

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID:

HOSPITAL ID:

Any inborn infant who dies in the delivery room or at any other location in your hospital within 12 hours after birth and prior to admission to the NICU is defined as a "Delivery Room Death." These locations may include the mother's room, resuscitation rooms, or any location other than the NICU in your hospital. Outborn infants and infants who are admitted to the NICU should not be classified as Delivery Room Deaths.

## IDENTIFICATION AND DEMOGRAPHICS

1.	Birth Weight:	_____	_____	_____	_____	grams		
2.	Head Circumference at Birth:	_____	_____	.	_____	cm	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Done
3.	Best Estimate of Gestational Age:	_____	a) Weeks (15-46)	_____	b) Days (0-6)	<input type="checkbox"/> Unknown		
4.	a. Birth Date: (MM-DD)	_____	-	_____	-2026			
	b. Birth Time: (00:00)	_____	:	_____	(use 24-hour clock)			
5.	Infant Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Unknown			
6.	Died in Delivery Room:	<input checked="" type="checkbox"/> Yes						

## MATERNAL HISTORY

9.	a. Maternal Date of Birth: (MM/DD/YY)	_____	/	_____	/	_____	b. Maternal Age:	_____	years	<input type="checkbox"/> Unknown
10.	Maternal Race Ethnicity: (select all that apply)									
	<input type="checkbox"/> American Indian/Native American	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Middle Eastern/North African					
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Declined	<input type="checkbox"/> Unknown					
11.	Prenatal Care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown						
12.	Group B Strep Positive:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Done	<input type="checkbox"/> Unknown					
13.	a. Is there documentation that Antenatal Steroids therapy was initiated before delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown						
	b. Is there documentation in the medical record of reason for NOT initiating antenatal steroid therapy before delivery? (This item is only applicable and optional for inborn infants who are <34 weeks GA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown						
	c. If Yes, what was the documented reason for NOT administering antenatal steroids? (This item is only applicable and optional for inborn infants who are <34 weeks GA)	<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Other active infection	<input type="checkbox"/> Immediate delivery	<input type="checkbox"/> Fetus has anomalies incompatible with life	<input type="checkbox"/> History of adverse reaction to corticosteroids	<input type="checkbox"/> Comfort Care	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown	
14.	Spontaneous Labor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown						
15.	a. Multiple Gestation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown						
	b. If Yes, to multiple gestation enter number of infants delivered including stillborn	<input type="text"/>	<input type="checkbox"/> Unknown	<input type="checkbox"/> NA						
	c. Birth Order:	<input type="text"/>	<input type="checkbox"/> Unknown	<input type="checkbox"/> NA						
16.	Delivery Mode (check only one)	<input type="checkbox"/> Spontaneous Vaginal	<input type="checkbox"/> Operative Vaginal	<input type="checkbox"/> Cesarean	<input type="checkbox"/> Unknown					
17.	Antenatal Conditions (select ALL conditions occurring in this pregnancy)									
	a. Maternal Antenatal Conditions	<input type="checkbox"/> None	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Other Infection	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prev. Cesarean	<input type="checkbox"/> Antenatal Magnesium Sulfate	<input type="checkbox"/> Other (describe): _____	<input type="checkbox"/> Unknown
	b. Fetal Antenatal Conditions	<input type="checkbox"/> None	<input type="checkbox"/> IUGR	<input type="checkbox"/> Non-Reassuring Fetal Status	<input type="checkbox"/> Anomaly	<input type="checkbox"/> Other Fetal (describe): _____	<input type="checkbox"/> Unknown			
	c. Obstetrical Conditions	<input type="checkbox"/> None	<input type="checkbox"/> Preterm (<37 wks) Labor	<input type="checkbox"/> Preterm (<37 wks) Premature ROM before onset of labor	<input type="checkbox"/> Term Premature ROM (≥37 wks) before onset of labor, not premature gestation	<input type="checkbox"/> Prolonged ROM (>18hrs)	<input type="checkbox"/> Malpresentation/Breech	<input type="checkbox"/> Bleeding/Abruption/Placenta	<input type="checkbox"/> Anhydramnios/Oligohydramnios	<input type="checkbox"/> Polyhydramnios
						<input type="checkbox"/> Other Obstetrical (describe): _____				

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## 18. Indications for Cesarean Section (select at least one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Not Applicable (No C/S)     | <input type="checkbox"/> Multiple Gestation          | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Elective                    | <input type="checkbox"/> Placental Problems          | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Malpresentation/Breech      | <input type="checkbox"/> Non-Reassuring Fetal Status | <input type="checkbox"/> Unknown                 |
| <input type="checkbox"/> Dystocia/Failed to Progress |  |  |

## DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

20. a. Apgar Scores:   1min ☐ Unknown   5 min ☐ Unknown   10 min ☐ Unknown
- ☐ Not Done ☐ Not Done ☐ Not Done

## 22. Delivery Room Resuscitation

- |                         |   |                               |   |
|-------------------------|---|-------------------------------|---|
| a. Supplemental Oxygen: | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | e. Epinephrine:               | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| b. Nasal CPAP:          | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | f. Cardiac Compressions:      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| c. PPV via Bag/Mask:    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | g. Noninvasive Ventilation    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| d. ETT Ventilation      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | h. Supraglottic Airway Device | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

## 23. Surfactant Treatment

- a. Was Surfactant given in the Delivery Room? ☐ Yes ☐ No ☐ Unknown
- b. Was Surfactant given at any time? ☐ Yes ☐ No ☐ Unknown
- c. Enter age at first dose: \_\_\_\_\_ hours \_\_\_\_\_ mins ☐ Unknown ☐ NA  
or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM)  
\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ : \_\_\_\_\_

## CONGENITAL INFECTIONS / ANOMALIES

42. Congenital Infection ☐ Yes ☐ No ☐ Unknown
- If Yes, specify up to 3 pathogens: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- Enter a description for pathogen code 8888 (other): \_\_\_\_\_
52. a. Congenital Anomalies ☐ Yes ☐ No ☐ Unknown
- b. If Yes, enter up to 5 congenital anomaly codes:
- Code 1. \_\_\_\_\_ Code 2. \_\_\_\_\_ Code 3. \_\_\_\_\_ Code 4. \_\_\_\_\_ Code 5. \_\_\_\_\_
- Enter a congenital anomaly description for codes 100, 150, 200, 300, 400, 504, 601, 605, 800 and 900:

## NOTES