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| COUNCIL OF OBSTETRIC & PAEDIATRIC MORTALITY & MORBIDITY LOGO | **TASMANIAN PERINATAL DATA COLLECTION FORM** | *Effective 1 January 2020* |
| **CONFIDENTIAL** *Obstetric and Paediatric Mortality and Morbidity Act 1994* | ***Data submission timeline:*** *within 7 days of the birth of a baby.* |
| This form is to be completed for all babies (both liveborn & stillborn) who have a gestational age of at least 20 weeks **and/or** weighing at least 400 grams at birth. **In the case of multiple births, a separate form must be completed in full for each baby.** | ***\*\* tick one or more*** |
| ***Note****: This form must be completed in the hospital where the birth occurs or where the mother is first admitted if the baby is born before arrival.* |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MOTHER’S DETAILS** | **Hospital code** |  |  |  |  | **URN** |  | D D M M Y Y Y Y |  |  |  |  |  |  |  |
| **Surname** |  | **First name** |  | **Date of birth**(DDMMYYYY) |  |  |  |  |  |  |  |  |
| **Country of birth** |  | **Suburb**  |  | **Postcode** |  |  |  |  |
| **Indigenous status** | [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Aboriginal and Torres Strait Islander [ ]  Neither |
| **Marital status** | [ ]  Never married [ ]  Widowed [ ]  Divorced [ ]  Separated [ ]  Married *(including de facto)* |

|  |
| --- |
| **PREVIOUS PREGNANCIES** |
|  |  |  |  |  |  |
|  |  | Livebirths |  |  | *Stillbirths* |
|  |  | Ectopic pregnancy |  |  | *Miscarriage* |
|  |  | Terminated pregnancy |
| Parity^ *(excluding this pregnancy)* |  |  |
| Number of neonatal deaths |  |  |
| Number of previous caesareans |  |  |
| **Mode of last delivery** |
| [ ]  Vaginal [ ]  Caesarean section [ ]  N/A |
| *^ No. of previous pregnancies resulting in births ≥ 20 wks or ≥ 400 g* |
|  |
| **THIS PREGNANCY** |
| **Estimated date of confinement** (DDMMYYYY)D D M M Y Y Y Y |
|  |  |  |  | 2 | 0 |  |  |
| **Determined by** *(select most accurate option only)* |
| [ ]  Known conception | [ ]  Known date LMP |
| [ ]  Ultrasound <12 wks | [ ]  Ultrasound >12 wks |
| **Is this pregnancy the result of assisted reproductive technology (ART)?** |
| [ ]  No [ ]  Yes  |
| **Intended place of birth** |
| [ ]  Hospital [ ]  Birth centre [ ]  Home/other |
| **Intending to breastfeed** |
| [ ]  No [ ]  Yes [ ]  Unsure |
| **Plurality** | [ ]  Single [ ]  Multiple, no.: |  |
| **Est. gestation at 1st antenatal visit** |  |  |
| **Total number of antenatal visits** |  |  |
| **Height** *(whole cm)* |  |  |  |
| **Weight** *(whole kg)* |  |  |  |
| *Self-reported at conception* |
|  |
| **ANTENATAL TESTING\*\*** |
| [ ]  | None  |
| [ ]  | 1st trimester Downs screening |
| [ ]  | 2nd trimester Downs screening |
| [ ]  | Amniocentesis |
| [ ]  | Chorionic villus sampling |
| [ ]  | Screening for gestational diabetes |
| [ ]  | GBS screen |
| [ ]  | Level 2 ultrasound |
| [ ]  | Non-invasive prenatal testing |
| **ANTENATAL SCREENING** |
|  | Yes | Not offered | Declined |
| **Mental health cond?** | **[ ]**  | **[ ]**  | **[ ]**  |
| **Domestic violence?** | **[ ]**  | **[ ]**  | **[ ]**  |
| **PRE PREGNANCY CONDITIONS \*\*** |
| [ ]  | None  | [ ]  | Cardiovascular | [ ]  | Thyroid |
| [ ]  | Diabetes mellitus |
|  | [ ]  | Pre-existing Type 1 diabetes |
|  | [ ]  | Pre-existing Type 2 diabetes |
|  | [ ]  | Other type of diabetes mellitus |
|  | Diabetes mellitus treatment \*\* |
|  | [ ]  | Insulin |
|  | [ ]  | Oral hypoglycaemic |
|  | [ ]  | Diet and exercise |
| [ ]  | Mental health | [ ]  | Renal disease |
| [ ]  | Epilepsy | [ ]  | Chronic hypertension |
| [ ]  | Other  |  |
|  |
| **SMOKING / ALCOHOL / DRUG** |
| **Did the mother at all during the first half (<20 weeks) of pregnancy?** |
| [ ]  No [ ]  Yes, avg cigarettes/day? |  |  |
| **Did the mother at all during the second half (≥20 weeks) of pregnancy?** |
| [ ]  No [ ]  Yes, avg cigarettes/day? |  |  |
| **Did the mother consume alcohol at all during the first half (<20 weeks) of pregnancy?****Frequency of drinking:** |
| [ ]  Never [ ]  Monthly or less [ ]  2-4 times a month |
| [ ]  2-3 times a week [ ]  ≥4 times a week |
| No. of standard drinks on a typical day: |  |  |
| **Did the mother consume alcohol at all during the second half (≥20 weeks) of pregnancy?****Frequency of drinking:** |
| [ ]  Never [ ]  Monthly or less [ ]  2-4 times a month |
| [ ]  2-3 times a week [ ]  ≥4 times a week |
| No. of standard drinks on a typical day: |  |  |
| **Did the mother smoke marijuana during the pregnancy?** |
| [ ]  No [ ]  Yes [ ]  Not stated |
| **Did the mother use other recreational drugs during the pregnancy?** |
| [ ]  No [ ]  Yes [ ]  Not stated |
| **VITAMIN SUPPLEMENTS \*\*** |
| **Did the mother take vitamin supplements during the pregnancy?** |
| [ ]  None | [ ]  Vitamin D |
| [ ]  Iron | [ ]  Folate, pre-conceptually |
| [ ]  Iodine | [ ]  Folate, post-conceptually |
| [ ]  Multi vitamins (pregnancy) |
| [ ]  Multi vitamins (other) |
| **VACCINATIONS** |
| **Vaccinated during?** | **Pertussis** |  **Influenza** |
| 1st trimester | [ ]  | [ ]  |
| 2nd trimester | [ ]  | [ ]  |
| 3rd trimester | [ ]  | [ ]  |
|  |
| **MATERNITY MODEL OF CARE** |
|  | **Start of care** | **Time of birth** |
| Private obstetrician | [ ]  | [ ]  |
| Private midwifery care | [ ]  | [ ]  |
| GP obstetrician | [ ]  | [ ]  |
| Shared care | [ ]  | [ ]  |
| Combined care | [ ]  | [ ]  |
| Public hospital maternity | [ ]  | [ ]  |
| Public hospital high risk maternity | [ ]  | [ ]  |
| Team maternity care | [ ]  | [ ]  |
| MGP caseload care | [ ]  | [ ]  |
| Remote area maternity care | [ ]  | [ ]  |
| Private obstetrician and privately practising midwife joint care | [ ]  | [ ]  |
| Other | [ ]  | [ ]  |
|  |  |  |
| **ADMISSION** |
| **Date of admission** (DDMMYYYY) *(in which birth occurs)*D D M M Y Y Y Y |
|  |  |  |  | 2 | 0 |  |  |
| **Admitted patient election status** |
| [ ]  Public [ ]  Private [ ]  N/A |
| **Transfer of patient prior to delivery** |
| [ ]  No transfer | [ ]  Hospital to hospital |
| [ ]  Birth centre to hospital |
| [ ]  Home to hospital *(intended homebirth only)* |
|  |
| **OBSTETRIC COMPLICATIONS \*\*** |
| [ ]  | None |
| [ ]  | Bleed <20 weeks *(threatened miscarriage)* |
| [ ]  | Placenta praevia |
| [ ]  | APH undetermined origin |
| [ ]  | Placental abruption |
| [ ]  | Threatened premature labour |
| [ ]  | Hypertension |
|  | [ ]  | Pregnancy induced hypertension |
|  | [ ]  | Pre-eclampsia  |
|  | [ ]  | Eclampsia |
| [ ]  | Prolonged rupture of membranes *(>18 hours)* |
| [ ]  | Pre-labour rupture of membranes |
| [ ]  | Gestational diabetes, treatment \*\* |
|  | [ ]  | Insulin |
|  | [ ]  | Oral hypoglycaemic |
|  | [ ]  | Diet and exercise |
| [ ]  | Other  |  |
| **LABOUR AND DELIVERY** |
| **Onset of labour** |
| [ ]  Spontaneous [ ]  Induced [ ]  None |
| **Method of induction \*\*** |
| [ ]  | Prostaglandin | [ ]  | ARM |
| [ ]  | Balloon | [ ]  | Oxytocin |
| [ ]  | Antiprogestogen | [ ]  | Other |
| **Indication for induction of labour** *(max 5 reasons)* |
| *Rank the reasons from 1 (main) to 5 (least)* |
| [ ]  | Prolonged pregnancy |
| [ ]  | Prelabour rupture of membranes |
| [ ]  | Diabetes |
| [ ]  | Hypertensive disorders |
| [ ]  | Multiple pregnancy |
| [ ]  | Chorioamnionitis (incl suspected) |
| [ ]  | Cholestatsis of pregnancy |
| [ ]  | Antepartum haemorrhage |
| [ ]  | Maternal age |
| [ ]  | Body Mass Index (BMI) |
| [ ]  | Maternal mental health indication |
| [ ]  | Previous adverse perinatal outcome |
| [ ]  | Other maternal obs/med indication |
| [ ]  | Fetal compromise (incl suspected) |
| [ ]  | Fetal growth restriction (incl suspected) |
| [ ]  | Fetal macrosomia (incl suspected) |
| [ ]  | Fetal death |
| [ ]  | Fetal congenital anomaly |
| [ ]  | Administrative/geographical indication |
| [ ]  | Maternal choice |
| [ ]  | Other indication not elsewhere classified |
| **Augmentation of labour** |
| *Both ARM & Oxytocin may be ticked* |
| [ ]  Not augmented  |
| [ ]  ARM [ ]  Oxytocin |
| **Analgesia during labour \*\*** |
| [ ]  | None | [ ]  | IV Opioids |
| [ ]  | O2/Nitrous Oxide | [ ]  | Pudendal |
| [ ]  | IM Opioids | [ ]  | Spinal |
| [ ]  | Epidural/caudal | [ ]  | Other |
| **Principal accoucheur** |
| [ ]  | Obstetrician | [ ]  | Midwife |
| [ ]  | GP Obstetrician |
| [ ]  | Hospital Medical Officer | [ ]  | Other |
| **Labour & delivery complications \*\*** |
| [ ]  | None | [ ]  | Grade 2-3 meconium |
| [ ]  | Shoulder dystocia |
| [ ]  | Primary PPH *(>500 mls in first 24 hours)* |
|  | Est amount of blood loss |  | mls |
|  | PPH requiring blood transfusion? | [ ]  |
| [ ]  | Retained placenta *(requiring manual removal)* |
| [ ]  Other |  |
| **LABOUR AND DELIVERY** (cont.) |
| **Perineal status \*\*** |
| [ ]  | Intact | [ ]  | 3rd degree tear |
| [ ]  | 1st degree tear | [ ]  | 4th degree tear |
| [ ]  | 2nd degree tear | [ ]  | Episiotomy |
| **Indication for caesarean section** *(max 5 reasons)* |
| *Rank the reasons from 1 (main) to 5 (least)* |
| [ ]  | Fetal compromise |
| [ ]  | Suspected fetal macrosomia |
| [ ]  | Malpresentation |
| [ ]  | Lack of progress ≤3cm |
| [ ]  | Lack of progress in the 1st stage, 4 to <10 cm |
| [ ]  | Lack of progress in the 2nd stage |
| [ ]  | Placenta praevia |
| [ ]  | Placental abruption |
| [ ]  | Vasa praevia |
| [ ]  | Antepartum/intrapartum haemorrhage |
| [ ]  | Multiple pregnancy |
| [ ]  | Unsuccessful attempt at assisted delivery |
| [ ]  | Cord prolapse |
| [ ]  | Previous adverse perinatal outcome |
| [ ]  | Previous caesarean section |
| [ ]  | Previous severe perineal trauma |
| [ ]  | Previous shoulder dystocia |
| [ ]  | Other indication not elsewhere classified |
| [ ]  | Maternal choice |
| **Was the caesarean section:** |
| **a)** | [ ]  | Elective | **b)** | [ ]  | Primary |
|  | [ ]  | Emergency |  | [ ]  | Repeat |
| **Anaesthesia for delivery \*\*** |
| [ ]  | None | [ ]  | Local anaesthetic |
| [ ]  | Pudendal | [ ]  | Epidural/caudal |
| [ ]  | Spinal | [ ]  | General anaesthetic |
|  |
| **BABY’S DETAILS** |
|  |  |  |  |  |  |
| **URN** |  | D D M M Y Y Y Y |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Date of birth**(DDMMYYYY) |  |  |  |  | 2 | 0 |  |  |
| **Presentation at birth** |
| [ ]  Vertex  | [ ]  Face [ ]  Other |
| [ ]  Breech  | [ ]  Brow |
| **Mode of birth** |
| [ ]  | Non-instrumental vaginal |
| [ ]  | Forceps – low | [ ]  | Vacuum extraction |
| [ ]  | Forceps – mid | [ ]  | Vacuum rotation |
| [ ]  | Forceps rotation | [ ]  | Caesarean section |
| **Indigenous status** |
| [ ]  | Aboriginal | [ ]  | Torres Strait Islander |
| [ ]  | Aborig. & TSI | [ ]  | Neither |
| **Actual place of birth** |
| [ ]  | Hospital | [ ]  | Born before arrival |
| [ ]  | Birth Centre | [ ]  | Home/other |
|  |  |  |  |
| **BABY’S DETAILS** (cont.) |
| **Birth status** | [ ]  Liveborn [ ]  **Stillborn** **†** |
| **Apgar score** |  |  |  |  |  |  |  |  |
|  | 1 min |  | 5 mins |  | 10 mins |
| **Cord pH** | [ ]  Not done [ ]  <7.2 [ ]  ≥7.2 |
| **Gestational age at birth** |  |  | . |  |
| **Weight** *(whole gram)* |  |  |  |  |
| **Length** *(whole cm)* |  |  |
| **Head circumference** *(whole cm)* |  |  |
| **Sex** | [ ]  Male [ ]  Female [ ]  Indeterminate |
| **Birth order** |
| [ ]  | Singleton | [ ]  | Twin/Triplet 2 |
| [ ]  | Twin/Triplet 1 | [ ]  | Triplet 3 |
| **Resuscitation at birth \*\*** |
| [ ]  None [ ]  Suction [ ]  Adrenaline |
| [ ]  Passive oxygen therapy |
| [ ]  Bag & mask IPPV [ ]  CPAP |
| [ ]  Endotracheal intubation & IPPV |
| [ ]  External cardiac massage |
| **Medical admission to SCN/NICU** |
| [ ]  No [ ]  Yes, number of days |  |  |
|  |
| **CONGENITAL ABNORMALITIES \*\****Please complete the congenital abnormalities notification form* |
| [ ]  None  |
| [ ]  Malformation of nervous system  |
| [ ]  Malformation of eye, ear, face & neck  |
| [ ]  Malformation of circulatory system  |
| [ ]  Cleft lip and cleft palate  |
| [ ]  Malformation of digestive system  |
| [ ]  Malformation of genital organs  |
| [ ]  Malformation of urinary system  |
| [ ]  Malformation of musculoskeletal system  |
| [ ]  Chromosomal malformations  |
| [ ]  Inborn errors of metabolism  |
| [ ]  Other |  |
|  |
| **DISCHARGE** |
| **Mother discharge status** |
| [ ]  Discharged [ ]  Transferred [ ]  **Died ‡**D D M M Y Y Y Y |
| **Date** (DDMMYYYY) |  |  |  |  | 2 | 0 |  |  |
| **‡** *National Maternal Death Reporting Form* |
| **Breastfeeding at discharge** |
| [ ]  Fully [ ]  Partially [ ]  Not at all  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Baby discharge status** |
| [ ]  Discharged [ ]  Transferred [ ]  **Died †** |
| [ ]  Still in hospital at 28 daysD D M M Y Y Y Y |
| **Date** (DDMMYYYY) |  |  |  |  | 2 | 0 |  |  |
| **†** *National Perinatal Death Clinical Audit (NPDCA) Tool*  |
| **Reason for transfer of baby** |
| [ ]  Medical [ ]  Other |
|  |
| ***Completed by (name):*** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Contact details:***  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **COUNCIL OF OBSTETRIC & PAEDIATRIC MORTALITY & MORBIDITY LOGO** | **COUNCIL OF OBSTETRIC & PAEDIATRIC MORTALITY & MORBIDITY** |
|  |
| **TASMANIAN PERINATAL DATA COLLECTION FORM** |
| The Tasmanian Perinatal Data Collection Form is a mandatory requirement for data collection under the *Obstetric and Paediatric Mortality and Morbidity Act 1994* (previously known as *Perinatal Registry Act 1994*).The Tasmanian Perinatal Data Collection Form is required to be **completed by all private hospitals and birth centres where the birth occurs, or by private midwifery and medical practitioners who deliver babies outside hospitals**. Please use the electronic perinatal database system (i.e. ObstetrixTas) for all births reported in public and public contracted maternity hospitals.If the mother and/or baby are transferred from the hospital of confinement, the form should be completed by the hospital of birth. In cases where the mother is transferred to another hospital for operational birth and transferred back to the hospital of confinement immediately after the operation, the form should be **completed by the hospital of confinement**. If the mother and/or baby are admitted to hospital after the birth has occurred, a form should be **completed by the hospital where the mother is first admitted**. **NOTE: A multiple birth requires a separate Perinatal Data Collection Form to be completed for each baby with the same identifying maternal demographic information.** Please ensure that the second twin's Perinatal Data Collection Form is also submitted.**Data submission timeline**: within 7 days of the birth of a baby.General instructions* Please print clearly using a ballpoint pen and all writing and figures must be legible (paper submission only).
* Use ticks on the form to indicate the appropriate options.
* **ANSWER ALL QUESTIONS**. If a particular item of information is not available or unknown, please fill all numeric fields with '9' or record 'Unknown' in a text field.
* If any data items are not complete, the hospital of birth will be asked to supply the missing information.
* In the case of multiple births, a separate form should be completed for each baby. For example, in the case of twins, two forms are to be completed, identifying each twin as Twin 1 and Twin 2 in the Birth order question of the Baby's Details section.
* Where boxes are present, place a tick or write the appropriate number(s) in the relevant box(es).
* Where there are more boxes provided than necessary, please ‘right adjust’ your response.

|  |  |  |  |
| --- | --- | --- | --- |
| e.g. Weight – 58 kgs | 0 | 5 | 8 |

Queries relating to completion of this Form, please refer to the ***Guidelines for the completion of the Perinatal Data Collection Form*** available from the website or contact:Tasmanian Perinatal Data Collection ServicesHealth Information - Monitoring Reporting and Analysis UnitPlanning Purchasing and Performance GroupDepartment of HealthGPO Box 125Hobart TAS 7001Phone: (03) 6166 1012Email: ppp.perinataldata@health.tas.gov.au Web: <http://www.health.tas.gov.au/about_the_department/partnerships/registration_boards/copmm> Completing the FormIf you have completed the Form, please submit it by email or post:

|  |  |
| --- | --- |
| Email: | ppp.perinataldata@health.tas.gov.au |
| Post (using confidential envelope): | Health Information - Monitoring Reporting and Analysis UnitPlanning Purchasing and Performance GroupDepartment of Health GPO Box 125Hobart TAS 7001 |

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