



Government of South Australia

Department of Health

South Australian Perinatal Statistics Collection

GUIDELINES FOR THE SUPPLEMENTARY BIRTH RECORD

December 2006

Pregnancy Outcome Statistics Unit

Epidemiology Branch

Department of Health

Adelaide

December 2006

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Guidelines for the Supplementary Birth Record

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Pregnancy Outcome Unit

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INTRODUCTION

In 1980 the South Australian Health Commission established a Perinatal Statistics Unit for the specific purpose of collecting information on pregnancy outcome for South Australia. In the same year the National Perinatal Statistics Unit was set up by the Commonwealth Government to collate perinatal morbidity and mortality statistics throughout Australia. The South Australian Unit was renamed the Pregnancy Outcome (Statistics) Unit in 1986.

The South Australian perinatal statistics collection contains information on the pregnancy and outcome of all births occurring in this State. This information is reported by midwives and neonatal nurses on the Supplementary Birth Record under the provisions of the South Australian Health Commission (Pregnancy Outcome Statistics) Regulations 1999. Only coded information which will not identify the mother or her baby will be used to compile computerised data for statistical analysis.

The collection can be used to provide a Statewide picture of pregnancy characteristics and outcomes, obstetric problems and characteristics of perinatal care, as well as trends over time. It may also be used to provide regional or individual hospital profiles or profiles of groups of women eg Aboriginal women, or obstetric practice, eg Caesarean section. Risk factors for adverse outcome may be identified and monitoring of pregnancy outcomes may be undertaken. Perinatal data are sent to the National Perinatal Statistics Unit for national reporting.

Particular emphasis is given to the study of congenital abnormalities. Following the recording of identified congenital abnormalities by midwives, doctors provide detailed clinical information relating to these abnormalities on the special Congenital Abnormality Form. These congenital abnormality data are provided to the SA Birth Defects Register at the Women's and Children's Hospital, which also collects data on children with birth defects detected before the child's fifth birthday. This information is used to determine prevalence rates for congenital abnormalities in South Australia and may be used for studies into the causes and risk factors of congenital abnormalities, and for health planning. The data are also sent to the National Perinatal Statistics Unit to report national rates for birth defects.

These Guidelines provide information on the completion of the Supplementary Birth Record so that uniform criteria are used in the State in the provision of data.

THE FORMS

These guidelines are intended for use by midwives or neonatal nurses involved with the completion of the Supplementary Birth Records.

These should be submitted for every live birth and every stillbirth of at least 20 weeks gestation or 400g birthweight, including terminations of pregnancy for congenital abnormalities or medical reasons.

It is recommended that these guidelines be kept in an accessible place for quick reference. Additional copies are available from:

Pregnancy Outcome Unit
South Australian Department of Health
PO Box 6, Rundle Mall
ADELAIDE 5000

If you require any further information or assistance in completing the Supplementary Birth Records, please contact Joan Scott on 8226-6380 or Maureen Fisher on 8226-6382 at the above address.

Using the forms - general information

Note: As the forms have a carbon paper backing, they should **not** be placed on top of one another when they are being completed. (Otherwise, spurious marks will appear on the duplicate and triplicate copies and make them difficult to interpret).

When completing the forms:

1. Please **PRINT** clearly.
2. Please **DO NOT** write in the **PINK** coding boxes. These are to be completed by Pregnancy Outcome Unit coding staff.
3. Place the appropriate code in the **WHITE** coding boxes, or the appropriate response in the white boxes. If 'Other', specify in the white spaces provided.
4. All questions must have a response. If information is not applicable, indicate with 'N'. If information is unknown indicate with 'U'.
5. Unknown dates, time or number of pregnancy outcomes should be indicated with a 'U'.

Supplementary Birth Record Form

The **Supplementary Birth Record Form** currently in use consists of one (1) page only for mother and baby. The forms are in triplicate:

- **The original** (pink) copy, which is to be returned to the Pregnancy Outcome Unit on Mother's and/or Baby's discharge or transfer from the hospital of birth.
- **The duplicate** (green) copy should be retained in your own hospital records.
- **The triplicate** (yellow) copy is to be used if baby and/or mother are transferred/retrieved to another hospital.

Additional Baby Form

The **Additional Baby Form** is a separate green colour coded form. It is supplied specifically for:

1. **Multiple births** - in the case of multiple births, eg twins, a separate form is required for each baby and therefore **one additional baby** form should be completed for twin 2 - twin 1 details having been completed on the **pink** supplementary birth record. Please transcribe the serial number from the Supplementary Birth Record (located in the right hand corner) into the space provided in the lower right hand corner of the Additional Baby Forms.
2. **Babies intended for adoption**
(Some hospitals, for example, Women's and Children's Hospital, use the Additional Baby Form for transfer/retrieval of baby without the accompanying triplicate (yellow) copy of the Supplementary Birth Record from the Hospital of Birth).

Number of copies

The forms are in triplicate:

- The **original** (green) form is to be returned to the Pregnancy Outcome Unit on the baby's discharge or death.
- The **duplicate** (green) copy should be retained in your own hospital records.
- The **triplicate** (yellow) copy is to be used if baby is transferred/retrieved to another hospital.

Disposal of forms

- (1) **Mother and baby (or babies) are discharged home together:** then the completed original pink form is forwarded to:-

Pregnancy Outcome Unit
South Australian Department of Health
PO Box 6, Rundle Mall
ADELAIDE 5000

- (2) **Mother is discharged only:** please return the original **pink** copy to the Pregnancy Outcome Unit on mother's discharge, and retain the **green** (duplicate) and **yellow** (triplicate) Supplementary Birth Record Forms.

On baby's discharge or death, forward the completed **yellow** (triplicate) copy to the Pregnancy Outcome Unit at the above address. If a baby requires hospitalisation for 28 days or more, please record the actual number of days in each level of care until discharge.

- (3) **Mother and baby transferred/retrieved to another hospital**

Because of the increasing number of transfers between hospitals, the **pink** copy of the Supplementary Birth Record should be sent directly to the Pregnancy Outcome Unit on transfer - with an indication in Question 34 for Mother and Question 17 for baby as to where the mother and/or baby are being transferred, and the date of transfer filled in the coding boxes as per example:

0	7	0	1	0	7
day		month		year	

The **green** copy of the Supplementary Birth Record should be retained in the patient's notes and the **yellow** copy sent with the mother and baby to the receiving hospital for their records.

Staff from the Pregnancy Outcome Unit will then contact the receiving hospital for final discharge dates and outcomes.

- (4) **Baby only is transferred/retrieved to another hospital:** please retain the pink (original) copy with mother and green (duplicate) copy, and forward the yellow (triplicate) copy with the baby and return it to the Pregnancy Outcome Unit on discharge, or death of the baby.

The pink (original) copy is forwarded to the Pregnancy Outcome Unit on discharge of Mother.

- (5) **Transfers to the Women's and Children's Hospital (W&CH):** the pink copy of the Supplementary Birth Record should be sent directly to the Pregnancy Outcome Unit with an indication that the mother/and/or baby were transferred to the **Women's and Children's Hospital**. Pregnancy Outcome Unit staff will then follow the outcome of this baby and/or mother at the W&CH.

COMPLETING THE SUPPLEMENTARY BIRTH RECORD

NB This Information is for initial identification and will not be included in the computer record used for statistical analysis.

Top Section

1. MOTHER'S NAME

Please **PRINT CLEARLY** the surname first and then mother's given names.

If mother and baby have different surnames (eg if baby has been given a surname other than that of mother), please indicate in the space provided.

2. MOTHER'S ADDRESS

State the full address of the usual residence of the mother. If the mother has been staying in Adelaide during her pregnancy but normally resides in the country, interstate or overseas, then this address should be given. If the usual address is interstate, please include full address. If the usual address is overseas, then only give the country (eg Germany, not Europe; USA not America; Uganda not Africa).

Postcode: record appropriate code in space provided.

3. HOSPITAL/PLACE OF BIRTH

Please **PRINT** the name of the hospital or address for homebirth.

4. MOTHER'S CASE RECORD NUMBER

Please **PRINT** the mother's case record number.

If the hospital does not use case record numbers please indicate with 'N' = not applicable.

5. PLURALITY

In order to identify multiple births, please indicate in the box provided by placing a 1,2,3,4 etc to indicate if a single, twin, triplet or quadruplet pregnancy.

For multiple births an Additional Baby Form should be completed for baby 2, 3 etc. Each form must have the same serial number as the Supplementary Birth Record recorded in the space provided on the bottom right hand corner.

Mother's Information

Coding will commence in this part of the form.

1. MOTHER'S DATE OF BIRTH

Record day, month and year, using all boxes - for example, 3 April 1977 record:

0	3	0	4	7	7
day		month		year	

If Date of Birth is unknown, please fill last box with 'U'.

Caution: Do NOT record baby's date of birth or the mother's admission date here.

2. MOTHER'S RACE

This information should be available from the hospital admission form. Place appropriate code 1-6 into single white coding box.

1. **Caucasian:** white skinned 'European'.
2. **Aboriginal:** this includes part-Aboriginals as well as full blood Aboriginals. An Aboriginal is a person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives.
3. **Asian:** (exclude Asia Minor) - In this category, include women originating from all Asian countries, including the Indian subcontinent (India, Bangladesh, Pakistan, Nepal, Sri Lanka).
4. **Torres Strait Islander (TSI):** A Torres Strait Islander is a person of Torres Strait Islander descent who identifies as a Torres Strait Islander and is accepted as such by the community in which he or she lives.
5. **Aboriginal & TSI:** persons of both Aboriginal **and** Torres Strait Islander descent.
6. **Other:** Races other than (1) - (5). Include women from the Middle East and Africa.

Guidelines for use regarding Indigenous status - categories (2), (4) and (5).

There are three components to the definition:

- o descent
- o self identification
- o community acceptance

It is not possible to collect the three components of the definition in a single question. The Australian Bureau of Statistics (ABS) proposes that the focus of a single question should be the descent, the first component of the definition.

The ABS therefore proposes the use of the following alternative questions, depending on whether the person is present or not.

Where the person is present

"Are you of Aboriginal or Torres Strait Islander origin?"

OR where the person is not present and someone who knows the person well responds for him/her

"Is the person of Aboriginal or Torres Strait Islander origin?"

If the response is “Yes”, then clarify whether the person is of Aboriginal origin (2), Torres Strait Islander origin (4) or both Aboriginal **and** Torres Strait Islander origin (5).

Self-reporting of descent is not equivalent to self-reporting of identity, but because of the absence of a second ‘identity’ question some respondents will interpret the ‘origin’ question to mean both descent and identification. What identification in the context of the variable Indigenous Status should measure is an individual’s self assessed historical and cultural affiliation.

3. COUNTRY OF BIRTH

Please write the country the woman was born in eg England, Australia, Vietnam, Poland etc in the space provided. This information should be available from the hospital admission form. If this is not known please write '**Unknown**'.

4. TYPE OF PATIENT

There are two categories here to identify the type of patient. They are:

1. Hospital/Public patient
2. Private patient

Please place a **1 or 2** in the coding box provided.

5. MARITAL STATUS

Place appropriate code into the single white coding box.

1. **Never married**
2. **Married/De facto** - living presently in the same residence as partner.
3. **Widowed** - husband deceased and patient not remarried.
4. **Divorced** - previously married, but now marriage legally dissolved.
5. **Separated** - presently married, but living apart from husband.

6. OCCUPATION

Baby's father

- (a) Describe the occupation of the baby’s father as accurately as possible for example, 'Accounts clerk' rather than simply 'Clerk', 'Farm labourer', 'Builder's labourer', rather than simply 'Labourer'. In the case of armed forces personnel please indicate specific occupation. Individuals employed in the Army, Navy or Air force may range in occupation from driver to engineer to medical officer.

NOTE: If it is well known that the father has been exposed to any potential teratogens, please define agent as accurately as possible.

- (b) If main income is derived from unemployment benefit or other social security support whilst unemployed, write '**Unemployed**'.
- (c) If the father is a pensioner, identify type, for example, ‘invalid pensioner’, and any occupation prior to receipt of invalid pension.
- (d) If the father is unknown, please indicate '**N**' = **Not applicable**.
- (e) If occupation unknown, please indicate '**U**' = **Unknown**.

Baby's mother

Indicate any occupation prior to and/or during pregnancy before 'home duties'.

If a student, please indicate what type - for example, University, School, Trade School etc.

If mother has never been employed or involved in a self-employment occupation please indicate.

Previous Pregnancy Outcomes

7. NUMBER OF PREVIOUS PREGNANCIES

Please fill in the coding boxes with the number of previous pregnancies.

For example, if the mother had two previous pregnancies

0	2
---	---

8. NUMBER OF PREVIOUS PREGNANCIES RESULTING IN BIRTHS \geq 20 WEEKS (PARITY)

This question will ascertain the mother's parity. This will exclude pregnancies resulting only in ectopic pregnancies, miscarriages and terminations of pregnancy before 20 weeks gestation and include pregnancies resulting in livebirths (and neonatal deaths) and stillbirths.

Please fill in the coding boxes, for example

0	3
---	---

if the mother has had 3 previous pregnancies resulting in births.

9. NUMBER OF PREVIOUS OUTCOMES

The intention of this question is to ascertain the number of previous specific outcomes separately for singleton and multiple pregnancies.

Different coding boxes have been provided for livebirths which survived the neonatal period, and live births which were neonatal deaths (deaths within the first 28 days of life).

Identify number of pregnancy outcomes as follows:

- (a) **Livebirths** - this refers to any baby, irrespective of the duration of pregnancy, which after complete expulsion or extraction from its mother, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.
- (b) **Stillbirths** - this refers to any stillborn baby or late fetal death of 20 weeks gestation or 400g birthweight or more born to this mother.
- (c) **Miscarriages** - this is a spontaneous early fetal death of less than 20 weeks gestation or less than 400g birthweight.
- (d) **Ectopic pregnancy** - fertilised ovum implanted outside the uterus, usually in the fallopian tubes.
- (e) **Terminations of pregnancy** - induced abortions.

Record for each category (singleton and multiple) the number of:

- livebirths which were not neonatal deaths (i.e. deaths within the first 28 days of life)
- livebirths which were neonatal deaths
- stillbirths
- miscarriages
- ectopic pregnancies
- terminations of pregnancy

In most cases, there would have been only singleton pregnancies, therefore record **0** in each box in the column for multiple pregnancies.

- 1 Please note that as from 1998 Miscarriages and Ectopic pregnancies are separate fields, and neonatal deaths have been included into a separate livebirth category.
- 2 If there was none of a specified outcome, eg stillbirth, then fill coding boxes with **00**.
- 3 If **no** previous pregnancies, enter **00** in all white coding boxes for 'singleton' and **0** in all white coding boxes for 'multiple'.

10. OUTCOME OF LAST PREGNANCY

Please specify here whether the last pregnancy outcome was a livebirth, stillbirth, miscarriage etc. If this was a multiple pregnancy, please state outcomes for all babies. This will be coded by Pregnancy Outcome Unit staff as follows:

1 = Single livebirth/survived at least 28 days

2 = Single livebirth/neonatal death (within 28 days)

3 = Single stillbirth

4 = Spontaneous abortion/miscarriage

5 = Induced abortion

6 = Ectopic pregnancy

7 = Multiple livebirth/all survived at least 28 days

8 = Multiple birth/one or more neonatal deaths (within 28 days) or stillbirths

In the case of multiple pregnancy with fetal loss before 20 weeks, the outcome of surviving fetus(es) beyond 20 weeks will be coded.

11. DATE OF DELIVERY/TERMINATION OF LAST PREGNANCY

Please indicate in the coding boxes provided, the month and year.

0	7	2	0	0	4
month		year			

12. METHOD OF DELIVERY IN LAST BIRTH

If there was no previous birth (≥ 20 weeks gestation) please write in the white coding box.

If there was a previous birth, write:

for vaginal delivery

for caesarean delivery and

if method of delivery was not known

13. NUMBER OF PREVIOUS CAESAREANS

In the white coding box:

- if there were no previous Caesarean deliveries write
- if there were previous Caesarean deliveries write the number, for example, for two previous Caesarean deliveries write

This question and the one preceding are used to assist in providing obstetric clinical indicator data.

This Pregnancy

14. DATE OF LAST MENSTRUAL PERIOD

Give the day, month and year (for example, 3/6/2006) of first day of last normal menstrual period.

If the exact date is not known, then give the month and year, and record the day with '00', for example:

0	0	0	6	2	0	0	6
day		month		year			

If date is unknown, please code 'U' in last coding box.

15. INTENDED PLACE OF BIRTH

Please code directly into the white coding box.

1. Hospital
2. Birth centre
3. Home
4. Other (Specify)
5. Not booked

16a. NUMBER OF ANTENATAL VISITS

This information may be obtained from the Pregnancy Record or the case notes of the patient. If there is no Pregnancy Record, provide an estimated number of attendances by asking the patient. This question is designed to assess the amount of antenatal care. Write number of attendances in white coding boxes.

If a single digit, for example, 7 attendances then prefix with 0

0	7
---	---

If the number of antenatal visits is unknown, please indicate with a 'U' in the right hand coding box, for example,

	U
--	---

16b. FIRST ANTENATAL VISIT

These new items were introduced in 2007.

This information may be obtained from the woman's Pregnancy Record and is being collected to monitor the prevalence of obesity in our population and its association with outcomes of pregnancy.

This information is related to the gestation of the pregnancy. Enter the woman's recorded weight in kilograms, and height in cms at the first antenatal visit.

The computer will calculate BMI (Body Mass index) if we have the weight and height measurements. The BMI may be entered if known.

If unknown, please indicate with a 'U' in the right hand coding box, for example,

	U
--	---

Please fill in the white coding boxes, for example:

Gestation (weeks)	<table border="1"><tr><td>0</td><td>9</td></tr></table>	0	9	
0	9			
Height (cm)	<table border="1"><tr><td>1</td><td>5</td><td>8</td></tr></table>	1	5	8
1	5	8		
Weight (kg)	<table border="1"><tr><td></td><td>7</td><td>9</td></tr></table>		7	9
	7	9		
BMI	<table border="1"><tr><td></td><td>U</td></tr></table>		U	
	U			

17. TYPE OF ANTENATAL CARE

1. ☐ No antenatal care
2. ☐ Hospital clinic
3. ☐ Obstetrician in private practice
4. ☐ General practitioner
5. ☐ Birth centre
6. ☐ Home birth midwife
7. ☐ Obstetrician/midwife (shared care) in private practice
8. ☐ GP/midwife (shared care)
9. ☐ Other (specify) eg NWCHC
10. ☐ Not stated

Please use the tick boxes to indicate the type of antenatal care the woman received. Please indicate if more than one type of care was received, for example, GP and Obstetrician.

18. TOBACCO SMOKING STATUS AT FIRST VISIT

This question ascertains a woman's tobacco smoking status at her first antenatal visit and has been included because of the possible effects of smoking on the fetus and pregnancy. Code directly into the white coding box.

1. Smoker
2. Quit in pregnancy before first visit
3. Non smoker
4. Unknown smoking status

19. AVERAGE NO OF TOBACCO CIGARETTES SMOKED PER DAY IN 2ND HALF OF PREGNANCY

For the woman's smoking status in the 2nd half of her pregnancy, ie after 20 weeks gestation, please tick the appropriate box on the left for the number of cigarettes smoked per day. If this is at least one per day please insert the number in the space provided after No. per day.

- ☐ None
- ☐ No. per day =.....
- ☐ <1 (occasional)
- ☐ Unknown no.

20. MEDICAL CONDITIONS PRESENT IN THIS PREGNANCY

This question applies to medical conditions PRESENT IN THIS PREGNANCY only.

For example, for asthma, only tick the appropriate box if the woman was on medication to prevent or treat asthma or had symptoms of asthma during this pregnancy. Do not tick the box if she had an episode/episodes of asthma only in childhood or before she became pregnant this time.

Tick box number **1 = None** if no condition was present. If any conditions listed as 2-7 occurred, tick the appropriate box. If a condition other than those listed occurred, tick box **8 = Other** and specify this condition.

1. ☐ None
2. ☐ Anaemia (Hb<10gms per 100ml)
3. ☐ Urinary tract infection (confirmed by bacteriological culture of urine - specify organism isolated)
4. ☐ Hypertension (pre-existing)
5. ☐ Diabetes (pre-existing)
6. ☐ Epilepsy
7. ☐ Asthma
8. ☐ Other (specify)

Please specify in '**Other**' if any of the following conditions occur:

bronchitis	lupus erythematosus
cancer (specify type)	rheumatic fever
cardiac disease (specify type)	thyroid disease (specify type)
chronic renal disease	tuberculosis
Crohn's disease	ulcerative colitis
hepatitis (specify type)	

If in doubt whether to include a condition please do so and it can be decided by Pregnancy Outcome Unit staff if it meets the criteria for inclusion.

21. OBSTETRIC COMPLICATIONS

If no obstetric complications have been experienced by mother **during this pregnancy** please indicate 1 = None in appropriate small box.

If mother has had obstetric complication(s), then indicate in appropriate box or boxes. If complication is not listed, then record under 'Other' and specify in the white space provided. APH = bleeding at 20 weeks or later in pregnancy.

The tick boxes are:

1. ☐ None
2. ☐ Threatened miscarriage - bleeding before 20 weeks gestation.
3. ☐ APH - Abruption.
4. ☐ APH - Placenta praevia. (If placenta praevia without bleeding, include only under 9 Other - specify placenta praevia)
5. ☐ APH - other & unknown cause
6. ☐ Pregnancy hypertension (all types).

Blood Pressure $\geq 140/90$ on two occasions at least four hours apart, or $\geq 170/110$ on one occasion:

±Proteinuria

±Generalised oedema

This specifically **excludes** essential hypertension or other categories of pre-existing hypertension occurring **alone** but include if there was superimposed pre-eclampsia.

Proteinuria: A trace of protein occurring once would best be ignored from the point of view of these statistics. Include if $\geq 1+$ or $\geq 0.3\text{g}/24$ hours.

Eclampsia: Should be separately identified under '**Other**' as a specified complication.

Indicate when convulsions occurred, eg antenatal, intrapartum.

7. ☐ Suspected Intrauterine Growth Restriction (IUGR)
8. ☐ Gestational diabetes

There is still no universal agreement on the criteria for gestational diabetes and impaired glucose tolerance. **Place a tick in the box for gestational diabetes if the clinician has documented that this woman has gestational diabetes based on the criteria of the hospital or laboratory where the test was performed.** (The criteria currently used by the Australasian Diabetes in Pregnancy Society (ADIPS) and the World Health Organisation (WHO) for the 75g oral glucose tolerance test are as follows:

	<i>ADIPS</i>	<i>WHO</i>
Gestational diabetes		
Fasting Result:	≥5.5 mmols/l	≥7.8 mmols/l
or 2 hour Result:	≥8.0 mmols/l	≥11.1 mmols/l
Impaired glucose tolerance		
Fasting Result:		5.2 - 7.7 mmols/l
or 2 hour Result:		7.8 - 11.0 mmols/l

9. ☐ Other (specify, including impaired glucose tolerance in the space provided).

In the absence of universal agreement on the criteria for impaired glucose tolerance, **include this as a specific complication if the clinician has documented that this woman has impaired glucose tolerance or glucose intolerance of pregnancy, based on the hospital/laboratory report.**

If mother has one of the following complications please include under 'Other' and specify:

- **Maternal isoimmunisation** - incompatibility between mother's and baby's blood group, eg Rh, ABO, or Kell antibodies.
- **Hyperemesis gravidarum** - severe vomiting requiring special medical care.
- **Polyhydramnios** - liquor in excess of 2 litres. May be associated with fetal anomalies or maternal diabetes.
- **Oligohydramnios** - scanty liquor may be associated with a congenital abnormality (eg renal agenesis) or postural deformation (eg talipes) or intrauterine growth restriction.
- **Prelabour rupture of membranes** - Spontaneous rupture of membranes for more than 24 hours before onset of labour.
- **Preterm labour** - Spontaneous onset of labour before 37 weeks gestation.
- **Cervical incompetence** - requiring suture.

22. DATE OF ADMISSION PRIOR TO DELIVERY

This is the admission date closest to the woman delivering her baby. Enter day, month, year, for example:

0	1	0	1	0	7
day		month		year	

23. PROCEDURES PERFORMED IN THIS PREGNANCY

This question will require only a tick(s) in the small box(es) provided. There are two tick boxes for each procedure : tick in the 'Yes' box if the test was undertaken, or tick in the Unknown box if you do not know whether the test was undertaken. Do not tick in either box if you are sure the test was **not** undertaken. Tick the Yes box for both 1 and 2 if the mother had MSAFP for NTD screening and a Triple/Quadruple screen.

Tick if Yes		Tick if Unknown
1.	<input type="checkbox"/> MSAFP (Maternal serum alpha-fetoprotein).	<input type="checkbox"/>
2.	<input type="checkbox"/> Triple/Quadruple screen (Down's etc)	<input type="checkbox"/>
3.	<input type="checkbox"/> Ultrasound examination	<input type="checkbox"/>
4.	<input type="checkbox"/> Chorion villus sampling	<input type="checkbox"/>
5.	<input type="checkbox"/> Amniocentesis	<input type="checkbox"/>
6.	<input type="checkbox"/> Cordocentesis	<input type="checkbox"/>
7.	<input type="checkbox"/> Other surgical procedure (specify). Please indicate this in the space provided eg appendicectomy	

24. ONSET OF LABOUR

Insert appropriate code directly into single white coding box:

1. Spontaneous
2. No labour (LSCS)
3. Induction (excluding augmentation)

If induction occurred, please specify in the space provided **the reason/s for the induction**, for example, postmaturity (41 completed weeks) or hypertension. If induction was for postmaturity/postdates, please specify length of gestation, i.e. Term (T) +..... days.

25. IF INDUCTION, OR AUGMENTATION AFTER SPONTANEOUS ONSET, SPECIFY METHOD/S

Please indicate in the appropriate box/es the method or methods used.

1. ☐ ARM
2. ☐ Oxytocics
3. ☐ Prostaglandins
4. ☐ Other (*specify*)

26. PRESENTATION PRIOR TO DELIVERY

Please indicate the presentation prior to delivery by placing the appropriate code into the single white coding box.

1. **Vertex** ie - the occiput is the point of reference.
2. **Breech** ie - flexed breech
 extended breech
 footling breech
3. **Face**
4. **Brow**
5. **Other** for any of the following malpresentations:
 cord
 shoulder
 transverse lie etc
6. **Unknown** for any delivery where the presentation was not known.

27. METHOD OF DELIVERY

Code the appropriate number indicating method of delivery into the double white coding box.

Please right align if using a single digit to denote the type of delivery,

for example,

0	1
---	---

1. Normal spontaneous
2. Forceps
3. Assisted breech (no forceps)
4. LSCS (elective)
5. LSCS (emergency)
 If LSCS **state reason/s**. Please specify in the space provided the primary reason for the LSCS with any secondary reasons.
6. Ventouse
7. Breech extraction
8. Breech spontaneous
9. Unknown
10. Assisted breech (with forceps for head)

Where an emergency LSCS followed a failed forceps, please code '5' for emergency LSCS, that is, indicate the final method of delivery.

This would also be the case for a ventouse followed by the application of forceps - this would be coded as a '2' for forceps delivery.

If an assisted breech delivery utilised forceps for the after coming head, code as assisted breech (with forceps for head) ('10').

Assisted breech - Maternal effort with assistance being given for the delivery of the shoulders and head. (This has been categorised in 2007 into births with or without forceps for the after coming head as required for national data.)

Breech extraction - an operative delivery under anaesthesia.

Breech spontaneous - No assistance given.

Elective caesarean section: - one which takes place as a planned procedure before the spontaneous onset of labour.

Emergency caesarean section: one which is undertaken for a complication:

- (a) before the onset of labour.
- (b) during labour, whether that labour is of spontaneous onset or follows induction of labour.

28. COMPLICATIONS OF LABOUR, DELIVERY AND PUERPERIUM

Refers to **this pregnancy only**. The puerperium for the statistical collection refers to the postnatal period up to date of maternal discharge.

If mother did not experience any difficulty with labour, delivery or puerperium then place a tick in the **1 = None** box.

- 1. ☐ **None**
- 2. ☐ **PPH (Primary)** - a blood loss of 600 mls or more. Please note this option is only for primary postpartum haemorrhage occurring within 24 hours of birth. If the woman has a secondary postpartum haemorrhage, specify under '**Other**'.
Please tick the appropriate box as to the estimated blood loss.
 - ☐ 600-999 mls
 - ☐ 1000 ml or more. This new tick box was introduced in 2007 to identify significant blood loss which is a Core Maternity Indicator.
- 3. ☐ **Fetal distress** - Definition will be influenced by availability of monitoring facilities. **Tick if clinician has documented that there was fetal distress.**
Some indications of fetal distress:
 - Bradycardia - heart rate <120 beats / min
 - Tachycardia - heart rate >160 beats / min
 - Irregular heart rate
 - Meconium stained liquor
 - Fetal scalp pH of <7.25
- 4. ☐ **Retained placenta** - a third stage lasting more than 30 minutes.
- 5. ☐ **Prolonged labour** - a labour exceeding 18 hours.
- 6. ☐ **Cord prolapse.**
- 7. ☐ **Wound infection** of Caesarean or episiotomy wound or vaginal or perineal tear.
- 8. ☐ **Failure to progress** (specify). Please include **when clinician has documented that there was 'failure to progress'** and specify underlying cause, for example, **cephalopelvic disproportion, uterine inertia, persistent occipitoposterior position.**
- 9. ☐ **Other** - if mother has one of the following complications, please include under '**Other**' and specify.

Pre-eclamptic toxemia (PET)

This is best described as hypertension of pregnancy, with either proteinuria or oedema, or both.

Blood Pressure $\geq 140/90$ on two occasions at least four hours apart, or $\geq 170/110$ on one occasion.

±Proteinuria

±Generalised oedema

This specifically excludes essential hypertension or other categories of pre-existing hypertension occurring **alone**.

Proteinuria: A trace of protein occurring once would best be ignored from the point of view of these statistics. Include if $\geq 1+$ or $\geq 0.3\text{g}/24$ hours.

Identify **eclampsia** separately under '**Other**' as a specified complication. Indicate when convulsions occurred eg intrapartum, postpartum.

Hypertension occurring for the first time during labour: This is difficult to define because of the normal increase in systolic and diastolic blood pressure during labour. Define as above, but levels should be persistently elevated and sufficient to cause concern and perhaps treatment.

- **Complicated or difficult delivery:** 'complicated' means that to effect vaginal delivery some manipulation has been required by the accoucheur. This does not include an assisted breech delivery which is NOT a complicated delivery. A difficult delivery implies some relative disproportion, strong traction with forceps, or difficult manipulation, eg breech with extended head.
- **Urinary tract infection** - confirmed by bacteriological culture of urine.
- **Genital tract infection** - confirmed by bacteriological culture of vaginal or uterine swabs.
- **Breast infection/Mastitis** - reddened tender segment(s) of breast with an associated pyrexia or confirmed by bacteriological culture of expressed milk.
(DO NOT include a simple cracked nipple or engorged breasts).
- **Venous thrombosis** -specify whether superficial thrombophlebitis or deep venous thrombosis.
- **Secondary PPH** - due to retained portion of placenta or membranes or associated with a postpartum endometritis.
- **Puerperal psychosis** - This does not include postpartum 'blues' - but a major psychiatric disorder.
- **Postpartum pyrexia** - temperature exceeding 38°C in any 2 hour period excluding the first 24 hours after delivery.
- **Pulmonary embolism**
- **Post-anaesthetic complications** eg Pneumonia, dural tap.
- **Vulval haematoma** - treated by exploration/resuture of perineum, etc.
- **Wound or perineal breakdown requiring resuturing.**

29. PERINEAL STATUS AFTER DELIVERY

Please tick

1. ☐ Intact
2. ☐ 1st degree tear/vaginal graze
3. ☐ 2nd degree tear
4. ☐ 3rd degree tear (tear through to anal sphincter)
5. ☐ 4th degree tear (complete tear through the anal sphincter into rectum)
6. ☐ Repair of tear
7. ☐ Episiotomy
8. ☐ Other (*specify*).....
9. ☐ Not stated

Please tick the appropriate tick boxes. If there was a tear and repair of tear as well as an episiotomy, please tick all three relevant boxes.

30. CTG PERFORMED DURING LABOUR

1. None 2. External 3. Scalp clip

Please indicate in the white coding box the appropriate number.

If unknown please indicate with U

If both External and Scalp clip are performed please code 3

31. FETAL SCALP pH TAKEN DURING LABOUR

1. No
2. Yes

Please indicate in the white coding box the appropriate number.

If unknown please indicate by a U

32. ANALGESIA FOR LABOUR

Please indicate by ticking the small coding box provided the type of analgesia used. If no analgesia was used please tick No **1 = None**.

1. ☐ None
2. ☐ Nitrous oxide and oxygen
3. ☐ Narcotic (parenteral)
4. ☐ Epidural (lumbar/caudal)
5. ☐ Spinal
6. ☐ Other (specify). This may include acupuncture or TENS (Transcutaneous electric nerve stimulation)
7. ☐ Combined spinal - epidural

33. ANAESTHESIA FOR DELIVERY

Please indicate by ticking the small coding box provided the type of anaesthesia used. If no anaesthesia was used please tick No 1 = **None**.

1. ☐ None
2. ☐ Local anaesthesia to perineum
3. ☐ Pudendal
4. ☐ Epidural (lumbar/caudal)
5. ☐ Spinal
6. ☐ General anaesthesia
7. ☐ Other (specify). Please indicate here if any other anaesthesia was used.
8. ☐ Combined spinal - epidural

(Do not include a GA given for manual removal of the placenta after delivery).

‘Combined spinal – epidural’ has been included as a new category for Analgesia and Anaesthesia as required for national data.

34. MOTHER’S OUTCOME FOR BIRTH HOSPITAL/HOMEBIRTH

1. ☐ Discharged
2. ☐ Transferred
3. ☐ Died

Please indicate in the appropriate tick box if the mother was transferred, and indicate where transferred to in the space provided. In the white coding boxes please indicate the date of transfer, for example:

0	4	0	1	0	7
day		month		year	

35. MOTHER'S FINAL DISCHARGE/DEATH

To be completed with the woman’s final discharge date from birth hospital, or hospital to which transferred for care, for example:

0	8	0	1	0	7
day		month		year	

Baby Details

1. CASE RECORD NUMBER

Record the hospital case record number used by your hospital to identify this baby. If your hospital does not use case record number, then please indicate with 'N' = **not applicable**.

2. PLACE OF BIRTH

This could be in any of the locations listed below, so please insert appropriate code directly into single white coding box.

1. **Hospital**
2. **BBA - Born Before Arrival** (ie during transit to hospital).
3. **Domiciliary** - A planned home delivery.
4. **Birthing unit/centre.** This would only be appropriate for the hospitals that have recognised Birthing Units, for example, the Lyell McEwin Hospital, the W&CH and FMC.

3. DATE OF DELIVERY

Record day, month and year of birth directly into white coding boxes, for example:

0	1	0	1	0	7
day		month		year	

4. HOUR OF BIRTH

Record the time of birth according to the 24 hour clock.

For example if **4.30pm**, then record as **1630** or if **4.05am** record as

0	4	0	5
---	---	---	---

If hour of birth is unknown then indicate with a 'U' in the last white coding box.

5. SEX

Record appropriate code **1** - male, **2** - female, **3** - indeterminate directly into single white coding box.

6. BIRTHWEIGHT

Please record the weight in grams directly into white coding boxes. A baby may not be weighed, for example, some home births or a baby born before arrival (BBA) - so please give an estimated weight, preceded by **est.**

If the baby weighs less than **1000** grams please prefix with a '0', for example

750 grams =

0	7	5	0
---	---	---	---

If birth weight is **unknown**, code 'U' into the last coding box.

7. GESTATION AT BIRTH (best clinical estimate in weeks)

Insert number of weeks into the white coding boxes. The gestation at birth may be determined from the date of the first day of the last menstrual period where dates are considered to be reliable, and supported by early (up to 20 weeks) ultrasound assessment of gestational age. The clinical examination of the baby after birth by the clinician will support these or may be used in their absence or where there is uncertainty. In premature babies up to 34 weeks, an assessment of lens vascular maturity may be used.

If gestation **unknown**, code 'U'.

8. APGAR SCORE

Record as accurately as possible as this is the main indicator of the level of neonatal well being. This is a numerical scoring system applied after birth (usually at 1 minute and again at 5 minutes) to evaluate the condition of the baby, as specified below:

SIGN	SCORE		
	0	1	2
Heart rate	Absent	Slow (below 100 per minute)	100 or more per minute
Respiratory effort	Absent	Slow, irregular	Good, crying
Muscle tone	Flaccid	Some flexion of extremities	Active motion
Reflex irritability	No response	Grimace	Vigorous cry
Colour	Blue, pale	Body pink, extremities blue	Completely pink

Both the 1 minute and 5 minute scores should be recorded directly into white coding boxes with a 2 digit number, so single digits are to be prefixed with a 0.

For example:

At 1 minute if the Apgar score was 9 at 1 minute

At 5 minute if the Apgar score was 10 at 5 minutes

If there is **no** Apgar score (ie Stillborn), should be recorded

If Apgar score is **unknown**, code in last white coding box

9. TIME TO ESTABLISH REGULAR BREATHING

Indicate (to the nearest minute) the length of time baby takes to establish regular, spontaneous breathing.

Prefix single digit with 0, for example, 2 minutes = directly into white coding boxes.

10. RESUSCITATION AT DELIVERY

More fields have been included to more accurately ascertain the types of resuscitation used for babies.

Place a tick in the appropriate tick box(es). If 'Other' resuscitation used, please specify in white space provided.

1. ☐ None
2. ☐ Aspiration
3. ☐ O₂
4. ☐ IPPV - bag & mask
5. ☐ IPPV - intubation
6. ☐ Narcotic antagonist
7. ☐ Sodium bicarbonate
8. ☐ Ext. cardiac massage
9. ☐ Other (specify)

11. CONDITION OCCURRING DURING BIRTH

If the following conditions occur they should be indicated by ticking the appropriate small white box(es).

1. ☐ **None**
2. ☐ **Fracture**
3. ☐ **Dislocation**, for example, dislocation of shoulder (excludes dislocation of hips which is regarded as a congenital abnormality).
4. ☐ **Nerve Injury** - Erb's palsy, Facial palsy.
5. ☐ **Other** includes soft tissue injury such as:
 - Severe bruising of scalp
 - Cephalhaematoma
 - Other haematoma - testes, vulva
 - Lacerations, eg scalp wound
 - Eye damage

12. CONGENITAL ABNORMALITIES

If **Nil apparent** please indicate in appropriate small white box.

If **Yes** please indicate in appropriate small white box and specify all abnormalities, in order of severity, if possible.

Please refer to:

Appendix A: - for examples of anomalies or malformations.

Appendix B: - exclusion list for isolated minor abnormalities.

If a congenital abnormality is identified in this question, please ensure the medical officer responsible for care completes a Congenital Abnormality Form (Appendix E).

13. TREATMENT GIVEN

Tick box **1** if none of the treatment listed in **2 - 5** was given.

Please tick the appropriate small box(es) if any of the following treatments **2 - 5** was given.

2. ☐ Oxygen therapy >4 hours.
3. ☐ Phototherapy for jaundice.
4. ☐ Gavage feeding more than once.
5. ☐ Any intravenous therapy (including blood transfusion).

14. NURSERY CARE REQUIRED

If the baby required special nursery (level 2) care, or was admitted to Neonatal intensive care (NICU) at the Women's and Children's Hospital, or the Flinders Medical Centre indicate in the appropriate box and give the number of days in these units in the appropriate space provided. This is also the case for Paediatric Intensive Care (PICU) at the Women's and Children's Hospital. If specialised care was not required tick the small white box indicating '**1 = Level I only**'.

15. WAS TRANSFER TO NICU/PICU FOR A CONGENITAL ABNORMALITY?

Please tick the appropriate box if this question is relevant to this baby.

☐ Yes

☐ No

This question is asked to generate an obstetric clinical indicator.

16. OUTCOME OF BABY

Record the appropriate code into single white coding box.

1. Fetal Death (or stillbirth)
2. Discharged (before 28 days of birth)
3. In hospital at 28 days
4. Neonatal Death (within 28 days of birth)

17. TRANSFERRED TO ANOTHER HOSPITAL

If the baby was transferred from his/her birthplace, please specify where to in the space provided and code the date of transfer directly into the white coding boxes provided, for example:

0	2	0	1	0	7
day		month		year	

18. DATE OF FINAL DISCHARGE (OR DEATH)

Code date directly into appropriate white coding boxes, for example:

0	4	0	1	0	7
day		month		year	

Prefix single numbers with an 0. If baby was transferred from your hospital please leave this field blank as the receiving hospital or the Pregnancy Outcome Unit staff will put in baby's final discharge date.

COMPLETING THE ADDITIONAL BABY FORM

The identifying information on the top of the forms includes:

HOSPITAL OF BIRTH

Please print the name of the hospital where the baby was born. If a home delivery, indicate by recording **HOME** and address and postcode.

MOTHER'S NAME

Please print clearly, the surname first and then mother's given names.

CHILD'S SURNAME

If mother and baby have different surnames (eg if baby has been given a surname other than that of mother) please indicate in the space provided.

PLURALITY

Please code directly into the coding box the plurality of this baby and indicate in the space provided on the form the **birth order** of additional babies eg, for twins, **plurality = 2** and **birth order** of baby **No 2 = 2**; for triplets, **plurality = 3** and babies **2 and 3** are **birth order** second and third respectively.

NOTE: The questions on this form are included in the standard Supplementary Birth Record and should be completed in the same manner. For multiple births only, please give more detail of presentation and method of delivery.

DETAILS OF TRANSFER/RETRIEVAL

If the baby is either transferred or retrieved to another hospital please give the date and destination of transfer/retrieval in the appropriate areas indicated on the form.

SERIAL NUMBER

There is no serial number given on this Additional Baby Form so please ensure the serial number from the Supplementary Birth Record is transcribed into the space provided, bottom right hand corner.

Note: The mother and baby/babies **must** have the same serial number.

APPENDIX A

CONGENITAL ABNORMALITIES – INCLUSIONS

Diagnostic Information

A congenital abnormality is defined as any abnormality of prenatal origin. Thus, structural (eg spina bifida), genetic, chromosomal (eg Down syndrome) and biochemical (eg phenylketonuria) abnormalities are included. Excluded are most minor malformations unless they are disfiguring or require treatment.

The following list of congenital abnormalities is not complete, but many of the common abnormalities included are mentioned. This list contains examples only. If an abnormality is not listed here or if in doubt, please notify the abnormality, unless it is on the exclusion list.

INCLUSIONS (examples only)

NERVOUS SYSTEM

Anencephaly
Spina bifida
Encephalocele
Congenital hydrocephalus
Microcephaly
Dandy Walker syndrome
Craniosynostosis
Cerebral palsy

EYE

Microphthalmia/ Anophthalmia
Congenital glaucoma
Congenital cataract
Coloboma

GENITAL SYSTEM

Undescended testis (requiring treatment)
Hypospadias
Indeterminate sex

CHROMOSOMAL ANORMALIES

Down Syndrome
Trisomy 13
Trisomy 18
Turner syndrome
Cri-du-chat syndrome
Fragile X

URINARY SYSTEM

Cystic kidney
Absent kidney
Ectopic kidney
Double ureter
Ectopic ureter ± ureterocele
Vesico-ureteric reflux

MUSCULO-SKELETAL SYSTEM

Congenital dislocation of hip
Congenital talipes equinovarus
Polydactyly
Syndactyly
Absence (complete or partial) of limbs
Osteogenesis imperfecta
Congenital spinal anomalies
Congenital torticollis
Congenital scoliosis
Bone dysplasias
Muscular dystrophy

CARDIOVASCULAR SYSTEM

Congenital heart defects
Coarctation of the aorta
Patent ductus arteriosus*
Dextrocardia

RESPIRATORY SYSTEM

Pulmonary hypoplasia

Diaphragmatic hernia

Choanal atresia

Congenital lung cyst

GASTRO-INTESTINAL SYSTEM

Cleft lip, palate

Tracheo-oesophageal fistula

Pyloric stenosis

Intestinal atresia

Hirschsprung disease

Ectopic anus

Imperforate anus

Exomphalos

METABOLIC DISORDERS - INBORN**ERRORS OF METABOLISM**

Phenylketonuria

Cystic fibrosis

Congenital hypothyroidism

Adreno-genital syndrome

Glycogen storage disorders

Lipid storage disorders

Mucopolysaccharidoses

Albinism

SKIN

Cystic hygroma

Birthmarks) If large ($> 4\text{cm}^2$),

Haemangiomas) multiple or

Naevi) requiring surgery

Ichthyosis congenita

Epidermolysis bullosa

TERATOGENS

Fetal alcohol syndrome

Fetal hydantoin syndrome

BLOOD

Thalassaemia major

Sickle cell anaemia

Haemophilia

G6PD deficiency

CONGENITAL INFECTION

Toxoplasmosis

Rubella

Cytomegalovirus

Herpes simplex

Syphilis

*** Criteria for Inclusion of Patent Ductus Arteriosus (PDA)**

- 1 All term babies (37 weeks and beyond) where the duct remains open after 72 hours.
- 2 All preterm babies where the duct remains open past the expected date of delivery.

Note: If PDA exists in the presence of other congenital heart disease it is always notified.

APPENDIX B

CONGENITAL ABNORMALITIES – EXCLUSIONS

**Excluded are the following, when occurring in isolation:
this is not a complete list of exclusions. If in doubt, please notify**

Balanced translocation in normal individual	Laryngomalacia
Blocked tear duct	Low birthweight
Broncho-pulmonary dysplasia	Lymphangioma, haemangioma, naevus or other birthmark under 4cm ²
Calcaneovalgus deformity	Include if > 4cm ² or multiple
Clicky hips	Meconium ileus (unless the result of cystic fibrosis)
Congenital pneumonia	Mental retardation in isolation
Delayed milestones	Metatarsus adductus even if treated
Deviated nasal septum	Mongolian blue spot
Ear anomalies - minor	Patent foramen ovale
Epigastric hernia	Persistent fetal circulation
Epilepsy	Pilonidal sinus
Failure to thrive	Sacral dimple
Foot deformities - minor	Sacral sinus unrelated to occult spinal dysraphism
positional not requiring treatment	Single palmar crease
Gastro-oesophageal reflux	Skin tag
Hydrocele testis	Single umbilical artery
Hydrops - immune. Include non-immune hydrops	Strabismus
Hypoglycaemia	Submucous retention cyst
Imperforate hymen	Supraventricular tachycardia
Infection in utero if no associated birth defect	Thalassaemia minor
Inguinal hernia	Toe anomalies - minor
Intrauterine growth retardation	Tongue tie, even if surgery
Intussusception	Trigger finger/thumb
Labial adhesion or fusion	Umbilical hernia
Large fontanelles	Undescended testis (unless treated)
Laryngeal stridor unless treated	Wide suture lines
	Webbing of 2nd and 3rd toes (minor degrees)

APPENDIX C ~ Supplementary Birth Record



Government of South Australia
Department of Health

2007 SUPPLEMENTARY BIRTH RECORD

FOR COMPLETION BY MIDWIVES AND NEONATAL NURSES

Mother's name..... Surname..... Given Names.....

Child's surname (if different)..... Hospital/Place of birth.....

Mother's address..... Mother's Case Record Number.....

Postcode..... Plurality (1=single, 2=twin, 3=triplet, 4=quad).....

Personal information above this line is confidential SLA..... For multiple births, please complete a separate baby form for each baby.

MOTHER'S INFORMATION

1 Mother's date of birth.....

2 Race
1. Caucasian
2. Aboriginal
3. Asian
4. Torres Strait Islander (TSI)
5. Aboriginal & TSI
6. Other.....

3 Country of birth.....

4 Type of patient
1. Hospital/Public
2. Private

5 Marital status
1. Never married
2. Married/Die facto
3. Widowed
4. Divorced
5. Separated

OCCUPATION

6 Baby's father.....

Baby's mother.....

PREVIOUS PREGNANCY OUTCOMES

7 Number of previous pregnancies.....

8 Number of previous pregnancies resulting in births >20 weeks (parity).....

9 Number of previous outcomes

	Singleton	Multiple
Livebirths, not neonatal deaths		
Livebirths, neonatal deaths		
Stillbirths		
Miscarriages		
Ectopic pregnancies		
Terminations of pregnancy		

10 Outcome of last pregnancy.....

11 Date of delivery/termination of last pregnancy.....

12 Method of delivery in last birth
0. No previous birth
1. Vaginal
2. Caesarean
9. Not known

13 Number of previous caesareans.....

THIS PREGNANCY

14 Date of last menstrual period.....

15 Intended place of birth
1. Hospital
2. Birth centre
3. Home
4. Other (specify).....
5. Not booked

16a Number of antenatal visits.....

16b First antenatal visit
Gestation (weeks).....

Height (cm).....

Weight (kg).....

BMI.....

Please return top copy to:
Pregnancy Outcome Unit, PO Box 6,
Rundle Mall, Adelaide SA 5000

17 Type of antenatal care

1. ☐ No antenatal care
2. ☐ Hospital clinic
3. ☐ Obstetrician in private practice
4. ☐ General practitioner
5. ☐ Birth centre
6. ☐ Home birth midwife
7. ☐ Obstetrician/midwife (shared care) in private practice
8. ☐ GP/midwife (shared care)
9. ☐ Other (specify).....
10. ☐ Not stated

18 Tobacco smoking status at first visit

1. Smoker
2. Quit in pregnancy before first visit
3. Non smoker
4. Unknown smoking status

19 Average number of tobacco cigarettes smoked per day in 2nd half of pregnancy

☐ None
Number per day =
☐ <1 (occasional)
☐ Unknown number

20 Medical conditions present in this pregnancy

1. ☐ None
2. ☐ Anaemia
3. ☐ Urinary tract infection
4. ☐ Hypertension (pre-existing)
5. ☐ Diabetes (pre-existing)
6. ☐ Epilepsy
7. ☐ Asthma
8. ☐ Other (specify).....
21 Obstetric complications
1. ☐ None
2. ☐ Threatened miscarriage
3. ☐ APM - Abruptio
4. ☐ APM - Placenta praevia
5. ☐ APM - Other & unknown cause
6. ☐ Pregnancy hypertension (all types)
7. ☐ Suspected IUGR
8. ☐ Gestational diabetes
9. ☐ Other (specify, including impaired glucose tolerance).....

22 Date of admission prior to delivery

..... day..... month..... year.....

23 Procedures performed in this pregnancy

Tick if Yes Tick if Unknown

1. ☐ MSAFP (NTD etc)
2. ☐ Triple/Quadruple screen (Down's etc)
3. ☐ Ultrasound examination
4. ☐ Chorion villus sampling
5. ☐ Amniocentesis
6. ☐ Cordocentesis
7. ☐ Other surgical procedures (specify).....

LABOUR AND DELIVERY

24 Onset of labour
1. Spontaneous
2. No labour (LSCS)
3. Induction (excluding augmentation)
Give reason/s for induction (If postdates, state T+..... days)

25 If induction, or augmentation after spontaneous onset, specify method/s

1. ☐ ARM
2. ☐ Oxytocics
3. ☐ Prostaglandins
4. ☐ Other (specify).....

26 Presentation prior to delivery

1. Vertex
2. Breech
3. Face
4. Brow
5. Other
6. Unknown

27 Method of delivery

1. Normal spontaneous
2. Forceps
3. Assisted breech (no forceps)
4. LSCS (elective)
5. LSCS (emergency)
If LSCS state reason/s:
6. Ventouse
7. Breech extraction
8. Breech spontaneous
9. Unknown
10. Assisted breech (with forceps for head)

28 Complications of labour, delivery and puerperium

1. ☐ None
2. ☐ PPH (Primary)
☐ 600 - 999ml
☐ 1000ml or more
3. ☐ Fetal distress
4. ☐ Retained placenta
5. ☐ Prolonged labour (>18 hrs)
6. ☐ Cord prolapse
7. ☐ Wound infection
8. ☐ Failure to progress (specify).....
9. ☐ Other (specify).....

29 Perineal status after delivery

Tick tear, repair & episiotomy if all

1. ☐ Intact
2. ☐ 1st degree tear/vaginal graze
3. ☐ 2nd degree tear
4. ☐ 3rd degree tear
5. ☐ 4th degree tear
6. ☐ Repair of tear
7. ☐ Episiotomy
8. ☐ Other (specify).....
9. ☐ Not stated

30 CTG performed during labour

1. None
2. External
3. Scalp clip

31 Fetal scalp pH taken during labour

1. No
2. Yes

32 Analgesia for labour

1. ☐ None
2. ☐ Nitrous oxide and oxygen
3. ☐ Narcotic (parenteral)
4. ☐ Epidural (lumbar/caudal)
5. ☐ Spinal
6. ☐ Other (specify).....
7. ☐ Combined spinal-epidural

33 Anaesthesia for delivery

1. ☐ None
2. ☐ Local anaesthesia to perineum
3. ☐ Pudendal
4. ☐ Epidural (lumbar/caudal)
5. ☐ Spinal
6. ☐ General anaesthesia
7. ☐ Other (specify).....
8. ☐ Combined spinal-epidural

34 Mother's outcome for birth hospital/home birth

1. ☐ Discharged
2. ☐ Transferred
3. ☐ Died
Transferred to.....
on..... day..... month..... year.....

35 MOTHER'S FINAL DISCHARGE/DEATH

Date..... day..... month..... year.....

BABY DETAILS

1 Case record number.....

2 Place of birth
1. Hospital
2. BBA
3. Domiciliary
4. Birthing unit/centre

3 Date of delivery..... day..... month..... year.....

4 Hour of birth (24 hour clock)

.....

5 Sex

1. Male
2. Female
3. Indeterminate

6 Birthweight (grams)

.....

7 Gestation at birth (best clinical estimate in weeks)

.....

CONDITION AT BIRTH

8 Apgar Score

1 minute..... 5 minute.....

9 Time to establish regular breathing (to nearest minute)

.....

10 Resuscitation at delivery

1. ☐ None
2. ☐ Aspiration
3. ☐ Oxygen
4. ☐ IPPV - bag & mask
5. ☐ IPPV - intubation
6. ☐ Narcotic antagonist
7. ☐ Sodium bicarbonate
8. ☐ Ext. cardiac massage
9. ☐ Other (specify).....

11 Condition occurring during birth

1. ☐ None
2. ☐ Fracture
3. ☐ Dislocation
4. ☐ Nerve injury
5. ☐ Other (specify).....

12 Congenital abnormalities

1. ☐ Nil apparent
2. ☐ Yes (specify).....

13 Treatment given

1. ☐ None of the treatments below
2. ☐ Oxygen therapy > 4 hours
3. ☐ Phototherapy for jaundice
4. ☐ Gavage feeding more than once
5. ☐ Any intravenous therapy

14 Nursery care required

1. ☐ Level 1 only
2. ☐ Special nursery (Level 2)
Number of days.....
3. ☐ Neonatal Intensive Care Unit (NICU) - FMC/WCH (Level 3)
Number of days.....

15 Was transfer to NICU/PICU for a congenital abnormality?

☐ Yes
☐ No

OUTCOME OF BABY

16 Outcome of baby

1. Fetal death
2. Discharged
3. In hospital at 28 days
4. Neonatal death

17 Baby transferred to

..... on..... day..... month..... year.....

18 Date of final discharge (or death)

..... day..... month..... year.....

APPENDIX D ~ Additional Baby Form



Government of South Australia
Department of Health

SUPPLEMENTARY BIRTH RECORD ADDITIONAL BABY FORM

Hospital/Place of Birth

Details of Transfer/Retrieval

Mother's Name
(Surname) (Initials)

Date: / / 20

Child's Surname (if different)

Destination:

Plurality (1 = single, 2 = twin, 3 = triplet, 4 = quad) ☐

Baby for Adoption: 1 ☐ No 2 ☐ Yes

Personal information above this line is confidential

BABY DETAILS

1 CASE RECORD NUMBER

2 PLACE OF BIRTH

1. Hospital
2. BBA
3. Domiciliary
4. Birthing Unit/Centre

3 DATE OF DELIVERY

day month year

4 HOUR OF BIRTH (24 hour clock)

5 SEX

1. Male
2. Female
3. Indeterminate

Birth Order

Presentation

Method of Delivery

If LSCS, state reasons (If different from Maternal form)

6 BIRTHWEIGHT (in grams)

7 GESTATION AT BIRTH (best clinical estimate in weeks)

CONDITION AT BIRTH

8 APGAR SCORE:

1 minute

5 minute

9 TIME TO ESTABLISH REGULAR BREATHING (To nearest minute)

10 RESUSCITATION AT DELIVERY

1. ☐ None
2. ☐ Aspiration
3. ☐ O₂
4. ☐ IPPV - bag & mask
5. ☐ IPPV - intubation
6. ☐ Narcotic antagonist
7. ☐ Sodium bicarbonate
8. ☐ Ext. cardiac massage
9. ☐ Other (specify)

11 CONDITION OCCURRING DURING BIRTH

1. ☐ None 2. ☐ Fracture
3. ☐ Dislocation 4. ☐ Nerve Injury
5. ☐ Other (specify)

12 CONGENITAL ABNORMALITIES

1. ☐ Nil apparent 2. ☐ Yes (specify)

13 TREATMENT GIVEN

1. ☐ None of the treatments below
2. ☐ Oxygen therapy > 4 hours
3. ☐ Phototherapy for jaundice
4. ☐ Gavage feeding more than once
5. ☐ Any intravenous therapy

14 NURSERY CARE REQUIRED

1. ☐ Level 1 only
2. ☐ Special Nursery (Level 2)
Number of days
3. ☐ Neonatal Intensive Care Unit (NICU) - FMC/WCH (Level 3)
Number of days
4. ☐ Paediatric Intensive Care Unit (PICU) - WCH
Number of days

15 Was transfer to NICU/PICU for a congenital abnormality?

Yes ☐ No ☐

16 OUTCOME OF BABY

1. Fetal Death
2. Discharged
3. In Hospital at 28 days
4. Neonatal Death

17 Baby transferred to

on

day month year

18 Date of Final Discharge (or death)

day month year

Serial Number

APPENDIX E ~ Congenital Abnormality Form



Government of South Australia
Department of Health

S.A. PREGNANCY OUTCOME STATISTICS UNIT,
PO Box 6, Rundle Mall, Adelaide SA 5000

CONGENITAL ABNORMALITY FORM

ACC NO. 4

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BABY'S SURNAME

BABY'S FIRST NAME

SEXIF MULTIPLE BIRTH, BIRTH ORDER.....

DATE OF BIRTH...../...../..... UR NO.

HOSPITAL

ADDRESS OF MOTHER.....

FAMILY HISTORY OF CONGENITAL ABNORMALITY Yes No Not known

1. Parents (specify)..... ☐ Yes ☐ No ☐ Not known

2. Siblings of this baby (including known stillbirths and 2nd trimester terminations of pregnancy) ☐ Yes ☐ No ☐ Not known

(specify)

3. Other relatives (specify)..... ☐ Yes ☐ No ☐ Not known

RESIDENCE OF MOTHER DURING THE FIRST 16 WEEKS OF PREGNANCY

--	--	--	--	--	--	--	--	--	--

EXPOSURE TO TERATOGENS

DURING THE FIRST 16 WEEKS OF PREGNANCY

This information can be provided by the doctor undertaking antenatal care

Yes If yes, details

1. Infection (including viral) ☐

2. Xrays ☐

3. Environmental chemicals ☐

4. Prescribed drugs ☐

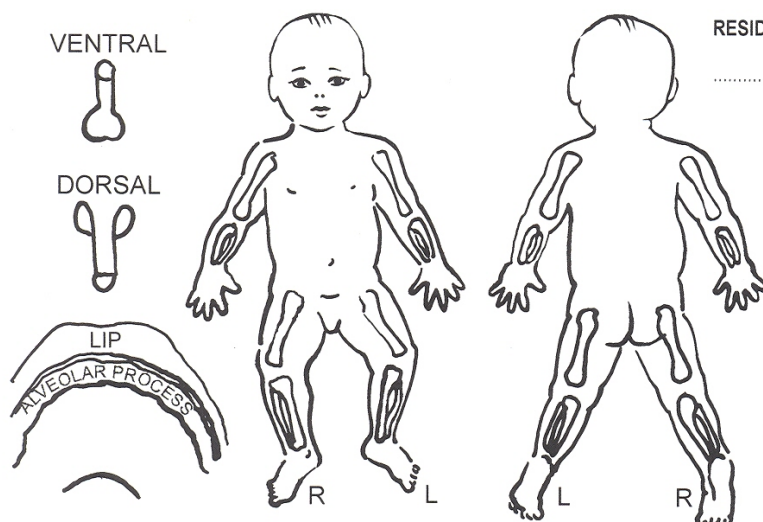
5. Over-the-counter drugs ☐

6. Alcohol ☐

7. Other addictive substances ☐

8. Any other substances ☐

Comments



CONGENITAL ABNORMALITIES / BIRTH DEFECTS PRESENT

(Please list all defects & specify where relevant right/left, anterior/posterior)

Office use only

1.....

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2.....

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3.....

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4.....

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5.....

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6.....

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7.....

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8.....

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9.....

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10.....

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SPECIFIC SYNDROME/S (if known)

.....

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HAS THE FATHER OF THIS CHILD A HISTORY OF EXPOSURE TO ANY POTENTIAL TERATOGENS? ☐ Yes ☐ No ☐ Not known

(specify)

ADDITIONAL INFORMATION (eg drinking water supply/local epidemics)

.....

PRENATAL DIAGNOSIS

Please tick all tests performed during this pregnancy

Please tick if abnormal result

- | | |
|---|--------------------------|
| 1. <input type="checkbox"/> MSAFP (NTD etc) | <input type="checkbox"/> |
| 2. <input type="checkbox"/> Triple/Quadruple screen (Down's, etc) | <input type="checkbox"/> |
| 3. <input type="checkbox"/> Ultrasound (morphology) | <input type="checkbox"/> |
| 4. <input type="checkbox"/> Chorion villus sampling | <input type="checkbox"/> |
| 5. <input type="checkbox"/> Amniocentesis | <input type="checkbox"/> |
| 6. <input type="checkbox"/> Cordocentesis | <input type="checkbox"/> |
| 8. <input type="checkbox"/> Other (specify) | <input type="checkbox"/> |
| 9. <input type="checkbox"/> Not known | <input type="checkbox"/> |

Comments

.....

NAME OF NOTIFYING DOCTOR Signed..... Date

NAME & ADDRESS OF OBSTETRICIAN/MIDWIFE (if not the same)