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September 10

Finger Lakes Regional Perinatal Data System

Response Sheet



CODERFax

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

Labor & Delivery

Fetal Presentation: (select one) <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other				
Route & Method: (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				
Trial Labor: If Cesarean section, was trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Indications for C-Section: <input type="checkbox"/> 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				
Characteristics of Labor & Delivery <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Induction of Labor-AROM <input type="checkbox"/> Induction of Labor -Medicinal <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Meconium Staining <input type="checkbox"/> Fetal Intolerance <input type="checkbox"/> External Electronic Fetal Monitoring <input type="checkbox"/> Internal Electronic Fetal Monitoring				
Obstetric Procedures <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Cervical Cerclage <input type="checkbox"/> Tocolysis <input type="checkbox"/> External Cephalic Version--- <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> Fetal Genetic Testing				
Apgar Scores 1 minute:	5 minutes:	10 minutes:	Clinical Estimate of Gestation: (Weeks)	Newborn Treatment Given: <input type="checkbox"/> Conjunctivities only <input type="checkbox"/> Both <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Neither
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)				