocinon <input type="checkbox"/> syntometrine</p> <p><input type="checkbox"/> other _____</p> <p>25 CORD CLAMPING AND CUTTING</p> <p><input type="checkbox"/> early cord clamping <input type="checkbox"/> delayed cord clamping</p> <p><input type="checkbox"/> unknown</p> <p>26 CONTROLLED CORD TRACTION USED</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<input type="checkbox"/> breech presentation	<input type="checkbox"/> CPD cephalopelvic disproportion												
<input type="checkbox"/> fetal distress	<input type="checkbox"/> previous caesarean												
<input type="checkbox"/> placenta praevia	<input type="checkbox"/> failed induction												
<input type="checkbox"/> eclampsia / pre-eclampsia	<input type="checkbox"/> maternal request												
<input type="checkbox"/> malpresentation (other than breech)	<input type="checkbox"/> multiple pregnancy												
<input type="checkbox"/> placental abruption	<input type="checkbox"/> other _____												

27 POSTPARTUM PROPHYLACTIC UTERINE MASSAGE

(tick ALL that apply)

- before placental delivery after placental delivery
 no unknown

If massage was performed, was it:

- single massage repeated massage unknown

28 POSTPARTUM HAEMORRHAGE

- Yes No

If yes, were oxytocic drugs given for PPH:

- Yes No Unknown

If yes, specify drug(s): (tick ALL that apply)

- ergometrine misoprostol
 oxytocin / syntocinon syntometrine
 other _____

29 POSTPARTUM BLOOD TRANSFUSION GIVEN

- Yes No Unknown

30 DEVELOPED PRE-ECLAMPSIA

- Mild Severe No Unknown

If mild or severe, when first observed:

- antenatally in labour postpartum

31 GIVEN MAGNESIUM SULPHATE FOR PRE-ECLAMPSIA

- Yes No Unknown

If yes, when first administered:

- antenatally in labour postpartum

32 HAD AN ECLAMPTIC FIT

- Yes No Unknown

If yes, when first observed:

- antenatally in labour postpartum

33 GIVEN MAGNESIUM SULPHATE FOR ECLAMPSIA

- Yes No Unknown

If yes, when first administered:

- antenatally in labour postpartum

34 GIVEN ANTENATAL CORTICOSTEROIDS (ANC)

- Yes No Unknown

If yes, at GA: (most recent dose)

- Weeks

If given ANCs and GA \geq 37 weeks, please complete Preterm Form

35 IMMUNISATION OF NEWBORN AGAINST HEPATITIS B

- Yes No Unknown

36 OTHER MATERNAL POSTNATAL DETAILS

- Puerperal pyrexia (>38°C) Yes No Unknown

- Antibiotics postpartum Yes No Unknown

If yes, why prescribed: (tick ALL that apply)

- endometritis URTI
 puerperal infection chorioamnionitis
 wound infection perineal infection
 mastitis PPRM
 UTI prophylaxis
 unknown other _____

37 MATERNAL DEATH BEFORE DISCHARGE

- Yes No

Cause of death: _____

38 STILLBIRTH

- Yes No

Cause of death: _____

39 BORN ALIVE BUT DEATH BEFORE DISCHARGE

- Yes No

Cause of death: _____

If yes, how many days after birth did the baby die:

- Days Unknown

40 DATE OF MATERNAL DISCHARGE (OR DEATH)

- Unknown
D D M M Y Y

41 DATE OF DISCHARGE OF BABY FROM DELIVERY HOSPITAL

- Unknown
D D M M Y Y

- Not Applicable (if 'Yes' to Q39)

42 ETHNIC GROUP (Malaysia only)

- Malay Indian
 Chinese Orang Asli
 Other _____

<input type="checkbox"/> Entered online	Date entered ____/____/200__	Initials
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