



BIRTH TO TWENTY: DELIVERY FORM

DATE: Day **Month** **Year**

BTT ID NUMBER:

BONE STUDY ID NUMBER:

HOSPITAL NUMBER

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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AGE OF MOTHER

<input type="text"/>	<input type="text"/>
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PREGNANCY HISTORY

PARA

<input type="text"/>	<input type="text"/>
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GRAVIDA

<input type="text"/>	<input type="text"/>
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ESTIMATED PERIOD OF GESTATION IN WEEKS

<input type="text"/>	<input type="text"/>
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HISTORY OF APH

Yes=1	No=2
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BLOOD PRESSURE ON ADMISION

<input type="text"/>

DATE OF DELIVERY (dd/mm/yy)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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TIME OF BIRTH (hour)

<input type="text"/>	hr	<input type="text"/>	min
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LENGTH OF FIRST STAGE

	hr		min
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LENGTH OF SECOND STAGE

	hr		min
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WAS LABOUR INDUCED

Yes=1	No=2
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DATE OF RUPTURE OF MEMBRANES

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TIME OF RUPTURE OF MEMBRANES

	hr		min
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MECONIUM STAINED LIQUOR

Yes=1	No=2
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PRESENTATION

VERTEX	1
BREECH	2
T/V LIE	3
FACE	4
BROW	5

TYPE OF DELIVERY

NORMAL VAG.	1
VACUUM	2
FORCEPS	3
C/ SECTION	4

IF ASSISTED DELIVERY
WAS THIS BECAUSE OF

DELAYED 2 ND STAGE	1
MALPOSITION	2
BREECH	3
FOETAL DISTRESS	4
OTHER	5

IF CAESAREAN SECTION
WAS THIS

ELECTIVE	1
EMERGENCY	2

INDICATION FOR CAESAREAN SECTION

DISPROPOTION	1
FOETAL DISTRESS	2
MATERNAL DISTRESS	3
PREVIOUS CAES/ SEC	4
MALPRESENTATION	5
A P H	6
OTHER	7

IF OTHER, PLEASE SPECIFY

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IF CAESAREAN, ANAESTHETIC USED

GA	1
EPIDURAL	2
SPINAL	3

PAIN RELIEF DURING LABOUR

PETHIDINE	Yes=1	No=2
EPIDURAL	Yes=1	No=2
OTHER	Yes=1	No=2

IF OTHER, PLEASE SPECIFY

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BABY

1	Male	2	Female
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WAS THE BABY A BBA

Yes=1	No=2
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WEIGHT (grams)

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GESTATIONAL AGE (in weeks)

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APGAR 1 MINUTE

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APGAR 5 MINUTES

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RESUSCITATION

OXYGEN ONLY	1
BAG AND MUSK	2
INTUBATION	3
NONE OF THESE	4

DOES THE BABY HAVE ANY ABNORMALITY

Yes=1	No=2
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IF YES, PLEASE SPECIFY

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NAME OF MOTHER	
PHYSICAL ADDRESS	
NAME OF HOSPITAL/ CLINIC WHERE BIRTH TOOK PLACE	