Tasmanian Perinatal Data Collection Form
Obstetric and Paediatric Mortality and Morbidity Act 1994

CONFIDENTIAL
For births occurring on or after 1 January 2024

This form is to be completed for all babies (both liveborn and 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.** 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 ☐☐☐☐☐☐☐☐☐

Surname ____________________

First name ____________________

Date of birth (DDMMYYY) ☐☐☐☐☐☐☐☐

Country of birth ____________________

Suburb ____________________

Postcode ☐☐☐☐

Aboriginality status

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal & Torres Strait Islander
- ☐ Neither

Marital status

- ☐ Never married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Married *(including de facto)*

Maternal education

- ☐ Year 9 or equivalent or below
- ☐ Year 10 or equivalent
- ☐ Year 12 or equivalent
- ☐ Certificate I to IV (incl trade certificate)
- ☐ Advanced diploma/Diploma
- ☐ Bachelor degree or above
- ☐ Not stated/unknown

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 weeks or ≥ 400g

THIS PREGNANCY

Estimated date of confinement (DDMM20YY)

				2	0		

Determined by *(select most accurate option only)*

- ☐ Known conception
- ☐ Known date LMP
- ☐ Ultrasound <12 weeks
- ☐ Ultrasound >12 weeks

Is this pregnancy the result of assisted reproductive technology (ART)?

☐ No ☐ Yes

This pregnancy (continued)

Intended place of birth

☐ Hospital ☐ Birth centre ☐ Home/other

Intending to breastfeed

☐ No ☐ Yes ☐ Unsure

Plurality

☐ Single ☐ Multiple, no.: ☐

Estimated gestation at 1st antenatal visit ☐☐

Total number of antenatal visits ☐☐

Height *(whole cm)* ☐☐☐

Weight *(whole kg)* ☐☐☐

Self-reported at conception

ANTENATAL TESTING (tick one or more)

- ☐ None
- ☐ 1st trimester Downs screening
- ☐ 2nd trimester Downs screening
- ☐ Amniocentesis
- ☐ GBS screen
- ☐ Chorionic villus sampling
- ☐ Level 2 ultrasound
- ☐ Screening for gestational diabetes
- ☐ Non-invasive prenatal testing

ANTENATAL SCREENING

	Mental health condition?	Domestic violence?
Yes	☐	☐
Not offered	☐	☐
Declined	☐	☐
Not stated	☐	☐

PRE-PREGNANCY CONDITIONS (tick one or more)

- ☐ None
- ☐ Cardiovascular
- ☐ Thyroid
- ☐ Diabetes mellitus
  - ☐ Pre-existing Type 1 diabetes
  - ☐ Pre-existing Type 2 diabetes
  - ☐ Other type of diabetes mellitus

Diabetes mellitus treatment (tick one or more)

- ☐ Insulin
- ☐ Oral hypoglycaemic
- ☐ Diet and exercise

- ☐ Mental health
- ☐ Renal disease
- ☐ Epilepsy
- ☐ Chronic hypertension
- ☐ Other

VITAMIN SUPPLEMENTS (tick one or more)

Did the mother take vitamin supplements during the pregnancy?

- ☐ None
- ☐ Folate, pre-conceptually
- ☐ Iron
- ☐ Folate, post-conceptually
- ☐ Iodine
- ☐ Multi vitamins (pregnancy)
- ☐ Vitamin D
- ☐ Multi vitamins (other)

VACCINATIONS

	Pertussis	Influenza
Not vaccinated	☐	☐
Vaccinated during 1st trimester	☐	☐
Vaccinated during 2nd trimester	☐	☐
Vaccinated during 3rd trimester	☐	☐
Vaccinated but unknown trimester	☐	☐

TOBACCO SMOKING & VAPING

Did the mother smoke tobacco at all during the first half (<20 weeks) of pregnancy?

☐ No ☐ Yes, avg cigarettes/day? [|]

Did the mother smoke tobacco at all during the second half (≥20 weeks) of pregnancy?

☐ No ☐ Yes, avg cigarettes/day? [|]

Did the mother use e-cigarettes (vaping) at all during the first half (<20 weeks) of pregnancy?

☐ No ☐ Yes

Did the mother use e-cigarettes (vaping) at all during the second half (≥20 weeks) of pregnancy?

☐ No ☐ Yes

ALCOHOL & DRUG

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

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 (DDMM20YY) *(in which birth occurs)*

				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 (tick one or more)

☐ None

☐ Bleed <20 weeks *(threatened miscarriage)*

☐ Placenta praevia ☐ Placental abruption

☐ APH undetermined origin ☐ Threatened premature labour

☐ Hypertension

- ☐ Pregnancy induced hypertension
- ☐ Pre-eclampsia ☐ Eclampsia

☐ Prolonged rupture of membranes *(>18 hours)*

☐ Pre-labour rupture of membranes

☐ Gestational diabetes, treatment (tick one or more)

- ☐ Insulin ☐ Oral hypoglycaemic
- ☐ Diet and exercise

☐ Other ______________________

LABOUR AND DELIVERY

Onset of labour

☐ Spontaneous ☐ Induced ☐ None

Method of induction (tick one or more)

☐ 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)

☐ Cholestasis of pregnancy

☐ Antepartum haemorrhage

☐ Maternal age

☐ Body Mass Index (BMI)

☐ Maternal mental health indication

☐ Previous adverse perinatal outcome

☐ Other maternal obstetric/medical 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

LABOUR AND DELIVERY *(continued)*

Augmentation of labour

Both ARM & Oxytocin may be ticked

☐ Not augmented ☐ ARM ☐ Oxytocin

Analgesia during labour (tick one or more)

☐ None ☐ Pudendal
☐ O_2/Nitrous Oxide ☐ Spinal
☐ IM Opioids ☐ Epidural/caudal
☐ IV Opioids ☐ Other

Principal accoucheur

☐ Obstetrician ☐ Hospital Medical Officer
☐ Midwife ☐ Other
☐ GP Obstetrician

Labour & delivery complications (tick one or more)

☐ None
☐ Grade 2-3 meconium
☐ Shoulder dystocia
☐ Primary PPH *(>500mls in the first 24 hours)*
Estimated amount of blood loss ______________ mls
PPH requiring blood transfusion? ☐
☐ Retained placenta *(requiring manual removal)*
☐ Other ______________________________

Perineal status (tick one or more)

☐ 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 <10cm
☐ 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 or emergency? ☐ Elective ☐ Emergency
b) Primary or repeat? ☐ Primary ☐ Repeat

Anaesthesia for delivery (tick one or more)

☐ None ☐ Local anaesthetic
☐ Pudendal ☐ Epidural/caudal
☐ Spinal ☐ General anaesthetic

BABY'S DETAILS

URN | | | | | | | | | |

Date of birth (DDMM20YY) | | | | | 2 | 0 | | |

Presentation at birth

☐ Vertex ☐ Breech ☐ Face
☐ Brow ☐ Other

Mode of birth

☐ Non-instrumental vaginal
☐ Forceps – low ☐ Vacuum extraction
☐ Forceps – mid ☐ Vacuum rotation
☐ Forceps rotation ☐ Caesarean section

Aboriginality status

☐ Aboriginal ☐ Torres Strait Islander
☐ Aboriginal & Torres Strait Islander ☐ Neither

Actual place of birth

☐ Hospital ☐ Born before arrival
☐ Birth Centre ☐ Home/other

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 ☐ Another term

Birth order

☐ Singleton
☐ Twin/Triplet 1
☐ Twin/Triplet 2
☐ Triplet 3

Resuscitation at birth (tick one or more)

☐ None
☐ Suction
☐ Passive oxygen therapy
☐ Bag & mask IPPV
☐ CPAP
☐ Endotracheal intubation & IPPV
☐ External cardiac massage
☐ Adrenaline

Medical admission to SCN/NICU

☐ No ☐ Yes, number of days [|]

CONGENITAL ABNORMALITIES (tick one or more)

☐ 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 malformation
☐ Inborn errors of metabolism
☐ Other ____________________

DISCHARGE

Mother discharge status

☐ Discharged ☐ Transferred ☐ **Died**‡

‡ *Please complete National Maternal Death Reporting Form*

Date (DDMM20YY)

				2	0		

Breastfeeding at discharge

☐ Fully ☐ Partially ☐ Not at all

…………………………………………………………………………………………..

Baby discharge status

☐ Discharged ☐ Transferred ☐ **Died**†

☐ Still in hospital at 28 days

† *Please complete Australian Perinatal Mortality Clinical Audit Tool*

Date (DDMM20YY)

				2	0		

Reason for transfer of baby

☐ Medical ☐ Other

Completed by (name): ____________________

Contact details: ____________________

CONGENITAL ABNORMALITY NOTIFICATION FORM

Must be completed by the Paediatrician
Please list each anomaly separately

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

Case summary

____

Completed by (Paediatrician): ____________________

Contact details: ____________________

More resources are available on the COPMM section of the Department of Health website (www.health.tas.gov.au/copmm) including:

- Guidelines for the completion of the Perinatal Data Collection Form
- National Maternal Death Reporting Form
- Australian Perinatal Mortality Clinical Audit Tool

Please submit the completed Tasmanian Perinatal Data Collection Form by email or post.

Email: pppr.perinataldata@health.tas.gov.au

Post (using confidential envelope):
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