

Labor and Delivery Medical Record Abstraction Form

This form should be used for abstraction of medical records from **all labor and delivery care providers** seen during **index pregnancy**.

A single abstraction form should be used for all relevant providers.

Below list all providers that contributed data to this form.

OF NOTE: It is NOT necessary to indicate the specific provider record source for each individual data item on this form. It will be too cumbersome to try and detail exactly which record(s) provided which data. Hopefully, in most cases if the same information is provided in multiple different provider records, it will be consistent and complimentary. However, there might be cases in which conflicting information is presented in 2 different records. Use the data available to make your best judgment about the correct information and then add a comment providing details of the conflict between provider sources.

CONTRIBUTING PROVIDERS					
A.1. Name of Provider/Hospital					
A.2. Street Address					
A.3. City			A.4. State		A.5. Zip Code
ABSTRACTION LOG					
A.6. Date __/__/____		A.7. Date __/__/____		A.8. Date __/__/____	
A.6.1 to A.6.8 Time (*use military time)		A.7.1 to A.7.8 Time (*use military time)		A.8.1 to A.8.8 Time (*use military time)	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
A.9. Date __/__/____		A.10. Date __/__/____		A.11. Date __/__/____	
A.9.1 to A.9.8 Time (*use military time)		A.10.1 to A.10.8 Time (*use military time)		A.11.1 to A.11.8 Time (*use military time)	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____

B.1. Name of Provider/Hospital					
B.2. Street Address					
B.3. City			B.4. State		B.5. Zip Code
ABSTRACTION LOG					
B.6. Date __/__/____		B.7. Date __/__/____		B.8. Date __/__/____	
B.6.1 to B.6.8 Time (*use military time)		B.7.1 to B.7.8 Time (*use military time)		B.8.1 to B.8.8 Time (*use military time)	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
B.9. Date __/__/____		B.10. Date __/__/____		B.11. Date __/__/____	
B.9.1 to B.9.8 Time (*use military time)		B.10.1 to B.10.8 Time (*use military time)		B.11.1 to B.11.8 Time (*use military time)	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____

A. IDENTIFYING INFORMATION No information for any item in section

1. Mother's name (Last, First, Middle)		2. Study ID#
3. Maiden Name	4. AKA	5. Mother's DOB
6. Street Address (from L&D chart)		
7. City	8. State	9. Zip Code -----
10. Place of Delivery		
1. <input type="checkbox"/> Hospital (enter Name in 11) 2. <input type="checkbox"/> Car (Skip to) 3. <input type="checkbox"/> Ambulance (Skip to) 4. <input type="checkbox"/> Parking Lot (Skip to) 5. <input type="checkbox"/> Home (Skip to) 6. <input type="checkbox"/> Work (Skip to) 7. <input type="checkbox"/> Other, specify _____ 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR		
11. Delivery Hospital Name		
12. Hospital Street Address		
13. City	14. State	15. Zip Code -----
Comments:		

Sections B-N: How to Document Various Types of Missing Information**A. No information -- entire section**

Each section of each form will include either one or two universal missing check boxes. If either are checked, no further data are recorded for the entire section.

1. No information for any item in section

Checked if:

No relevant tests or procedures appear to have been ordered by any contributing medical care providers; and/or
No information was recorded for relevant health status, medical conditions, medications.

2. Test/procedure for one or more items in section indicated but no information on dates, results, etc.

(will only apply to certain sections as indicated)

B. Information available for one or more items within a section BUT no information for selected items

If there is information in the chart for one or more items in a given section on a given abstraction form, all pertinent data should be recorded. However, there is still the possibility that there will be missing data within these sections. Three types of missing data codes are recognized:

NA – NOT APPLICABLE (for use with certain items such as those with skip patterns and those for which multiple tests/procedures/etc. might have been performed and all are requested in abstraction form. After last relevant item is recorded, the subsequent item on abstract form is NA to indicate the end of reporting).

IL -- NOT LEGIBLE (self-explanatory)

NR – NO info in RECORD (“true missing” There *should* be information for an item, but it cannot be located.)

The following coding schemes will be applied to code these 3 types of missing:

Categorical variables with a finite coding scheme

77 NA

88 IL

99 NR

Dates and times – these may be completely missing or partially missing.

Data entry format is ___/___/_____ and ___:___

For dates and time (military hours and minutes)

For day, month, hours, and minutes, enter **77, 88, or 99** as appropriate

For year the enter **7777, 8888, or 9999** as appropriate

Thus, these can be completely missing or mixed with valid data such as:

03/99/2003 and 10:88

Continuous/open ended data items: Since it will be overly burdensome to develop and employ a missing data scheme which individually considers each data item and the appropriate number of digits for missing values use the alpha codes for missing in these instances:

NA, IL, or NR

B. ADMISSION THAT LED TO DELIVERY No information for any item in section

1. Admit date ____/____/____	2. Admit time __:__:__	3. Delivery date ____/____/____	4. Delivery time __:__:__	5. Discharge date ____/____/____
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6. Admitting Diagnoses

6a. DX1: _____ 77 NA 88 IL 99 NR6b. DX2: _____ 77 NA 88 IL 99 NR6c. DX3: _____ 77 NA 88 IL 99 NR6d. DX4: _____ 77 NA 88 IL 99 NR6e. DX5: _____ 77 NA 88 IL 99 NR**Comments:****C. MATERNAL TRANSPORT BY AMBULANCE** No information for any item in section

1. Transporting Facility	2. Admit date ____/____/____	3. Admit time __:__:__	4. Departure date ____/____/____	5. Departure time __:__:__	6. 1. <input type="checkbox"/> Med record adequate 2. <input type="checkbox"/> Order medical record 3. <input type="checkbox"/> Record not available 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
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7. Reason for transport

Comments:

D. INJECTIONS/VACCINATIONS NOTED THIS ADMISSION THROUGH 24 HOURS POSTPARTUM

No information for any item in section

Injection/Vaccination	Date	Dose	Manufacturer	Product Name	Lot #
1. Rhogam (other RH(D)) Immunoglobulin 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	(1.dt1, 1.dt2) 1st ___/___/_____ 2nd ___/___/_____ _____	(1.ds.1, 1.ds.2) 1st _____ 2nd _____ _____	(1.m.1, 1.m.2) 1st _____ 2nd _____ _____	(1.p.1, 1.p.2) 1st _____ 2nd _____ _____	(1.lot.1, 1.lot.2) _____ _____ _____
2. Influenza Vaccine 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2.dt Date ___/___/_____ _____	2.m Manufacturer _____ _____		2.lot Lot # _____ _____	
3. Other 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR 3a.sp (specify) _____ _____	3a.dt Date ___/___/_____ _____	3a.m Manufacturer _____ _____		3a.lot Lot # _____ _____	
3b.sp Other (specify) _____ _____	3b.dt Date ___/___/_____ _____	3b.m Manufacturer _____ _____		3b.lot Lot # _____ _____	
3c.sp Other (specify) _____ _____	3c.dt Date ___/___/_____ _____	3c.m Manufacturer _____ _____		3c.lot Lot # _____ _____	
3d.sp Other (specify) _____ _____	3d.dt Date ___/___/_____ _____	3d.m Manufacturer _____ _____		3d.lot Lot # _____ _____	
3e.sp Other (specify) _____ _____	3e.dt Date ___/___/_____ _____	3e.m Manufacturer _____ _____		3e.lot Lot # _____ _____	
3f.sp Other (specify) _____ _____	3f.dt Date ___/___/_____ _____	3f.m Manufacturer _____ _____		3f.lot Lot # _____ _____	

Comments:

E. Cervical Exam on Admission

Note: Dilation may be noted as complete, please record as 10cm; Effac may be noted as complete, please record as 100%

No information for any item in section

1a. Date ____/____/____	1b. Time ____:____	1c. Dil (cm) 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1d. Effac (%) 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1e. Station 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1f. 1. <input type="checkbox"/> SSE 2. <input type="checkbox"/> SVE 3. <input type="checkbox"/> US 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	Comments:
2a. Date ____/____/____	2b. Time ____:____	2c. Dil (cm) 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2d. Effac (%) 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2e. Station 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2f. 1. <input type="checkbox"/> SSE 2. <input type="checkbox"/> SVE 3. <input type="checkbox"/> US 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	Comments:

Comments:

F. INDUCTION OR AUGMENTATION OF LABOR

No information for any item in section

Method: 1= Prostaglandins for cervical ripening, 2= Artificial rupture of membranes (AROM), 3= Oxytocin/pitocin
4= Misoprostol 6= Other (specify), 88=Not Legible 99=Not Recorded

Reasons for induction/augmentation:

- 1= PIH
- 2= Bleeding
- 3= Polyhydramnios
- 66= Other (specify)
- 4= Chorionamnionitis
- 5= Low biophysical profile
- 6= Low AFI or oligohydramnios
- 77=NA
- 88=Not Legible

7= Premature ROM

- 8= Prolonged premature ROM
- 9= Prolonged ROM (term)
- 10= Prolonged labor/uterine dystocia
- 99=Not Recorded

11= Mature amnio

- 12= Post date
- 13= Fetal Distress

1a1. Date initiated ____/____/____	1a2. Time Initiated ____:____	1c. Method	1d. Purpose 1. <input type="checkbox"/> Induction 2. <input type="checkbox"/> Augmentation 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1e. Reason	1f. Comments
1b1. Date stopped ____/____/____	1b2. Time Stopped ____:____				
2a1. Date initiated ____/____/____	2a2. Time Initiated ____:____	2c. Method	2d. Purpose 1. <input type="checkbox"/> Induction 2. <input type="checkbox"/> Augmentation 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2e. Reason	2f. Comments
2b1. Date stopped ____/____/____	2b2. Time Stopped ____:____				
3a1. Date initiated ____/____/____	3a2. Time Initiated ____:____	3c. Method	3d. Purpose 1. <input type="checkbox"/> Induction 2. <input type="checkbox"/> Augmentation 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3e. Reason	3f. Comments
3b1. Date stopped ____/____/____	3b2. Time Stopped ____:____				
4a1. Date initiated ____/____/____	4a2. Time Initiated ____:____	4c. Method	4d. Purpose 1. <input type="checkbox"/> Induction 2. <input type="checkbox"/> Augmentation 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4e. Reason	4f. Comments
4b1. Date stopped ____/____/____	4b2. Time Stopped ____:____				

Comments:

G. RUPTURE OF MEMBRANES

If "yes" is indicated for medications, please fill out Section N.

No information for any item in section

<p>1. Date</p> <p>____/____/____</p>	<p>2. Time</p> <p>1. <input type="checkbox"/> at delivery ____:____</p> <p>2. <input type="checkbox"/> at c-section ____:____</p> <p>3. <input type="checkbox"/> other time ____:____</p>	<p>3. Length of time before delivery</p> <p>1. <input type="checkbox"/> <1 h 2. <input type="checkbox"/> 1-12h 3. <input type="checkbox"/> 12-24h 4. <input type="checkbox"/> >24 h 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4. Method</p> <p>1. <input type="checkbox"/> Spontaneous 2. <input type="checkbox"/> Artificial 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>5. Confirming dx (select all that apply)</p> <p>1. <input type="checkbox"/> +Pooling 2. <input type="checkbox"/> +Nitrazine 3. <input type="checkbox"/> +Ferning 4. <input type="checkbox"/> +Indigo dye test 5. <input type="checkbox"/> +History 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>6. Description of fluid at time of rupture (select all that apply)</p> <p>1. <input type="checkbox"/> Clear 2. <input type="checkbox"/> Yellow 3. <input type="checkbox"/> Bloody 4. <input type="checkbox"/> Purulent 5. <input type="checkbox"/> Foul odor 6. <input type="checkbox"/> Meconium NOS 7. <input type="checkbox"/> Thin meconium 8. <input type="checkbox"/> Thick meconium 9. <input type="checkbox"/> Moderate meconium 10. <input type="checkbox"/> Terminal mec 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>			<p>7. Note any changes in fluid color/odor</p> <p>1. <input type="checkbox"/> No Change Noted 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	
<p>8. Mother's statement (include where, when, description)</p>			<p>9. Medication given during ROM</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	

Comments:

H. DELIVERY SUMMARY

No information for any item in section

Plurality: 11 = Singleton 20 = Twin NOS 30 = Triplet NOS 40 = Quadruplet NOS
 21 = Twin A 31 = Triplet A 41 = Quadruplet A
 22 = Twin B 32 = Triplet B 42 = Quadruplet B
 33 = Triplet C 43 = Quadruplet C
 44 = Quadruplet D

<p>1. Gender</p> <p>1. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female 3. <input type="checkbox"/> Ambiguous 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>2. Plurality</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3. Zygosity</p> <p>1. <input type="checkbox"/> Monozygotic (MZ) 2. <input type="checkbox"/> Dizygotic (DZ) 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p> <p>3a. Zygosity determined by:</p>	<p>4. Weight (gm)</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>5. Length (cm)</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>6. Head circumference (cm)</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
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7. Apgar scores

1'	5'	10'	15'

88 IL 99 NR

<p>8. Type of delivery</p> <p>1. <input type="checkbox"/> NSVD 2. <input type="checkbox"/> Operative vaginal delivery 3. <input type="checkbox"/> C-section 4. <input type="checkbox"/> Breech extraction 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>9. Presentation at delivery</p> <p>1. <input type="checkbox"/> Vertex 2. <input type="checkbox"/> Transverse lie (shoulder presentation) 3. <input type="checkbox"/> Face/brow 4. <input type="checkbox"/> Breech 6. <input type="checkbox"/> Other, (specify): _____ 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>10. Description of delivery</p> <p>1. <input type="checkbox"/> Normal 2. <input type="checkbox"/> Precipitous 3. <input type="checkbox"/> Prolonged 1st stage 4. <input type="checkbox"/> Prolonged 2nd stage 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
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<p>11. Meconium staining of baby's (select all that apply)</p> <p>1. <input type="checkbox"/> Skin 4. <input type="checkbox"/> Cord 2. <input type="checkbox"/> Nails 5. <input type="checkbox"/> No staining 3. <input type="checkbox"/> Placenta</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>12. Birth defects (use codes from medical conditions list; write out verbatim any conditions not on list)</p> <p>12a. Dx1 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 12b. Dx2 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 12c. Dx3 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 12d. Dx4 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 12e. Dx5 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 12f. Dx6 code _____ Text _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p>
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<p>13. Date onset labor</p> <p>___ / ___ / _____</p>	<p>14. Time onset</p> <p>___ : ___</p>	<p>15. If date/time unknown, mother's statement</p>
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<p>16. Analgesia in labor 16a. Agent (select all that apply)</p> <p><input type="checkbox"/> Nubain <input type="checkbox"/> Stadol <input type="checkbox"/> Demerol <input type="checkbox"/> Fentanyl <input type="checkbox"/> Other: Specify: _____ _____</p> <p><input type="checkbox"/> None</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>16b. Complications:</p> <p>16b1 Complication 1 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 16b2 Complication 2 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 16b3 Complication 3 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 16b4 Complication 4 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 16b5 Complication 5 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 16b6 Complication 6 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p>
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16c. Method (when not stated use delivery time)

1. <input type="checkbox"/> Epidural	Epidural start time: ____ : ____ Date: _____
2. <input type="checkbox"/> Spinal	Spinal/Intrathecal start time: ____ : ____ Date _____
3. <input type="checkbox"/> Local	
4. <input type="checkbox"/> General	
5. <input type="checkbox"/> Perineal	
6. <input type="checkbox"/> Paracervical (saddle block)	Spinal/Intrathecal start time: ____ : ____ Date _____
7. <input type="checkbox"/> Pudendal	Spinal/Intrathecal start time: ____ : ____ Date _____
8. <input type="checkbox"/> Other (specify): _____	

88 IL
 99 NR

<p>19a. Prep solutions used</p> <p>1. <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p> <p>19b. Location: _____ _____ _____</p>	<p>20. Preterm delivery</p> <p>1. <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>21. Reason for preterm delivery per MD</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
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21. Newborn Screening Accession Number: _____ 88 IL 99 NR

Comments:

I. PLACENTA AND CORD

No information for any item in section

<p>1. Date of Placenta Delivery</p> <p>____/____/____</p>	<p>2. Time of Placenta Delivery</p> <p>____:____</p>	<p>3. 1. <input type="checkbox"/> Spont. 2. <input type="checkbox"/> Assisted 3. <input type="checkbox"/> Manual</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>4. Nuchal cord</p> <p>4.b.</p> <p>1. <input type="checkbox"/> Tight 2. <input type="checkbox"/> Loose 3. <input type="checkbox"/> NOS 4. <input type="checkbox"/> Other: _____ Specify _____</p> <p>5. <input type="checkbox"/> Nuchal cord not noted</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p> <p>4a. Times wrapped around neck</p> <p style="text-align: center;">X _____</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>5. Cord length</p> <p>1. <input type="checkbox"/> Long 2. <input type="checkbox"/> Short 4. <input type="checkbox"/> Stated length: _____</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>
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<p>6. Other cord abnormalities (select all that apply)</p> <p>1. <input type="checkbox"/> True knot 2. <input type="checkbox"/> Thin 3. <input type="checkbox"/> Two vessels 4. <input type="checkbox"/> Three vessels (normal) 5. <input type="checkbox"/> Velamentous/marginal insertion 6. <input type="checkbox"/> Cord prolapse</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>7. Infarcts noted on OB/CNM exam</p> <p>1. <input type="checkbox"/> Old 2. <input type="checkbox"/> New 3. <input type="checkbox"/> NOS 4. <input type="checkbox"/> None noted</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p> <p>7a. Size _____</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>8. Description of placenta on OB/CNM exam (select apply that apply)</p> <p><input type="checkbox"/> Small placenta <input type="checkbox"/> Fetal papyraceous <input type="checkbox"/> Abruption _____% <input type="checkbox"/> Placenta accreta, increta or percreta <input type="checkbox"/> Placenta previa <input type="checkbox"/> Complete/total <input type="checkbox"/> Partial/marginal <input type="checkbox"/> Low lying <input type="checkbox"/> Missing lobes <input type="checkbox"/> Calcification <input type="checkbox"/> Vascular abnormalities <input type="checkbox"/> Clot noted <input type="checkbox"/> other: specify _____</p> <p>88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>
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Comments:

J. PLACENTAL PATHOLOGY

No information for any item in section

1. Pathology report copied
2. Placenta not sent to pathology (discarded)
3. Status unclear/report not in chart

Comments:

K. DELIVERY INTERVENTIONS

No information for any item in section

Interventions		Comments	
<p>1a. Version</p> <p>1. <input type="checkbox"/> yes 2. <input type="checkbox"/> no</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>1b. Date: ___/___/_____</p>	<p>1c. 1. <input type="checkbox"/> Successful 2. <input type="checkbox"/> Failed</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	
<p>2a. Amnio Infusion</p> <p>1. <input type="checkbox"/> yes 2. <input type="checkbox"/> no</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>2b. Specify complications:</p> <p>2b1 Complication 1 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p> <p>2b2 Complication 2 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p> <p>2b3 Complication 3 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p> <p>2b4 Complication 4 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p> <p>2b5 Complication 5 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p> <p>2b6 Complication 6 _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL</p>		
<p>3a. Vacuum</p> <p>1. <input type="checkbox"/> yes 2. <input type="checkbox"/> no</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3b. 1. <input type="checkbox"/> Successful 2. <input type="checkbox"/> Failed</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3c. Total time on _____ min</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3d. Number of Pulls _____</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>4a. Forceps</p> <p>1. <input type="checkbox"/> yes 2. <input type="checkbox"/> no</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4b. 1. <input type="checkbox"/> Successful 2. <input type="checkbox"/> Failed</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4c. Total time on _____ min</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4d. Number of Pulls _____</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>5a. Cesarean Section</p> <p>1. <input type="checkbox"/> yes 2. <input type="checkbox"/> no</p> <p>77 <input type="checkbox"/> NA 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>5b. 1. <input type="checkbox"/> Elective 2. <input type="checkbox"/> Unscheduled 3. <input type="checkbox"/> Emergency, 5b1. Specify: _____</p> <p>88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>		

Comments:

Section K Part 2: Complications of Labor and Delivery

Check all that apply

 No Complications Noted
(Skip to section L)

 Active Phase Arrest (APA)

 Arrest of descent

 Cephalopelvic Disproportion
(CPD)

 Cholestasis of pregnancy or
intrahepatic cholestasis

 Deep Transverse Arrest

 Failed Trial of Labor

 Failure to progress (FTP)

 Failure to descend

 Fetal distress or intolerance of labor
(FIOL)

 Herpes (genital), Active only

 Intra-uterine growth retardation (IUGR)

 Low BPP or non-reassuring fetal testing

 Macrosomia

 Maternal death

 Oligohydramnios or Low AFI

 Persistent OP

 Polyhydramnios

 Post-dates

 Postpartum hemorrhage

 Hemabate given

 Methergine given

 Uterine Artery Embolization

 Prolonged latent stage

 Retained placenta

 Seizure, infant

 Shoulder dystocia

 Slow Slope Active Phase

 Uterine atony

 Uterine rupture

 Vasa previa

 VBAC

 Other

(specify): _____

L (part 1). MATERNAL INFECTIONS NOTED THIS ADMISSION THROUGH 24 HOURS POSTPARTUM

Extra sheet provided in Appendix A if needed

Dx: Use codes from infection list (Appendix D)

If cultures were performed, note in section M.

If “yes” is indicated for medications, please fill out Section N.

No information for any item in section

<p>1a Dx</p>	<p>1b.1 Date diagnosed ____/____/____ OR 1b.ga GA _____ wks OR 1b.tri Trimester _____</p>	<p>1c Duration _____ days</p>	<p>1d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown</p>	<p>1e.1 Highest Temp _____ 1e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>1f.1 Lowest Temp _____ 1f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>1g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>1h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>2a Dx</p>	<p>2b.1 Date diagnosed ____/____/____ OR 2b.ga GA _____ wks OR 2b.tri Trimester _____</p>	<p>2c Duration _____ days</p>	<p>2d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown</p>	<p>2e.1 Highest Temp _____ 2e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>2f.1 Lowest Temp _____ 2f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>2g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>2h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>3a Dx</p>	<p>3b.1 Date diagnosed ____/____/____ OR 3b.ga GA _____ wks OR 3b.tri Trimester _____</p>	<p>3c Duration _____ days</p>	<p>3d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown</p>	<p>3e.1 Highest Temp _____ 3e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3f.1 Lowest Temp _____ 3f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>3h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>
<p>4a Dx</p>	<p>4b.1 Date diagnosed ____/____/____ OR 4b.ga GA _____ wks OR 4b.tri Trimester _____</p>	<p>4c Duration _____ days</p>	<p>4d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown</p>	<p>4e.1 Highest Temp _____ 4e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4f.1 Lowest Temp _____ 4f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>	<p>4h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR</p>

Comments: Specify any other DX (code=600) as **1a.sp, 2a.sp, 3a.sp, 4a.sp**
Also list other comments.

L (PART 2) SIGNS AND SYMPTOMS (S/S) FOR DELIVERY TO 24 HOURS POSTPARTUM		
<input type="checkbox"/> No information for any item in section		
S/S	Date first noted	Time
1. Uterine Tenderness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	1a. ____/____/____	1b. ____:____
2. Foul vaginal discharge note (odor) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	2a. ____/____/____	2b. ____:____
3. Purulent amniotic fluid (color) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	3a. ____/____/____	3b. ____:____
4. WBC count > 15,000/mL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	4a. ____/____/____	4b. ____:____
5. Persistent mat't tachycardia (>100 bpm) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	5a. ____/____/____	5b. ____:____
6. Persistent fetal tachycardia (>160 bpm) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	6a. ____/____/____	6b. ____:____
7. Fetal bradycardia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	7a. ____/____/____	7b. ____:____
8. Periodic Changes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	8a. ____/____/____	8b. ____:____
9. Other, 9a. Specify _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspect <input type="checkbox"/> IL <input type="checkbox"/> NR	____/____/____	____:____
Comments:		

L (part 3). Fever >37.7 °C or 100 °F ON ADMISSION TO 24 HOURS POSTPARTUM No information for any item in section

	5 highest fevers	Date	Time
1.	1a.1 Highest Temp _____ 1a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1b ___ / ___ / ____	1c (military time) _____ : _____
2.	2a.1 Highest Temp _____ 2a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2b ___ / ___ / ____	2c (military time) _____ : _____
3.	3a.1 Highest Temp _____ 3a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3b ___ / ___ / ____	3c (military time) _____ : _____
4.	4a.1 Highest Temp _____ 4a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4b ___ / ___ / ____	4c (military time) _____ : _____
5.	5a.1 Highest Temp _____ 5a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	5b ___ / ___ / ____	5c (military time) _____ : _____

Comments:

M. CULTURES/RAPID STREP SCREENS OBTAINED THIS ADMISSION (RECORD ALL CULTURES /STREP SCREENS OBTAINED) Extra sheet provided in Appendix A if needed

Indicate the number of the event from section L or '0' If culture does not correspond to an event in section L.

No information for any item in section

Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Source: 1 = amniotic fluid; 2 = placenta; 3 = cervix; 4 = vagina; 5 = urine; 6 = blood; 7 = sputum; 8=throat; 9 = stool; 10=wound; 11= other (specify); 88 = Illegible 99=Not recorded

1a – 20a REF	1b – 20b Date Cultured	1c–20c 1c.sp- 20c.sp (specify) Source	1d – 20d (1d.6.sp – 20d.6.sp and 1d.9.sp – 20d.9.sp for specify fields) Results	1e – 20e Description (organisms, etc.)
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	

M.CULTURES/RAPID STREP SCREENS (continued)

Source: 1 = amniotic fluid; 2 = placenta; 3 = cervix; 4 = vagina; 5 = urine; 6 = blood; 7 = sputum; 8=throat; 9 = stool; 10=wound; 11= other (specify); 88 = Illegible 99=Not recorded

1a – 20a REF	1b – 20b Date Cultured	1c–20c 1c.sp- 20c.sp (specify) Source	1d – 20d (1d.6.sp – 20d.6.sp and 1d.9.sp – 20d.9.sp for specify fields) Results	1e – 20e Description (organisms, etc.)
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	

Comments:

N. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES, STEROIDS, HORMONES, AND OTHER MEDICATIONS) TAKEN THIS ADMISSION THROUGH 24 HOURS POSTPARTUM

Extra sheet provided in Appendix A if needed

No information for any item in section

Refer: Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'.

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 11 = steroids (other); 12 = hormones; 13 = thyroid; 14 = antibiotics; 15 = antifungals; 16 = antivirals; 17 = anesthetics (not labor and delivery); 18 = anticonvulsants; 19 = analgesics/hypnotics/sedatives/antipsychotics; 20 = antihypertensives/diuretics; 21 = cardiovascular; 22 = narcotic agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine, labor and delivery anesthetics (recorded in Section F)

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

ongoing 99. NR

N. ALL MEDICATIONS (continued)

Refer: Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'.

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 11 = steroids (other); 12 = hormones; 13 = thyroid; 14 = antibiotics; 15 = antifungals; 16 = antivirals; 17 = anesthetics (not labor and delivery); 18 = anticonvulsants; 19 = analgesics/hypnotics/sedatives/antipsychotics; 20 = antihypertensives/diuretics; 21 = cardiovascular; 22 = narcotic agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine, labor and delivery anesthetics (recorded in Section F)

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other_____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other_____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other_____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other_____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

N. ALL MEDICATIONS (continued)

Refer: Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'.

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 11 = steroids (other); 12 = hormones; 13 = thyroid; 14 = antibiotics; 15 = antifungals; 16 = antivirals; 17 = anesthetics (not labor and delivery); 18 = anticonvulsants; 19 = analgesics/hypnotics/sedatives/antipsychotics; 20 = antihypertensives/diuretics; 21 = cardiovascular; 22 = narcotic agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine, labor and delivery anesthetics (recorded in Section F)

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

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