Center Number: _____ Network ID Number: ☐☐☐☐☐

VERMONT OXFORD NETWORK
DELIVERY ROOM DEATH BOOKLET FOR INFANTS BORN IN 2019

Use the Delivery Room Death Booklet for eligible inborn infants who die in the delivery room or at any other location in your hospital within 12 hours of birth and prior to admission to the NICU.

This Worksheet contains protected health care information and must NOT be submitted to Vermont Oxford Network (VON). VON only accepts protected health care information in cases where members have both voluntarily elected to send this information to VON and have signed an appropriate Business Associate Agreement with VON.

Contents:

DELIVERY ROOM DEATH
PATIENT IDENTIFICATION WORKSHEET

Patient's Name: _____

Mother's Name: _____

Patient's Medical Record Number: _____

Date of Birth: _____/_____/_____
MM DD YYYY

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

VON Vermont Oxford NETWORK

Delivery Room Death Data Items - *For Infants Born in 2019*

VON Vermont Oxford NETWORK

Center Number: _____ **Network ID Number:** ☐☐☐☐☐ **Year of Birth:** _____

Birth Weight: _____ grams

Gestational Age Weeks _____ **Gestational Age Days (0-6)** _____

Died in Delivery Room: ☐ Yes ☐ No (*If No*, do not complete Delivery Room Death Data Items)

Location of Birth: ☐ Inborn ☐ Outborn (*If Outborn*, do not complete Delivery Room Death Data Items)

Head Circumference at Birth (in cm to nearest 10th): ☐☐.☐

Maternal Ethnicity/Race (Answer both Ethnicity and Race):

Ethnicity of Mother: ☐ Hispanic ☐ Not Hispanic

Race of Mother: ☐ Black or African American ☐ White ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Prenatal Care: ☐ Yes ☐ No

Antenatal Steroids: ☐ Yes ☐ No

Antenatal Magnesium Sulfate: ☐ Yes ☐ No

Chorioamnionitis: ☐ Yes ☐ No

Maternal Hypertension, Chronic or Pregnancy-Induced: ☐ Yes ☐ No

Maternal Diabetes ☐ Yes ☐ No

Mode of Delivery: ☐ Vaginal ☐ Cesarean Section

Sex of Infant: ☐ Male ☐ Female ☐ Unknown

Multiple Gestation: ☐ Yes ☐ No ***If Yes*, Number of Infants Delivered:** _____

Congenital Infection: ☐ Yes ☐ No

Congenital Infection, Organisms: _____ _____ _____
(If *Congenital Infection* is *Yes*, enter up to three infection codes from Manual of Operations, Part 2 – Appendix E)

APGAR Scores: **1 minute** _____ **5 minutes** _____

Initial Resuscitation:

Oxygen:	☐ Yes	☐ No
Face Mask Vent:	☐ Yes	☐ No
Laryngeal Mask Airway:	☐ Yes	☐ No
Endotracheal Tube Vent:	☐ Yes	☐ No
Epinephrine:	☐ Yes	☐ No
Cardiac Compression:	☐ Yes	☐ No
Nasal Vent:	☐ Yes	☐ No
Nasal CPAP:	☐ Yes	☐ No

Surfactant during Initial Resuscitation: ☐ Yes ☐ No

Surfactant at Any Time: ☐ Yes ☐ No (*Surfactant at Any Time* must be *Yes* if *Surfactant During Initial Resuscitation* is *Yes*)

***If Yes*, Age at First Dose of Surfactant:** Hours _____ Minutes (0-59) _____

Congenital Anomaly: ☐ Yes ☐ No

***If Yes*, enter up to five Congenital Anomaly Codes:** _____ _____ _____ _____ _____
See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes

***If Yes*, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, and 907:**
_____

If your center participates in the Expanded Database, answer Supplemental Data Items *Meconium Aspiration Syndrome* and *Tracheal Suction for Meconium Attempted during IR*.

Meconium Aspiration: ☐ Yes ☐ No

Tracheal Suctioning for Meconium Attempted during IR: ☐ Yes ☐ No ☐ N/A