

Phone: (585) 758-7811  
 Fax: (585) 424-1469  
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April 09

# Finger Lakes Regional Perinatal Data System

## Response Sheet



# CODERFax

## Twin A

To: **Barbara Suter** From: \_\_\_\_\_  
 Fax: **585-424-1469** Pages: \_\_\_\_\_  
 Phone: **585-758-7811** Date: \_\_\_\_\_  
 Re: **CODERFax** CC: \_\_\_\_\_

<b>Prenatal History</b>					
<b>Pregnancy History (Twin A)</b>					
Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
<b>Now Living</b> None or Number	<b>Now Dead</b> None or Number	<b>Less than 20 weeks</b> None or Number	<b>20 weeks or more</b> None or Number	None or Number	None or Number
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Live Birth: (MM/YYYY) /	Last Live Birth: (MM/YYYY) /	Last Other Pregnancy Outcome: (MM/YYYY) /	Prepregnancy Weight: lbs.	Height: ft. in.	
<b>Infant</b>					
<b>Apgar Scores</b>					
1 minute:	5 minutes	10 minutes:			
<b>Abnormal Conditions of the Newborn:</b>					
___ None ___ Unknown at this time					
<b>Select all that apply</b>					
___ Assisted ventilation required immediately following delivery		___ Assisted ventilation required for more than six hours			
___ NICU Admission		___ Newborn given surfactant replacement therapy			
___ Antibiotics received by the newborn for suspected neonatal sepsis		___ Seizures or serious neurologic dysfunction			
___ Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)					
<b>Labor &amp; Delivery</b>					
<b>Fetal Presentation:</b> (select one)					
___ Cephalic ___ Breech ___ Other					
<b>Route &amp; Method:</b> (select one)					
___ Spontaneous ___ Forceps-Mid ___ Forceps-Low/ Outlet ___ Vacuum ___ Cesarean ___ Unknown					
<b>Indications for C-Section:</b>					
___ Unknown					
<b>Select all that apply</b>					
___ Failure to progress		___ Malpresentation		___ Previous C-Section	
___ Fetus at Risk/ NFS		___ Maternal Condition-Not Pregnancy Related		___ Maternal Condition-Pregnancy Related	
___ Refused VBAC		___ Elective		___ Other	

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Response Sheet



**CODERFax**

**Twin B**

To: **Barbara Suter** From: \_\_\_\_\_  
 Fax: **585-424-1469** Pages: \_\_\_\_\_  
 Phone: **585-758-7811** Date: \_\_\_\_\_  
 Re: **CODERFax** CC: \_\_\_\_\_

<b>Prenatal History</b>					
<b>Pregnancy History (Twin B)</b>					
Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
<b>Now Living</b> None or Number	<b>Now Dead</b> None or Number	<b>Less than 20 weeks</b> None or Number	<b>20 weeks or more</b> None or Number	None or Number	None or Number
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Live Birth: (MM/YYYY) /	Last Live Birth: (MM/YYYY) /	Last Other Pregnancy Outcome: (MM/YYYY) /	Prepregnancy Weight: lbs.	Height: ft. in.	
<b>Infant</b>					
<b>Apgar Scores</b>					
1 minute:	5 minutes	10 minutes:			
<b>Abnormal Conditions of the Newborn:</b>					
<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU Admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizures or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)					
<b>Labor &amp; Delivery</b>					
<b>Fetal Presentation:</b> (select one)					
<input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other					
<b>Route &amp; Method:</b> (select one)					
<input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps-Mid <input type="checkbox"/> Forceps-Low/ Outlet <input type="checkbox"/> Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown					
<b>Indications for C-Section:</b>					
<input type="checkbox"/> Unknown					
<b>Select all that apply</b>					
<input type="checkbox"/> Failure to progress	<input type="checkbox"/> Malpresentation	<input type="checkbox"/> Previous C-Section			
<input type="checkbox"/> Fetus at Risk/ NFS	<input type="checkbox"/> Maternal Condition-Not Pregnancy Related		<input type="checkbox"/> Maternal Condition-Pregnancy Related		
<input type="checkbox"/> Refused VBAC	<input type="checkbox"/> Elective		<input type="checkbox"/> Other		