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January 2009

Finger Lakes Regional Perinatal Data System

Response Sheet

CODER Fax

To:	Barbara Suter	From:	
Fax:	585-424-1469	Pages:	
Phone:	585-758-7811	Date:	
Re:	CODER Fax	CC:	

Infant

If Multiple Births:
Number of Live Births: | Number of Fetal Deaths:

Birth Weight:
grams | bs. | oz.

Abnormal Conditions of the Newborn:
___ None ___ Unknown at this time
Select all that apply
___ Assisted ventilation required immediately following delivery
___ Assisted ventilation required for more than six hours
___ Admission to NICU
___ 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)

Fetal Presentation: *(select one)*
___ Cephalic ___Breech ___Other

Route & Method: *(select one)*
___ Spontaneous ___ Forceps-Mid ___ Forceps-Low/ Outlet ___ Vacuum ___ Cesarean ___Unknown

Cesarean Section History:
___ Previous C-Section Number ___

Trial Labor:
If Cesarean section, was trial labor attempted? ___ Yes ___ No

Indications for C-Section:
___ Unknown
Select all that apply
___ Failure to progress
___ Malpresentation
___ Previous C-Section
___ Fetus at Risk/ NFS
___ Maternal Condition-Not Pregnancy Related
___ Maternal Condition-Pregnancy Related
___ Refused VBAC
___ Elective
___ Other

Anesthesia / Analgesia:
___None ___Unknown at this time
Select all that apply
___Epidural (Caudal) ___ Local ___ Spinal
___General Inhalation ___ Paracervical ___ General Intravenous
___Pudendal
Was an analgesic administered?
___Yes ___No

Other Procedures Performed at Delivery
___None ___Unknown at this time
Select all that apply
___Episiotomy and Repair ___Sterilization