

Study ID: _____

Date completed (MM-DD-YY): ___/___/___

Name of Abstractor: _____

Prenatal Clinic: Chinle Gallup Shiprock Ft. Defiance Tuba City Other (Specify) _____

PRENATAL AND PREGNANCY MEDICAL RECORD ABSTRACTION FORM

PREGNANCY HISTORY

Grav _____ Para _____

Term _____ Premature _____

Abs _____ Living _____ Stillbirth _____ Neonatal death _____

Previous Pregnancies (Provide details for all live-born children):

1) Date of Birth ___/___/___ Weeks Gestation _____ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

2) Date of Birth ___/___/___ Weeks Gestation _____ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

3) Date of Birth ___/___/___ Weeks Gestation _____ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

4) Date of Birth ___/___/___ Weeks Gestation _____ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

5) Date of Birth ___/___/___ Weeks Gestation ___ ___ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

6) Date of Birth ___/___/___ Weeks Gestation ___ ___ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

7) Date of Birth ___/___/___ Weeks Gestation ___ ___ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

8) Date of Birth ___/___/___ Weeks Gestation ___ ___ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

9) Date of Birth ___/___/___ Weeks Gestation ___ ___ Singleton Multiple (Number___)

Type of Delivery Vaginal Vaginal-assisted Scheduled Cesarean Emergency Cesarean

Infant Sex Male Female [If more than one, place number in box for each infant sex]

Check this box if more than 9 (nine) live-born children

PRENATAL RISK ASSESSMENT

Reproductive History:

Age Under 16 or Over 35 _____ (1)
Parity 0 or Over 5 _____ (1)
Habitual Abortion _____ (1)
Infertility _____ (1)
P P Hem, Manual Removal _____ (1)
Previous baby >9lbs (4050 gms) _____ (1)
 <5 ½ lbs (2500 gms) _____ (2)
Previous Toxemia, Hypertension _____ (1)
Previous Cesarean Section _____ (3)
Previous Stillbirth or N N D _____ (3)
Prolonged Labor (>30 Hrs.) or
 Difficult Delivery _____ (1)
Other _____ (1)
Other _____ (1)

Associated Conditions:

Chronic Renal Disease _____ (2)
Diabetes: Gestational _____ (2)
Class B or Higher _____ (3)
Cardiac Disease _____ (1-3)
Major Gyn Surgery, Cone Bx _____ (2)
Other _____ (1-3)
Other _____ (1-3)
Other _____ (1-3)
Cigarette Smoking _____ (1)
Alcohol Use _____ (1-2)
Teratogen/Drug Exposure
_____ (1-2)
Significant Social Problem
_____ (1-3)

Present Pregnancy:

Bleeding Less than 20 wks _____ (1)
Bleeding After 20 wks _____ (1-3)
Anemia: Hematocrit <34 _____ (1)
Prolonged Pregnancy >42 wks _____ (3)
Hypertension, Preeclampsia _____ (2-3)
Premature Rupture Membranes _____ (3)
Polyhydramnios _____ (2)
Small for Dates _____ (3)
Multiple Pregnancy _____ (3)
Breech > 36 weeks _____ (3)
Rh Negative, Sensitized? _____ (1-3)
Genital Herpes, active _____ (3)
Excessive or inadequate wt. gain _____ (1-2)
Other _____ (1-3)

TOTAL RISK SCORE

CURRENT PREGNANCY

Gestational Assessments:

Menstrual History LNMP ___/___/___ Certainty of Date Yes No Don't know

Use of BCPs Yes No Don't know If yes, last date taken ___/___/___ Don't know

Attitude Towards Pregnancy: Planned Unplanned Don't know

Clinical Evaluation:

Is there evidence of a positive pregnancy test (hCG)? Yes No Don't know

Pregnancy Test Date ___/___/___

First uterine size estimate by bimanual examination ___/___/___ Gestational Age ___ weeks

Predicted EDC ___/___/___ Reliability of Estimate: Poor Good Excellent Don't know

First Ultrasound Date ___/___/___ Gestational Age ___ weeks Sonar EDC ___/___/___

Last Ultrasound Date ___/___/___ Gestational Age ___ weeks Sonar EDC ___/___/___

Number of fetuses Singleton Multiple If Multiple fetuses, how many? _____

Fetal heart tones first heard by Doppler Date: ___/___/___

Fetal heart tones first heard by fetoscope Date: ___/___/___

Fetal movement first perceived by patient (quickening) Date: ___/___/___

Prenatal Visit History:

Total Number of Prenatal Visits _____ [Check box if unknown

First Prenatal Visit Date ___/___/___ [Check box if unknown

Pre-pregnancy weight _____ lb, _____ oz. **or** _____ kg

Term pregnancy weight _____ lb, _____ oz. **or** _____ kg

Was RHO (D) immune globulin (Gamulin Rh, HypRho-D, Rhesonativ, RhoGAM) given to the patient during this

pregnancy? Yes No Don't know If yes, date: ___/___/___

Behavioral Assessment:

Smoking Tobacco Cigarettes during pregnancy Yes No Don't know

Number of Cigarettes per day during pregnancy ____

Smoking Tobacco Cigarettes before pregnancy Yes No Don't know

Number of Cigarettes per day before pregnancy ____

Alcohol use during pregnancy Yes No Don't know

Number of Alcoholic drinks per week during pregnancy ____

Alcohol use before pregnancy Yes No Don't know

Number of Alcoholic drinks per week before pregnancy ____

Ceremonial drug use during pregnancy (e.g. peyote) Yes No Don't know

If yes, specify type _____

Prescription drug use during pregnancy Yes No Don't know

If yes, specify type _____

Illicit drug use during pregnancy Yes No Don't know

If yes, specify type _____

Prenatal vitamin use during pregnancy Yes No Don't know

If yes, specify brand/type _____

Estimated start of use ____ (weeks of gestation)

Estimated compliance: Poor Good Excellent Don't know

Referrals/Counseling:

Did the patient receive any of the following types of **referrals or counseling** during her prenatal care?

Diabetic diet Yes No Don't know

Alcohol abuse Yes No Don't know

Drug abuse Yes No Don't know

Smoking cessation Yes No Don't know

Other (specify: _____) Yes No Don't know

ROUTINE LABORATORY TEST RESULTS (First Prenatal Visit -or- First Available)

GC Pos Neg Don't know/missing Date ___/___/___

Chlamydia Pos Neg Don't know/missing Date ___/___/___

B Strep Pos Neg Don't know/missing Date ___/___/___

Creatinine clearance (mL/min) _____ Date ___/___/___

Urine 24 hours protein (mg/24 hour) _____ Date ___/___/___

Hgb (g/dL) ____ . ____ Date ___/___/___

Hct (%) ____ Date ___/___/___

MCV (fL) _____ Date ___/___/___

RDW (%) ____ Date ___/___/___

Folate (ng/ml) ____ . ____ Date ___/___/___

E3 ____ . ____ Date ___/___/___

Serum AFP High Normal/Neg Low Don't know/missing Date ___/___/___

Rubella Immune Not Immune Don't know/missing Date ___/___/___

Hepatitis B (HBsAg) Positive Negative Don't know/missing Date ___/___/___

Syphilis Positive Negative Don't know/missing Date ___/___/___

VDRL (quantitative) _____ Date ___/___/___

Urine C&S Pos Neg Don't know/missing Date ___/___/___

Was patient ever treated for urinary tract infection (UTI) in current pregnancy? Yes No Don't know

If yes, how was patient treated? (specify) _____ Date ___/___/___

OTHER TESTING

Did the patient have an **amniocentesis** during the current pregnancy? Yes No Refused Don't know

If yes, date: ___/___/___

Chromosomal type Normal Abnormal Don't know/missing

Alpha-fetoprotein (AFP) High Normal/Neg Low Don't know/missing

Lecithin/Sphingomyelin (LS) ratio ___ . ___

Phosphatidyl-glycerol (PG) Trace Present Absent Don't know/missing

Other abnormality Yes No Don't know/missing If yes, specify: _____

Did the patient have an **chorionic villus sampling (CVS)** during the current pregnancy?

Yes No Refused Don't know If yes, date: ___/___/___

Chromosomal abnormality Yes No Don't know/missing If yes, specify: _____

Other abnormality Yes No Don't know/missing If yes, specify: _____

Gestational Diabetes Screening

Is patient known to have (pre-existing) diabetes? Yes No Don't know

Glucose Tests:

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose _____ mg/dL Date: ___/___/___ Fasting?: Yes No Don't know

Glucose Tolerance Testing:

Did patient complete a 1-hour, 50-g glucose load random screening test? Yes No Don't know

If yes, result _____ mg/dL Date of 1-hour screening test: ___ / ___ / ___

If yes, result _____ mg/dL Date of 1-hour screening test: ___ / ___ / ___

If yes, result _____ mg/dL Date of 1-hour screening test: ___ / ___ / ___

Did patient complete a 3-hour, 100-g glucose load test after overnight fasting? Yes No Don't know

If yes, results: Fasting _____ mg/dL Date of 3-hour test: ___ / ___ / ___

1-hour _____ mg/dL 2-hour _____ mg/dL 3-hour _____ mg/dL

If yes, results: Fasting _____ mg/dL Date of 3-hour test: ___ / ___ / ___

1-hour _____ mg/dL 2-hour _____ mg/dL 3-hour _____ mg/dL

If yes, results: Fasting _____ mg/dL Date of 3-hour test: ___ / ___ / ___

1-hour _____ mg/dL 2-hour _____ mg/dL 3-hour _____ mg/dL

Did the patient develop gestational diabetes during the current pregnancy? Yes No Don't know

If yes, date of diagnosis: ___ / ___ / ___

Was patient given medication for diabetes during the current pregnancy? Yes No Don't know

If yes, type of medication (specify) _____ Date started: ___ / ___ / ___

Pregnancy-Induced Hypertension

During the current pregnancy, was the patient ever diagnosed as having eclampsia, preeclampsia, toxemia, or pregnancy-induced hypertension?

Yes No Don't know If yes, date of diagnosis: ___ / ___ / ___

Was patient given medication for hypertension during the current pregnancy? Yes No Don't know

If yes, type of medication (specify) _____ Date started: ___ / ___ / ___

Was patient ever hospitalized for hypertension-related conditions during the current pregnancy?

Yes No Don't know If yes, (specify reason) _____ Date: ___ / ___ / ___

SYMPTOMS /FINDINGS

At any time during the **current pregnancy**, did the patient have any of the following **symptoms or findings**?

- Severe headache Yes No Don't know
- Mental status change Yes No Don't know
- Visual disturbances Yes No Don't know
- Right upper quadrant or epigastric pain Yes No Don't know
- Oliguria Yes No Don't know
- Pulmonary edema Yes No Don't know
- Seizures Yes No Don't know

Were any of the following noted as **possible problems** during the **current pregnancy**?

- Oligohydramnios Yes No Don't know
- Polyhydramnios Yes No Don't know
- Fetal growth retardation (IUGR) Yes No Don't know
- Large uterus for dates Yes No Don't know
- Preterm labor, premature rupture of membranes Yes No Don't know
- Other (specify _____) Yes No Don't know

RESTRICTED ACTIVITY

Did the patient ever **discontinue employment or reduce her usual activities** (other than bedrest) during this pregnancy?

Yes No Don't know If yes, date first stopped working /reduced: ___ / ___ / ___

Was the patient ever put on **bedrest** at home during this pregnancy? Yes No Don't know

If yes, date **bedrest** first started: ___ / ___ / ___

TRANSFER OF CARE

Is there evidence in the medical record indicating that a part of the patient's **regular prenatal care** was administered

elsewhere (at another clinic or facility)? Yes No Don't know

HOSPITALIZATIONS DURING PREGNANCY

Were there **any hospitalizations** during the current pregnancy? Yes No Don't know

If yes, date of admission: ___ / ___ / ___ date of discharge: ___ / ___ / ___

Specify reason for admission: _____

If yes, date of admission: ___ / ___ / ___ date of discharge: ___ / ___ / ___

Specify reason for admission: _____

If yes, date of admission: ___ / ___ / ___ date of discharge: ___ / ___ / ___

Specify reason for admission: _____

If yes, date of admission: ___ / ___ / ___ date of discharge: ___ / ___ / ___

Specify reason for admission: _____

If yes, date of admission: ___ / ___ / ___ date of discharge: ___ / ___ / ___

Specify reason for admission: _____

LABOR AND DELIVERY MEDICAL RECORD ABSTRACTION FORM

Admission Date ___/___/___ Admission Time ___:___ AM PM

Delivery Hospital: Chinle Gallup Shiprock Ft. Defiance Tuba City Other (Specify) _____

MATERNAL CHARACTERISTICS AT ADMISSION

Maternal weight at admission _____ *lb*, _____ *oz.* **or** _____ *kg*

Maternal height at admission _____ *ft*, _____ *in.* **or** _____ *cm*

Blood Pressure at admission: SBP _____ DBP _____

Cervical Dilation (cm) _____ Effacement (%) _____ Station ___ (-3 to +3) Check if no data

Onset of Labor: Date ___/___/___ Time ___:___ AM PM Don't know

ADMISSION COMPLICATIONS

Did any of the following conditions or problems occur during this admission, but prior to delivery?

Uterine bleeding, placenta previa/abruption Yes No Don't know

Premature rupture of membranes Yes No Don't know

Preterm labor Yes No Don't know

Secondary arrest/abnormal duration of labor Yes No Don't know

Failed forceps or vacuum Yes No Don't know

Cord prolapse Yes No Don't know

Shoulder dystocia Yes No Don't know

Meconium staining Yes No Don't know

Fetal distress Yes No Don't know

Amnionitis Yes No Don't know

Preeclampsia, eclampsia, toxemia, or pregnancy-induced hypertension Yes No Don't know

Other (Specify _____) Yes No Don't know

DELIVERY CHARACTERISTICS

Attending Provider: Obstetrician Family Practice Midwife Other (Specify) _____ Don't know

Type of Delivery: Vaginal Vaginal-Assisted Scheduled Cesarean Emergency Cesarean Don't know

If delivery was an **unscheduled C-Section**, what was reason(s) given? (specify) _____

Was the **delivery induced** using drugs to stimulate labor? Yes No Don't know

If yes, type? (specify) _____ When ____ : ____ AM PM

If yes, type? (specify) _____ When ____ : ____ AM PM

If yes, type? (specify) _____ When ____ : ____ AM PM

Which of the following **methods of anesthesia** were used during labor or delivery?

Paracervical block, pudendal block, local infiltration Yes No Don't know

Epidural, spinal Yes No Don't know

General Yes No Don't know

PREGNANCY OUTCOME

Live birth Stillbirth Miscarriage Don't know

If Stillbirth or Miscarriage, Date ____ / ____ / ____ Don't know

Multiple fetuses? Yes No If yes, number of live births

(If multiple birth, please complete birth characteristics for each infant below)

INFANT BIRTH CHARACTERISTICS

Infant 1: Date of Birth ____ / ____ / ____ Time of Birth ____ : ____ AM PM

Sex Male Female

Weight ____ lb, ____ oz. **or** ____ gm

Length ____ in **or** ____ cm

Occipitofrontal head circumference ____ in **or** ____ cm

Gestational age at birth ____ (weeks)

How estimated: Ballard Dubowitz Other (Specify) _____ Don't know or missing

Apgar Scores: 1 minute ____ 5 minute ____ 10 minute ____

Initiation of breastfeeding: Yes No Don't know

Infant 2: Date of Birth ____ / ____ / ____ Time of Birth ____ : ____ AM PM

Sex Male Female

Weight ____ lb, ____ oz. **or** ____ gm

Length ____ in **or** ____ cm

Occipitofrontal head circumference ____ in **or** ____ cm

Gestational age at birth ____ (weeks)

How estimated: Ballard Dubowitz Other (Specify) _____ Don't know or missing

Apgar Scores: 1 minute ____ 5 minute ____ 10 minute ____

Initiation of breastfeeding: Yes No Don't know

Infant 3: Date of Birth ____ / ____ / ____ Time of Birth ____ : ____ AM PM

Sex Male Female

Weight ____ lb, ____ oz. **or** ____ gm

Length ____ in **or** ____ cm

Occipitofrontal head circumference ____ in **or** ____ cm

Gestational age at birth ____ (weeks)

How estimated: Ballard Dubowitz Other (Specify) _____ Don't know or missing

Apgar Scores: 1 minute ____ 5 minute ____ 10 minute ____

Initiation of breastfeeding: Yes No Don't know

NEWBORN COMPLICATIONS DURING DELIVERY

Indicate if one or more newborns had any of the following **complications during delivery**:

Lacerations Yes No Don't know

Erb's palsy/brachial plexus injury Yes No Don't know

Facial paralysis Yes No Don't know

- Cephalohematoma Yes No Don't know
- Fracture of skull, clavicle, or femur Yes No Don't know
- Hyaline membrane disease (HMD) Yes No Don't know
- Meconium aspiration Yes No Don't know
- Nuchal cord Yes No Don't know
- Respiratory distress Yes No Don't know
- Seizures, intercranial hemorrhage Yes No Don't know
- Congenital anomaly Yes No Don't know
- Stillbirth Yes No Don't know
- Neonatal death Yes No Don't know
- Admission to NICU Yes No Don't know

MATERNAL POSTPARTUM COMPLICATIONS

Indicate if mother had any of the following **complications during or after delivery**:

- Bladder/ureteral injury Yes No Don't know
- Bowel injury Yes No Don't know
- Perineal lacerations/episiotomy extension Yes No Don't know
- Abdominal wound infection Yes No Don't know
- Endometritis Yes No Don't know
- Pelvic abscess/cellulitis/septic pelvis
thrombophlebitis Yes No Don't know
- Pneumonia Yes No Don't know
- Sepsis Yes No Don't know
- Deep vein thrombosis or pulmonary embolism Yes No Don't know

(confirmed)

Blood transfusion

Yes No Don't know

Return to operating or delivery room
(Specify _____)

Yes No Don't know

DISCHARGE SUMMARY

Mother's Discharge Date ___ / ___ / ___ Mother's Discharge Time ___ : ___ AM PM

Status of mother at discharge: Alive Dead Don't know

Was infant(s) discharged at the same date/time as mother? Yes No Don't know

If **no**, date and time of infant(s) discharge:

Infant Discharge Date ___ / ___ / ___ Infant Discharge Time ___ : ___ AM PM

Study ID: _____

Date completed (MM-DD-YY): ___/___/___

Name of Abstractor: _____

Clinic: Chinle Gallup Shiprock Ft. Defiance Tuba City Other (Specify) _____

INFANT MEDICAL RECORD ABSTRACTION (up to 1 year of Age)

Date of Birth ___/___/___

Sex: Male Female

Is this child from a set of twins or a multiple birth? Yes No Don't know

If yes, siblings with:

Study ID _____ Study ID _____ Study ID _____

Newborn Screening Results (within 24-48 hours of birth)

Date of Test ___/___/___

Did the child **screen positive** for *any* of the following conditions? (**Check one box for each condition below**)

Endocrine disorders:

1. Congenital Adrenal Hyperplasia (CAH) Yes No Don't know

2. Congenital hypothyroidism (CH) Yes No Don't know

Hemoglobinopathies:

3. Sickle Cell Anemia (HB S/S) Yes No Don't know

4. S-βeta thalassemia (HB S/A) Yes No Don't know

5. Sickle C-disease (HB S/C) Yes No Don't know

Other core condition(s):

6. Cystic Fibrosis (CF) Yes No Don't know

7. Biotinidase Deficiency (BIO) Yes No Don't know

8. Galactosemia(GALT) Yes No Don't know

9. Severe Combined Immunodeficiency Disorder (SCIDs)

Yes No Don't know

Fatty Acid Oxidation disorders (FOA):

10. Carnitine uptake defect (CUD)

Yes No Don't know

11. Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD)

Yes No Don't know

12. Medium chain acyl-CoA dehydrogenase deficiency (MCAD)

Yes No Don't know

13. Trifunctional protein deficiency (TFP)

Yes No Don't know

14. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD)

Yes No Don't know

Amino Acid Disorders:

15. Homocystinuria (HCY)

Yes No Don't know

16. Tyrosinemia type I (TYR-1)

Yes No Don't know

17. Phenylketonuria (PKU)

Yes No Don't know

18. Maple syrup urine disease (MSUD)

Yes No Don't know

Urea Cycle disorders:

19. Argininosuccinic acidemia (ASA)

Yes No Don't know

20. Citrullinemia type I (CIT-1)

Yes No Don't know

Organic Acidemia disorders:

21. 3-Hydroxy 3-Methyl Glutaric Aciduria (HGM)

Yes No Don't know

22. 3-methylcrotonyl-CoA deficiency (3-MCC)

Yes No Don't know

23. Beta-ketothiolase /Mitochondrial acetoacetyl-CoA thiolase deficiency (BKT)

Yes No Don't know

24. Isovaleric acidemia (IVA)

Yes No Don't know

25. Methylmalonic acidemia (MUT)

Yes No Don't know

26. Proponic acidemia (PROP)

Yes No Don't know

27. Multiple carboxylase deficiency (MCD)

Yes No Don't know

28. Glutaric acidemia type I (GA-1)

Yes No Don't know

Newborn Hearing Screening Test

Date of Test ___/___/___

Time ___:___ AM PM

Right ear: Pass Refer Don't know

Left ear: Pass Refer Don't know

Newborn Screening Results (repeat, 1-2 weeks after birth)

Date of Test ___/___/___

Did the child **screen positive** for *any* of the following conditions? (**Check one box for each condition below**)

Endocrine disorders:

1. Congenital Adrenal Hyperplasia (CAH)

Yes No Don't know

2. Congenital hypothyroidism (CH)

Yes No Don't know

Hemoglobinopathies:

3. Sickle Cell Anemia (HB S/S)

Yes No Don't know

4. S- β thalassemia (HB S/A)

Yes No Don't know

5. Sickle C-disease (HB S/C)

Yes No Don't know

Other core condition(s):

6. Cystic Fibrosis (CF)

Yes No Don't know

7. Biotinidase Deficiency (BIO)

Yes No Don't know

8. Galactosemia(GALT)

Yes No Don't know

9. Severe Combined Immunodeficiency Disorder (SCIDs)

Yes No Don't know

Fatty Acid Oxidation disorders (FOA):

10. Carnitine uptake defect (CUD)

Yes No Don't know

11. Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD) Yes No Don't know
12. Medium chain acyl-CoA dehydrogenase deficiency (MCAD) Yes No Don't know
13. Trifunctional protein deficiency (TFP) Yes No Don't know
14. Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD) Yes No Don't know

Amino Acid Disorders:

15. Homocystinuria (HCY) Yes No Don't know
16. Tyrosinemia type I (TYR-1) Yes No Don't know
17. Phenylketonuria (PKU) Yes No Don't know
18. Maple syrup urine disease (MSUD) Yes No Don't know

Urea Cycle disorders:

19. Argininosuccinic acidemia (ASA) Yes No Don't know
20. Citrullinemia type I (CIT-1) Yes No Don't know

Organic Acidemia disorders:

21. 3-Hydroxy 3-Methyl Glutaric Aciduria (HGM) Yes No Don't know
22. 3-methylcrotonyl-CoA deficiency (3-MCC) Yes No Don't know
23. Beta-ketothiolase /Mitochondrial acetoacetyl-CoA thiolase deficiency (BKT) Yes No Don't know
24. Isovaleric acidemia (IVA) Yes No Don't know
25. Methylmalonic acidemia (MUT) Yes No Don't know
26. Proponic acidemia (PROP) Yes No Don't know
27. Multiple carboxylase deficiency (MCD) Yes No Don't know
28. Glutaric acidemia type I (GA-1) Yes No Don't know

2nd Hearing Test (repeat, 1-2 weeks) Date of Test ___ / ___ / ___ Time ___ : ___ AM PM

Right ear: Pass Refer Don't know

Left ear: Pass Refer Don't know

Did child require a **third newborn screening test** (due to premature birth or NICU admission)?

Yes No Don't know If **yes**, Date of Test ___ / ___ / ___

Regularly-Scheduled Well-Child Follow-up Visits

Age: 1 week Visit Date ___ / ___ / ___

Weight ___ lb, ___ oz. **or** ___ gm

Length ___ in **or** ___ cm

Occipitofrontal head circumference ___ in **or** ___ cm

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

Is child **currently breastfeeding**? Yes No Don't know

If yes, **age** when breastfeeding was initiated: ___ hours -or- ___ days

If no, was breastfeeding ever initiated? Yes No Don't know

Age: 2 weeks Visit Date ___ / ___ / ___

Weight ___ lb, ___ oz. **or** ___ gm

Length ___ in **or** ___ cm

Occipitofrontal head circumference ___ in **or** ___ cm

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

Is child **currently breastfeeding**? Yes No Don't know

Age: 6 weeks Visit Date ___ / ___ / ___

Weight _____ lb, _____ oz. **or** _____ gm

Length _____ in **or** _____ cm

Occipitofrontal head circumference _____ in **or** _____ cm

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

Is child **currently breastfeeding**? Yes No Don't know

Age: 4 months Visit Date ____ / ____ / ____

Weight _____ lb, _____ oz. **or** _____ gm

Length _____ in **or** _____ cm

Occipitofrontal head circumference _____ in **or** _____ cm

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

ASQ Screening Test

Communication _____
Gross Motor _____
Fine Motor _____
Problem-solving _____
Personal-Social _____

Is child **currently breastfeeding**? Yes No Don't know

Age: 6 months Visit Date ____ / ____ / ____

Weight _____ lb, _____ oz. **or** _____ gm

Length _____ in **or** _____ cm

Occipitofrontal head circumference _____ in **or** _____ cm

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

ASQ Screening Test

Communication _____
Gross Motor _____
Fine Motor _____
Problem-solving _____
Personal-Social _____

Is child **currently breastfeeding**? Yes No Don't know

Age: 9 months Visit Date ___ / ___ / ___

Weight ___ ___ *lb*, ___ ___ *oz*. **or** ___ ___ ___ *gm*

Length ___ ___ *in* **or** ___ ___ *cm*

Occipitofrontal head circumference ___ ___ *in* **or** ___ ___ *cm*

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

ASQ Screening Test

Communication ___ ___
Gross Motor ___ ___
Fine Motor ___ ___
Problem-solving ___ ___
Personal-Social ___ ___

Is child **currently breastfeeding**? Yes No Don't know

Age: 12 months Visit Date ___ / ___ / ___

Weight ___ ___ *lb*, ___ ___ *oz*. **or** ___ ___ ___ *gm*

Length ___ ___ *in* **or** ___ ___ *cm*

Occipitofrontal head circumference ___ ___ *in* **or** ___ ___ *cm*

Signs of abuse/neglect Yes No Don't know

Has child reached appropriate developmental milestones? Yes No Don't know

ASQ Screening Test

Communication ___ ___
Gross Motor ___ ___
Fine Motor ___ ___
Problem-solving ___ ___
Personal-Social ___ ___

Is child **currently breastfeeding**? Yes No Don't know

Age when breastfeeding was discontinued: ___ ___ weeks **or** ___ ___ months

Age when solid food was introduced: ___ ___ weeks **or** ___ ___ months

Blood Lead Test ___ ___ . ___ ___ mcg/dL Date of test ___ / ___ / ___

Information to be abstracted from medical record as available.

1st trimester Before 13 weeks	PREGNANCY 2nd trimester 13-26 weeks	3rd trimester >27 weeks	DELIVERY Birth	POSTPARTUM 6 weeks
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Maternal

<p>Baseline Questionnaire</p> <p>Blood and Urine</p> <p>Prenatal chart review</p> <p>Blood pressure, vital signs, height, weight</p> <p>Complete blood count (CBC); Anemia = Hct<35%</p> <p>Blood Type and Rh Antibody Screen</p> <p>Glucose Tolerance Test (1-hour) plus 3-hour if abnormal</p> <p>HIV</p>	<p>Blood and Urine</p> <p>Prenatal chart review</p> <p>Blood pressure, vital signs, height, weight</p> <p>Complete blood count (CBC); Anemia = Hct<35%</p> <p>serum Alpha-Fetal Protein (AFP) "quad" 4-part also includes: hCG, estriol, inhibin</p> <p>Chorionic villus sampling</p>	<p>Blood and Urine</p> <p>Prenatal chart review</p> <p>Blood pressure, vital signs, height, weight</p> <p>Complete blood count (CBC); Anemia = Hct<35%</p> <p>Glucose Tolerance Test (1-hour) plus 3-hour if abnormal</p>	<p>Blood and Urine</p> <p>L&D chart review</p> <p>Blood pressure, vital signs, height, weight</p> <p>Delivery complications</p> <ul style="list-style-type: none"> • Meconium staining (of amniotic fluid) • Intrauterine hypoxia • Fetal distress • Stillbirth <p>Labor complications</p> <ul style="list-style-type: none"> - Precipitous labor - Prolonged labor - Shoulder dystocia - Breech presentation - Nuchal cord 	<p>Blood and Urine</p> <p>Postpartum chart review</p> <p>Blood pressure, vital signs, height, weight</p> <p>Follow-up Questionnaire</p>
<p>Hgb A1c</p> <p>Serology (Rapid Plasma Reagin (RPR) for Syphilis)</p> <p>Rubella Tier</p> <p>HBSAg (surface antigen of the Hepatitis-B Virus (HBV))</p> <p>GC Culture (Gonorrhea)</p> <p>Chlamydia Culture</p>	<p>ROM rupture of membranes</p> <p>PROM/premature rupture of membranes</p> <p>UOP urine output</p>	<p>ROM rupture of membranes</p> <p>PROM/premature rupture of membranes</p> <p>UOP urine output</p>	<p>• Fetal distress</p> <p>• Stillbirth</p> <p>• Labor complications</p>	
<p>Pap Smear as needed</p> <p>Urinalysis with Culture & Sensitivity</p> <p>Group B Streptococcus (GBS)</p> <p>Pregnancy-related medical conditions:</p> <ul style="list-style-type: none"> - Hypertension (HTN), blood pressure - Preeclampsia/Eclampsia - Preeclampsia with chronic HTN - Gestational diabetes - Hypothyroidism (including subclinical) - Autoimmune diseases - Anemia - Other pregnancy-onset conditions 	<p>Urinalysis with Culture & Sensitivity</p> <p>Pregnancy-related medical conditions:</p> <ul style="list-style-type: none"> - Hypertension (HTN), blood pressure - Preeclampsia/Eclampsia - Preeclampsia with chronic HTN - Gestational diabetes - Hypothyroidism (including subclinical) - Autoimmune diseases - Anemia - Other pregnancy-onset conditions 	<p>Urinalysis with Culture & Sensitivity</p> <p>Pregnancy-related medical conditions:</p> <ul style="list-style-type: none"> - Hypertension (HTN), blood pressure - Preeclampsia/Eclampsia - Preeclampsia with chronic HTN - Gestational diabetes - Hypothyroidism (including subclinical) - Autoimmune diseases - Anemia - Other pregnancy-onset conditions 	<p>Delivery Type</p> <ul style="list-style-type: none"> - Vaginal - Vaginal Assisted - Scheduled Cesarean - Emergency Cesarean - Placental abruption - Infection - STD - TORCH - other bacterial - other viral - Postpartum complications - Endometritis - Hemorrhage - Depression 	

Fetal

Ultrasound

Kick counts (diary)

Gestational age (weeks)

Multiple fetuses

Fetal growth/ intrauterine growth restriction

Ultrasound

Kick counts (diary)

Gestational age (weeks)

Multiple fetuses

Fetal growth/ intrauterine growth restriction

Baby

12 months

Cord blood

Birth chart review:

Infant sex (altered sex ratio)

Apgar scores

Neonatal complication

- Respiratory distress
- Meconium aspiration syndrome
- Neonatal jaundice
- Infection

Gestational age at birth

- Very preterm (<32 weeks)
- Preterm (<37 weeks)
- Postterm (>42 weeks)

Birth weight (BW)

- Very low BW (<1500g)
- Low BW (<2500g)
- Macrosomia (>4000g)

Birth length

OFC - Occipitofrontal circumference (head circumference)

Congenital anomalies, major

- Hearing loss (screening results)
- Metabolic (screening results)
- Immunodeficiency
- Immune function markers

Mortality

- Neonatal (birth to <28 days)
- Postneonatal (>28 to 364 days)
- Infant (birth to 364 days)
- Sudden infant death syndrome (SIDS)

Breastfeeding patterns

Weight, length, head circumference

Growth curve results

Infections (number and type)

Immunizations - to date

Diagnoses of any chronic conditions

Cause of mortality