

Response Sheet



CODERFax

To: Barbara Suter From: _____
 Fax: 585-424-1469 Pages: _____
 Phone: 585-758-7811 Date: _____

Infant

Apgar Scores 1 minute: _____ 5 minutes: _____ 10 minutes: _____			Is the Infant Alive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred/ Status Unknown		Clinical Estimate of Gestation: (Weeks)		Newborn Treatment Given: <input type="checkbox"/> Conjunctivities only <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Both <input type="checkbox"/> Neither	
How much is infant fed at discharge? (Select one) <input type="checkbox"/> Breast Milk Only <input type="checkbox"/> Formula Only <input type="checkbox"/> Both Breast Milk and Formula <input type="checkbox"/> Other <input type="checkbox"/> Do Not Know								
Abnormal Conditions of the Newborn: <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <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)								
Labor & Delivery								
Fetal Presentation: (select one) <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other								
Indications for C-Section: _____ Unknown Select all that apply <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								
Onset of Labor <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Prolonged Rupture of Membranes – (12 or more hours) <input type="checkbox"/> Premature Rupture of Membranes (prior to labor) <input type="checkbox"/> Precipitous Labor – (less than 3 hours) <input type="checkbox"/> Prolonged Labor (20 or more hours)								
Anesthesia / Analgesia: <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Epidural (Caudal) <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> General Inhalation <input type="checkbox"/> Paracervical <input type="checkbox"/> General Intravenous <input type="checkbox"/> Pudendal						Was an analgesic administered? <input type="checkbox"/> Yes <input type="checkbox"/> No		