

Center Number: _____

Network ID Number:

**VERMONT OXFORD NETWORK
DELIVERY ROOM DEATH BOOKLET FOR INFANTS BORN IN 2018**

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.

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**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



Delivery Room Death Data Items - For Infants Born in 2018



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

Birth Weight: _____ grams			
Gestational Age Weeks _____		Gestational Age Days (0-6) _____	
Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If No, do not complete Delivery Room Death Data Items)</small>			
Location of Birth: <input type="checkbox"/> Inborn <input type="checkbox"/> Outborn <small>(If Outborn, do not complete Delivery Room Death Data Items)</small>			
Head Circumference at Birth (in cm to nearest 10 th): <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>			
Maternal Ethnicity/Race (Answer both Ethnicity and Race):			
Ethnicity of Mother: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic			
Race of Mother: <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian			
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other			
Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Antenatal Steroids: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Antenatal Magnesium Sulfate: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Chorioamnionitis: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Maternal Hypertension, Chronic or Pregnancy-Induced: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Maternal Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mode of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section			
Sex of Infant: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			
Multiple Gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Number of Infants Delivered: _____			
Congenital Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Congenital Infection, Organisms: _____ <small>(If Congenital Infection is Yes, enter up to three infection codes from Manual of Operations, Part 2 – Appendix E)</small>			
APGAR Scores: 1 minute _____ 5 minutes _____			
Initial Resuscitation:	Oxygen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Face Mask Vent:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Laryngeal Mask Airway:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Endotracheal Tube Vent:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Epinephrine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cardiac Compression:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nasal Vent:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nasal CPAP:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surfactant during Initial Resuscitation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Surfactant at Any Time: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Surfactant at Any Time must be Yes if Surfactant During Initial Resuscitation is Yes)</small>			
If Yes, Age at First Dose of Surfactant: Hours _____ Minutes (0-59) _____			
Congenital Anomaly: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, enter up to five Congenital Anomaly Codes: _____ <small>See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes</small>			
If Yes, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, and 907: _____			
<small>If your center participates in the Expanded Database, answer Supplemental Data Items Meconium Aspiration Syndrome and Tracheal Suction for Meconium Attempted during IR.</small>			
Meconium Aspiration: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Tracheal Suctioning for Meconium Attempted during IR: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			