

Center Number: _____

Network ID Number:

VERMONT OXFORD NETWORK DELIVERY ROOM DEATH BOOKLET - **INFANTS BORN IN 2010**

Please use the Delivery Room Death Booklet for any eligible 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. **The Delivery Room Death Patient Identification Worksheet below contains personal patient identifiers and must not be submitted to Vermont Oxford Network. Vermont Oxford Network does not accept protected health care information.**

The Delivery Room Death Form should be completed and submitted to Vermont Oxford Network.

Refer to the Manual of Operations, Release 14.0, when completing Worksheets and Forms.

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Page 2: Delivery Room Death Form

DELIVERY ROOM DEATH PATIENT IDENTIFICATION WORKSHEET

W1. Patient's Name: _____

W2. Mother's Name: _____

W3. Patient's Medical Record Number: _____

W4. Date of Birth: / /
 MM DD YYYY

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information



DELIVERY ROOM DEATH FORM - *Infants Born in 2010*



Center Number: _____ Center Name: _____

Network ID Number:

Year of Birth: _____

1.	Birth Weight: _____ grams
2.	Gestational Age: a) Weeks _____ b) Days (0-6) _____
3.	Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No (If NO, do not use this Form)
4.	a) Location of Birth: <input type="checkbox"/> Inborn <input type="checkbox"/> Outborn (If OUTBORN, do not use this Form)
b & c) Not Applicable	
5.	Head Circumference at Birth (in cm to the nearest 10 th): <input type="text"/> <input type="text"/> . <input type="text"/>
6.	Maternal Ethnicity/Race: (Answer both a and b)
	a) Ethnicity of Mother: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic
	b) Race of Mother: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian or Pacific Islander
	<input type="checkbox"/> Native American <input type="checkbox"/> Other
7.	Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Antenatal Steroids: <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Chorioamnionitis: <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Maternal Hypertension, Chronic or Pregnancy-Induced: <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Mode of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section
12.	Sex of Infant: <input type="checkbox"/> Male <input type="checkbox"/> Female
13.	a) Multiple Gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No
	b) If Yes, number of infants delivered: _____
14.	APGAR Scores: a) 1 minute _____ b) 5 minutes _____
15.	Initial Resuscitation:
	a) Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Facial Mask Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Endotracheal Tube Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Epinephrine: <input type="checkbox"/> Yes <input type="checkbox"/> No
	e) Cardiac Compression: <input type="checkbox"/> Yes <input type="checkbox"/> No
16. - 22. Not Applicable	
23.	Surfactant Treatment:
	a) Surfactant in the DR: <input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Surfactant at Any Time: <input type="checkbox"/> Yes <input type="checkbox"/> No (Part b must be answered Yes if Part a is Yes)
	If Yes, enter Age at First Dose: c) hours _____ d) minutes (0-59) _____
24. - 43. Not Applicable	
44.	Birth Defect Present: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, enter Codes _____
	Include description for Codes 100, 504, 601, 605, 901, 902, 903, 904 & 907: _____
45. - 50. Not Applicable	