

MATERNITY RECORD

Instruction Manual

AUGUST 1980

INTERNATIONAL FERTILITY RESEARCH PROGRAM
RESEARCH TRIANGLE PARK, NC 27709 USA

dcx104

Table of contents

I. Introduction	1
II. Instructions for handling patient record forms	1
III. General instructions for completing the Maternity Record	2
Range of responses	2
Completing the boxes	2
"Unknown" responses	2
Avoiding the use of "unknown" responses	2
Inconsistent responses	2
Numbers following answer boxes	2
Recording the dates	3
Recording data on multiple births	3
IV. Completing the Maternity Record	3
Patient Identification <i>Items 1-4</i>	3
Study Identification <i>Items 5-9</i>	3
Patient Characteristics <i>Items 10-15</i>	4
Obstetric History <i>Items 16-25</i>	4
Medical Data <i>Items 26-43</i>	6
Pregnancy Outcome <i>Items 44-52</i>	9
Special Studies <i>Items 53-55</i>	11
Additional Information <i>Items 56-59</i>	11
Appendix A—Maternity Record	12
Appendix B—Shipping Control Sheet and Instructions	14
Appendix C—Conversion Chart: Hemoglobin in percentages to grams per 100 ml	16
Appendix D—Conversion Chart: Ounces to grams	16
Appendix E—Definitions of antenatal conditions	17
Appendix F—Death Report	20
Appendix G—Multiple Birth Record and Instructions	21
Index	25

INTRODUCTION

Purpose

The purpose of this record is to collect, analyze, and report data relating to obstetric delivery. These data may be of use to clinicians, program administrators, health planners, and research investigators. This manual has been prepared to ensure the uniform reporting of data by all Contributors engaged in cooperative research with the International Fertility Research Program (IFRP). It is suggested that the Contributor read this manual carefully before beginning the study and refer to it when questions arise.

Reports

The data submitted by Contributors to the IFRP will be analyzed and reported to the Contributor in a standard manner. These analyses will enable the Contributors to recognize trends in patient characteristics and to compare methods and complications of delivery and duration of hospital stay. The analyses will also facilitate the writing of reports including the annual report of your maternity service.

Unlike some other IFRP studies, there are no queries sent to the Contributor who completes the Maternity Record. Incomplete or inconsistent data are automatically changed to "unknown" by the computer. The report that the Contributor receives will specify the percentage distribution of all responses that are unknown or are converted to unknown, and the percentage of unknowns for each item will be shown in the standard analysis tables. It is, therefore, incumbent upon the Contributor himself to maintain a high standard of reporting and keep the number of inconsistent and missing responses to a minimum.

If data for a few specific items (see page 2) are missing or inconsistent, the entire form will be rejected by the computer. In this event the form will be returned to the Contributor who may then correct the form and, if he wishes, return it to the IFRP with his next shipment of forms. If the computer then accepts it, the data will be loaded and will appear in the standard analysis tables. The standard analysis tables will be based only on forms accepted by the computer.

The Contributor must remember that cases that are not reported to the IFRP will not be included in the standard analysis tables, and that these tables are complete only if the data submitted to the IFRP are complete. If the Contributor fails to report a delivery, or does not correct and return an unacceptable form, these cases will be omitted from the standard analysis tables.

Inclusion of patients

The Maternity Record (Appendix A) is completed for all women who are admitted to and who subsequently deliver at the hospital during this admission. Women should be included in the study regardless of the outcome of the delivery: mature or premature live birth, single or multiple birth, or stillbirth.

Do not include patients who are admitted in false labor. If the same patient later returns, however, and is delivered in the hospital, the Maternity Record should be completed for her at that time.

Do not include a patient with a molar pregnancy.

Do not include any patient admitted for an induced abortion. Do not include patients admitted for spontaneous abortion of a fetus weighing less than 500 grams, or if the fetus is not weighed, with an estimated gestation of less than 20 completed menstrual weeks.

Do not exclude patients who die and patients who deliver on weekends or holidays.

The Maternity Record should be completed for all births occurring at the Center during the reporting period. The following definition of birth is used in this manual: the complete expulsion or extraction of a fetus from its mother irrespective of whether or not the umbilical cord has been cut or the placenta is attached. Do not

record as births fetuses weighing less than 500 grams. In the absence of a measured birthweight, a gestational age of 20 completed weeks (since the onset of the last menstrual period) is considered equivalent to 500 grams. When neither birthweight nor gestational age is known, a body length (crown to heel) of 25 centimeters is considered equivalent to 500 grams. Although in the past (and still in some countries today) an infant weighing 1000 grams or less (28 weeks of gestation) was not considered viable, improved standards of neonatal care mean that some infants weighing as little as 500 grams (20 weeks of gestation) are viable and this is generally thought to be a more appropriate definition for today's maternity care. This definition of a birth is now generally accepted internationally and is approved by the International Federation of Gynaecology and Obstetrics. The Contributor is urged to accept these definitions for his study. If births are defined by some other criteria, the Contributor should remember that the standard analysis tables provided by the IFRP will include all acceptable forms submitted according to definitions in this manual.

A Contributor who is also completing the IFRP's Hospital Abortion Record should make sure that every termination of pregnancy is reported on either the Hospital Abortion Record or the Maternity Record, and that no case is reported on both forms. The Contributor must decide which form to complete based on the suggestions made in this section.

Deaths

A Death Report must be completed for every patient who dies after admission to the obstetric ward, even if the death occurs on another ward.

If a patient is admitted in labor and dies before delivery of the fetus, a Maternity Record should be completed. This is the only situation in which a Maternity Record should be completed for a patient with no delivery.

A few Death Reports are sent at the initiation of every Maternity Record study. If additional forms are needed, please write to the appropriate Regional Coordinator at the IFRP.

Confidentiality

The Maternity Record contains a section for personal identification data on each patient. The contributing Center retains this section. It will not be reported to the IFRP, will not be included in the statistical reports, and will not be used in any manner by the IFRP.

II. INSTRUCTIONS FOR HANDLING PATIENT RECORD FORMS

Completing the forms

The forms should be completed with a ball-point pen in the same language as the form you are using. No carbon paper is necessary since the writing on the original (top sheet) is transferred by chemical process to the duplicate. In order to avoid marking more than one form at a time, remove each form and its duplicate from the pile before completing it or place cardboard under the top form. The top sheet should be sent to the IFRP and the second sheet kept for hospital records.

It is essential that the person who completes the forms thoroughly understand each question. Every attempt should be made to obtain correct information for each item. Where it is appropriate, the interviewer should ask the patient direct and objective questions. When direct questioning fails, the response should be estimated as accurately as possible using allied information.

Patient order number

The first patient in the study should be given patient order number 00001, and patient order numbers should subsequently be

assigned in sequence. Care should be taken to avoid duplicate patient order numbers. Forms should be returned to the IFRP in numerical order.

Checking the completed forms

Someone other than the person who originally completed the form should check the completed form to ensure that all information is correct and complete.

Special attention should be paid to the following items that are shaded grey on the form:

- 5. Center number
- 6. Study number
- 7. Patient order number
- 34. Type of labor
- 38. Type of delivery
- 40. Primary complication: of labor and/or delivery
- 45. Sex of infant(s) born at this delivery
- 49. Death of fetus/newborn
- 50. Primary puerperal condition

Forms in which these data are missing or are inconsistent with other items will not be accepted and will be returned to the Contributor.

Do not separate the original from the duplicate until all items on the form are recorded.

Separating the forms

After the forms have been completed and checked for accuracy, the originals (top sheets) should be carefully separated from the duplicates by tearing along the perforated line at the top of the sheet (below Item 4 and above Items 5 and 36). The Center should keep the Patient Identification section of the original as well as the entire duplicate.

Original copy batching

The original of each Maternity Record, excluding the top portion marked Patient Identification (Items 1-4), should be collected to become part of a monthly shipping batch. A batch is a group of original, completed Maternity Records in numerical order that is forwarded to the IFRP for computer processing. Each batch is to be accompanied by one Shipping Control Sheet (Appendix B). All original forms—completed, incomplete, spoiled, and unused—must be returned to the IFRP.

Shipping

On the first day of every month all completed Maternity Records from the previous month and a Shipping Control Sheet should be airmailed to the following address:

International Projects
International Fertility Research Program
Research Triangle Park
North Carolina 27709 USA

For shipping instructions, see Appendix B.

III. GENERAL INSTRUCTIONS FOR COMPLETING THE MATERNITY RECORD

Range of responses

The categorized responses to items are intended to cover a broad range of possibilities not limited to the characteristics pecu-

lar to any one geographical area. Thus, while some items may not be completely applicable to some local situations, it is extremely important that all items be completed as accurately and as consistently as possible.

Completing the boxes

Use only Arabic numerals. Alphabetic or other characters may not be used. Never write two numbers in one box, but be sure to write one number in each box.

For example, on the Maternity Record, two boxes have been given for the response to Item 16—Total live births. If the response is ten, it will be coded as:

1	0
---	---

If, on the other hand, the response is three, it will be coded as:

0	3
---	---

For items that have several possible responses it is helpful to circle the number corresponding to the appropriate choice, but remember that the number must also be written in the box. The number recorded in the box is used for analysis.

If a number is incorrectly recorded in a box and cannot be corrected legibly within the box, cross out the number in the box and write the correct number in the margin beside the box.

"Unknown" responses

When, for any reason, the answer to an item is unknown, the person completing the Maternity Record should write 9 in the corresponding box. Where there is more than one box for the response, 9 must be written in each box. For example, after Item 24—Number of months since last pregnancy ended—there are two boxes. If the time since last pregnancy is unknown, the response would be written as:

9	9
---	---

Exceptions to this rule will be explained under the instructions for those questions to which they apply.

Avoiding the use of "unknown" responses

If the form is completed while the patient is present, there is almost no reason for an "unknown" response. When a patient refuses or is unable to answer a particular question, an "unknown" response is justified. Contributors who routinely have large numbers of "unknown" responses will not have complete and comparable data for analysis.

Inconsistent responses

When the responses to two or more items are not consistent with each other, the response to some or all of the items will be changed automatically to unknown. For some items this will result in complete rejection of the form.

Numbers following answer boxes

The numbers that follow the answer boxes can usually be ignored; for example:

5. Center name _____ and number:

--	--	--

 1-3

The computer keypunch operator uses these numbers in transcribing responses from the form to computer cards. They have no significance for the person completing the form except in a few questions; for example, for Items 17, 45 and 46 there are two responses, each one recorded in a separate box.

Recording the dates

Write the numbers corresponding to the date in the Gregorian calendar year. The order of the date should be day, month, and year. For example, in Item 8—Delivery date—the date April 6, 1978 should be recorded as:

06	04	78
<i>day</i>	<i>month</i>	<i>year</i>

A Western calendar should be kept at the Center for ready reference in order to record or convert local dates to the Western (Gregorian) dates.

Codes for months:

January = 01	July = 07
February = 02	August = 08
March = 03	September = 09
April = 04	October = 10
May = 05	November = 11
June = 06	December = 12

Recording data on multiple births

Several questions on the Maternity Record can be answered for more than one baby in the case of a multiple birth. All the questions of this type (i.e. 35, 44, 46-48) refer to the baby delivered by the method described in Item 38. Item 38 refers to the most difficult delivery. When none of the births can be designated "most difficult," all responses to items should refer to the firstborn infant.

A separate Multiple Birth Record should be completed for each infant born in a multiple birth, and submitted along with the Maternity Record. For details on completing the Multiple Birth Record see pages 22 and 23.

NOTE: If any of these instructions are not clear or do not appear consistent with your particular situation, write to the IFRP to request clarification before initiating the study.

IV. COMPLETING THE MATERNITY RECORD

Patient Identification Items 1-4

Information on Items 1-4 will not be mailed to the IFRP but will be retained by the Center.

1. Hospital or clinic no. _____

- This is the hospital or clinic registration number assigned to the patient.
- This patient number is for internal use by the hospital/clinic. It is an important means of locating missing information which may be requested by the IFRP.

2. Admission date _____
day *month* *year*

Record the day, month, and year in Arabic numerals in the space provided. For example, April 6, 1975 should be recorded as:

06	04	75
<i>day</i>	<i>month</i>	<i>year</i>

- Admission date is the date on which the patient was admitted to the hospital.
- If the patient is admitted to the hospital on one day, remains in the hospital overnight, and is delivered the following day, the Admission date is the day before delivery. Therefore, Item 8—Delivery date—may or may not be the same as the admission date.

3. Patient's name _____

Husband's name _____

4. Address _____

- This information is for internal use by the hospital/clinic.

Study Identification Items 5-9

5. Center name _____ and number:

--	--	--

 1-3

- Write the Center name in the space provided.
- Each participating Center is assigned a unique three-digit number. These three digits should be recorded in the space provided. For example, Center number 921 is recorded as:

9	2	1
---	---	---

 1-3

- This item may be completed before the patient is admitted into the study.

6. Study number

9	0	3
---	---	---

 4-6

- Each study is assigned a unique three-digit number which will be recorded in the three boxes provided.
- Study numbers are assigned by the IFRP. Special studies may be undertaken from time to time; for such studies, contact the IFRP for assignment of a special study number.

7. Patient order number:

--	--	--	--	--

 7-11

- Each patient must be given a unique patient order number.
- Patient order numbers should start with 00001 and be assigned consecutively. A system should be developed at the Center to insure that no two patients are assigned the same number and no number is missed.
- The patient order number cannot be more than five (5) digits long.
- The completed forms should be checked for missed or duplicate patient order numbers. Provision should be made at the Center for cross-reference of patient order number and corresponding hospital or clinic patient number for possible future queries. Refer to the subsection, "Separating the forms," in Section II, "Instructions for handling patient record forms."

8. Delivery date:

--	--

day

--	--

month

--	--

year 12-17

- This refers to the date on which the infant was delivered. It may be different from the date of admission.

9. Registration status: 0) not booked 1) booked, patient's choice 2) referred by physician 3) referred by midwife 4) emergency 8) other _____

--

 18

- Booked means that the patient had antenatal visits and that accommodations in the hospital are anticipated for her about the time of delivery.
- Not booked means either that there were no antenatal visits or that a room was not scheduled for her.
- Emergency admissions, whether booked or not, referred or not, should be coded 4.

Patient Characteristics Items 10-15

10. Residence: 1) urban 2) rural 3) urban slum
4) rural slum

 19

- Residence is where the patient lived during most of the preceding year.
- An area is classified as urban, rural, or slum according to the country's definition. If the patient does not know how to classify her residence, the following criteria are used to decide whether she has been living in an urban or rural area
- An urban area is an organized community where commerce, manufacturing, business, finance, government, and academic institutions predominate and provide employment for most of the inhabitants.
- A rural area is a village or agrarian area where agriculture dominates the life style of the inhabitants
- The above definitions are used because urban-rural definitions based only upon the population size vary widely

11. Patient's status: 1) private 2) not private 8) other

 20

- **NOTE:** This question indirectly measures the socioeconomic status of the patient. The classification of private and nonprivate may vary from Center to Center. If the following definitions do not apply, write to the IFRP with your suggestions for classification.
- Private refers to patients for whom the majority of the expenses for this delivery were provided from nongovernmental sources, such as the patient's private finances, personal medical insurance, or nongovernmental agencies. For example, if a patient and/or her private insurance pays three fourths of the delivery expenses and the government pays only one fourth of these expenses, write 1 in the box.
- Not private refers to patients for whom the majority of expenses for the delivery were provided from governmental sources, including government insurance
- Write in the box the number corresponding to the correct alternative.

12. Patient's age: (completed years)

 21-22

- Write the exact number of years completed since birth.
- If the patient does not know her age, the clinician should estimate her age from visual and other evidence.

13. Patient's education: (school year completed) 0) 0
1) 1-2 2) 3-4 3) 5-6 4) 7-8 5) 9-10 6) 11-12
7) 13-14 8) 15+

 23

- Write in the box the number corresponding to the correct category of school year completed. This refers to the level of formal education, including primary, high school, university, professional schools, trade schools, business schools, but not such training as apprentice training. It does not refer to the total number of years spent in school in order to attain a particular level. For example, if the patient took two years to complete the fifth grade and did not continue studying, the number of school years completed by her is five years. Do not count years spent in preschool, nursery school, or kindergarten. This item has to be answered according to the educational structure of the given country. Some examples follow for clarification:

EXAMPLE: The educational structure of a country is six years of primary school, five years of secondary school, and university. Trade school requires the completion of primary school. **Business**

school requires the completion of three years of secondary school. Therefore:

- If the patient completed primary school and two years in trade school, write **4** in the box.
- If the patient completed primary school, the first year of secondary school, and two years in trade school, write **5** in the box.
- If the patient completed primary school, secondary school, and two years of business school, write **7** in the box
- If the patient completed one year of nursery school and three years of primary school, write **2** in the box
- If the patient attended primary school for five years but only completed the third level of the educational system, write **2** in the box
- If the patient has no formal education, write **0** in the box.

14. Marital status: 1) never married 2) currently married
3) divorced 4) separated 5) widowed 6) consensual
union 8) other

 24

- Never married means that the patient has never been married (as defined under the next alternative, currently married).
- Currently married means that the patient is recognized as having been married by civil or religious ceremony
- Divorced means that the patient is recognized as having been divorced by civil or religious ceremony.
- Separated refers to women who are permanently or temporarily separated from their husbands but not divorced. This category also includes women whose husbands are permanently or temporarily employed in a location that prevents them from living with their wives
- Widowed means that the patient's husband (in marriage or consensual union) is dead
- Consensual union refers to couples living together by common consent and couples in common-law marriages
- Write in the box the number corresponding to the correct alternative. If the woman's marital status falls into the category of "other," write **8** in the box

15. Age at first marriage/union: (completed years)

 25-26

- In countries where the marriage ceremony precedes the consummation of the marriage by some time (usually in the case of very young brides), the age when the sexual union was established should be recorded
- Where the patient has been married more than once, record the age of the first marriage or union

Obstetric History Items 16-25

NOTE: Items 16-25 refer to the outcomes of all pregnancies other than the current pregnancy and its termination.

16. Total live births:

 27-28

- Live birth is defined as the process of birth of an infant weighing 500 grams or more and with any sign of life, regardless of the subsequent outcome. In the absence of known birthweight, 20 or more completed menstrual weeks of gestation (calculated from the first day of the last normal menstrual period) is considered equivalent to 500 grams or more birthweight.
- Write the number of live births in the boxes.
- Record each infant in a multiple birth as an individual birth.
- If the patient has not previously given birth to live children, write **0** in each of the boxes.
- **NOTE:** The response for this item should not be less than the sum of the responses in Items 17 and 20.

17. Children now living:

number of males
(8 or more = 8)
number of females

	29
	30

- This item refers only to children born to this patient and does not include adopted children or her husband's children by any other wife.
- The number of Item 17—Children now living—does not necessarily equal Item 16—Total live births. The number of children now living can never exceed the number of total live births.
- Write the number of living male and living female children in the appropriate box.
- If there are no living male or female children, write **0** in the appropriate box.
- If there are eight or more living male or female children, write **8** in the appropriate box.

18. Duration of breast-feeding of last live birth

(in months) 0) did not breast-feed 1) <3 2) <6
3) <9 4) <12 5) <15 6) <18 7) <21 8) ≥21

	31
--	----

- Record the duration of breast-feeding of the last child who was born alive even if that child is no longer living.

EXAMPLE: If the patient breast-fed the last child for four months, record **2** in the box, i.e. at least three but less than six completed months.

19. Number of stillbirths: (8 or more = 8)

	32
--	----

- Stillbirth is defined as the process of birth of a fetus weighing 500 grams or more (equivalent to 20 menstrual weeks' gestation) with no evidence of life after birth.
- Write in the box the total number of previous pregnancies terminated in stillbirth.
- If there were eight or more previous stillbirths, write **8** in the box.

20. Number of infant deaths: (less than 12 completed months; 8 or more = 8)

	33
--	----

- Infant death is defined as death after a live birth (see Item 16) but before 12 completed months of life.
- Record all infant deaths, even if the infant died shortly after a live birth.
- If there were eight or more infant deaths, write **8** in the box provided.

21. Number of spontaneous abortions (8 or more = 8)

	34
--	----

- Spontaneous abortion is the expulsion from its mother of a fetus or embryo weighing less than 500 grams (equivalent to 20 completed menstrual weeks of gestation) or other product of gestation of any weight (e.g. hydatidiform mole) irrespective of gestational age, without willful interference even if a curettage or other interference was subsequently used to complete the abortion. "Miscarriages" are to be reported in this item.
- Write in the box the total number of previous pregnancies that terminated as spontaneous abortions. If there were eight or more spontaneous abortions, write **8** in the box.

22. Number of induced abortions: (8 or more = 8)

	35
--	----

- Induced abortion is defined as the artificial (willful or intentional)

termination of any pregnancy before viability of the fetus.

- Write in the box the total number of previous pregnancies terminated by induced abortion at any gestation.
- If there were eight or more previous induced abortions, write **8** in the box.

23. Outcome of last pregnancy. 0) not previously pregnant

1) live birth, full term, still living 2) live birth, full term, deceased 3) live birth, premature, still living 4) live birth, premature, deceased 5) stillbirth 6) induced abortion 7) spontaneous abortion 8) other

	36
--	----

- Care should be taken that the response to this item is consistent with responses to Items 16, 19, 21 and 22.
- Live birth (See Item 16).
- Full term is defined as any infant delivered at 37 or more completed menstrual weeks of gestation. (This includes "post-term" infants of 42 or more completed weeks of gestation.)
- Premature is defined as any infant delivered at less than 37 weeks of gestation.
- Stillbirth (see Item 19).
- Induced abortion (see Item 22).
- Spontaneous abortion (see Item 21).
- If the last pregnancy was ectopic or molar, write **8** in the box.

24. Number of months since last pregnancy ended:
(98 or more = 98)

		37-38
--	--	-------

- Write in the boxes the number of months since the termination of the last pregnancy, whether it was the delivery of an infant, an abortion, or surgical intervention for an ectopic pregnancy.
- Please note that this item does *not* refer to the number of months between pregnancies. The number of months coded must be at least as long as the duration of this pregnancy.
- If the last pregnancy was terminated more than eight years ago, write **98** in the boxes.
- If the current pregnancy is the woman's first, write **00** in the boxes.

25. Contraceptive method mainly used before conception:

0) none 1) IUD 2) orals/injectables 3) female sterilization
4) male sterilization 5) condom 6) withdrawal/rhythm
7) foam/diaphragm/jelly 8) other _____

	39
--	----

- Write in the box the number corresponding to the contraceptive method *most* frequently used *before* conception.
- IUD: any intrauterine contraceptive device.
- Orals/injectables: oral contraceptive pills or injections of such substances as Depo Provera® (medroxyprogesterone acetate).
- Female sterilization: any operation intended to cause permanent sterilization of the female partner.
- Male sterilization: any operation intended to cause permanent sterilization of the male partner.
- Condom: male sheath.
- Withdrawal/rhythm: coitus interruptus/safe period. (Even if the patient has been using these methods incorrectly, write **6** in the box.)
- Foam/diaphragm/jelly: modern or traditional spermicidal preparations applied intravaginally or an intravaginal diaphragm or both.
- Other: In the space provided, write the name of any other contraceptive method, such as douche, commonly used by the couple. If a brand name is used, specify the type of contraceptive. Do not include such methods as lactation amenorrhoea.

Medical Data Items 26-43

26. Number of antenatal visits (8 or more = 8)

- If the patient was not seen before this admission, write **0** in the box. Otherwise record the number of antenatal visits. Record eight or more antenatal visits as **8**.

27. Primary antenatal condition (see code list)

- Antenatal conditions are defined in Appendix E.
- If the patient's antenatal condition is normal and satisfactory, write **0** in each of the boxes.
- If the antenatal conditions are unknown, write **9** in each of the boxes.
- Record the antenatal condition as specifically as possible.
- If the patient has more than one antenatal condition, record the one that has the greatest clinical significance for the mother, rather than the fetus. For example, if there is preeclamptic toxemia in the third trimester and rubella in the first trimester, record preeclamptic toxemia.
- Record placenta previa/abruptio only if diagnosed antenatally.
- If in doubt, write to the IFRP and request a code assignment.
- If necessary, specify any details of the condition or any additional conditions on the back of the form.

28. Hospitalization required during this pregnancy: 0) no; 1) yes, for condition indicated in Item 27; 2) yes, for condition other than the one indicated in Item 27; specify condition _____

- This refers to hospitalization at any time during the pregnancy for any condition whether or not it was related to the pregnancy.
- If the hospitalization was for the condition indicated in Item 27, write **1** in the box. If the response to this item is **1**, the response to Item 27 must not be **0**.
- If the hospitalization was for a condition not indicated in Item 27, write **2** in the box, and specify the condition in the space provided.

29. Tobacco smoking during pregnancy: 0) none. During part of pregnancy (cigarettes/day): 1) 1-10; 2) 11-20; 3) 21 or more. Throughout pregnancy (cigarettes/day): 4) 1-10; 5) 11-20; 6) 21 or more; 8) cigars, pipes, etc.

- If the patient smoked cigarettes during any part of her pregnancy, record **1**, **2** or **3** in the box.
- If she smoked cigarettes during her entire pregnancy, record **4**, **5** or **6** in the box.
- If the patient smoked tobacco in any form other than cigarettes (cigars, pipe) during all or any part of her pregnancy, record **8** in the box.
- The use of tobacco in a form not smoked (snuff, chewing tobacco) should not be recorded.
- The use of products other than tobacco should not be recorded.

30. Number of previous cesarean sections:

- Write in the box the number of cesarean sections before this pregnancy.
- If the patient has had more than eight cesarean sections previously, write **8** in the box.
- Do not include cases where there was laparotomy in order to repair uterine rupture.

31. Estimated duration of pregnancy (menstrual age in completed weeks)

- If this item is recorded **99** (unknown), the form will be rejected and returned to the Contributor.
- Duration of pregnancy is the number of completed weeks from the onset of the patient's last normal menstrual period to the day of delivery. If the date of the last menstrual period is unknown, estimate it from clinical evidence such as fundal height or fetal head size.

32. Hemoglobin at admission for delivery (to nearest gm):

1) 5 gm; 2) 6 gm; 3) 7 gm; 4) 8 gm; 5) 9 gm; 6) 10 gm; 7) 11 gm; 8) > 12 gm; 9) not done

- Record the patient's hemoglobin at admission, NOT at her last antenatal visit or after delivery.
- Round to the nearest whole gram, e.g. 6.5 grams is recorded as **3**) 7 gm.
- If hematocrit is taken, estimate the gm % hemoglobin by dividing the hematocrit % by three and rounding to the nearest whole number. For example, when hematocrit = 41%, $41 \div 3 = 13.7$ gm %. write **8** in the box.
- Do not record hemoglobin as percentage of normal. Convert to grams % according to the schedule in Appendix C.
- If neither hemoglobin nor hematocrit was recorded at admission, write **9** in the box.

33. Rupture of membranes: Spontaneous: 1) < 24 hrs before delivery; 2) ≥ 24 hrs before delivery. Artificial: 3) < 24 hours before delivery; 4) ≥ 24 hrs before delivery; 5) during cesarean section

- Artificial rupture is defined as rupture of the amniotic sac by the birth attendant (amniotomy).
- The code for this item must be consistent with Item 34. If the response to this item is **1**, **2** or **5**, the response to the next item cannot be **2**, **4**, **5** or **7**. However, if artificial rupture of membranes (ARM) is reported in this item, it must also be reflected in the response to Item 34.

34. Type of labor: 0) no labor; 1) spontaneous; 2) spontaneous, augmented with artificial rupture of membranes (ARM); 3) spontaneous, augmented with drugs; 4) spontaneous, augmented with ARM and drugs; 5) induced, with ARM; 6) induced, with drugs; 7) induced, with ARM and drugs; 8) other _____

- If this item is recorded **9** (unknown), the form will be rejected and returned to the Contributor.
- If a patient has no labor, such as a patient undergoing elective cesarean section, write **0** in the box.
- Spontaneous labor is defined as labor that began without intervention, even if it is later augmented by intervention. If the patient's labor was spontaneous, write **1**, **2**, **3** or **4** in the box. Induced labor is defined as labor initiated by the birth attendant by administering drugs (usually oxytocics), by artificially rupturing the membranes, or by both. If the patient's labor was induced, write **5**, **6** or **7** in the box.
- If labor follows the administration of enemas or cathartics, do not record it as induced or augmented.
- If labor started spontaneously, but drugs were given or amniotomy performed to accelerate it, record it as spontaneous, not induced, labor.

Recording data on multiple births

Several questions on the Maternity Record can be answered for more than one baby in the case of a multiple birth. All the questions of this type (i.e. 35, 44, 46, 47 and 48) refer to the baby that is delivered by the method described in Item 38. Item 38 refers to the most difficult delivery. When none of the births can be designated "most difficult," all responses to items should refer to the firstborn infant. Complete a separate Multiple Birth Record for each infant.

EXAMPLES:

- A twin delivery in which the firstborn is in the vertex position and is delivered spontaneously, and the second is in the breech position and is delivered with forceps to the aftercoming head. All items will refer to the second twin.
- A twin delivery in which both infants are in the vertex position and both are delivered spontaneously. All items will refer to the first twin.
- A triplet delivery in which the first two babies are delivered spontaneously at home, the third is retained in utero and delivered by cesarean section in hospital. All items refer to the infant delivered in hospital.

35. Type of presentation during labor. 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other _____ 51

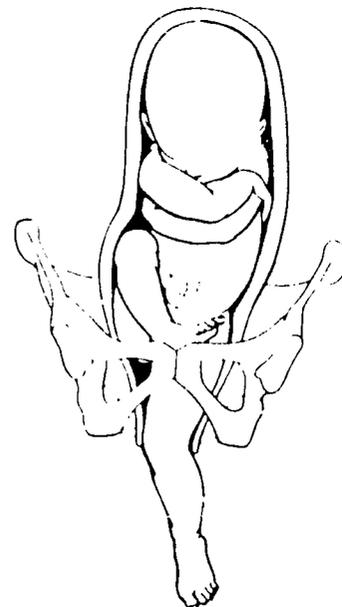
- The presentation of the infant whose delivery is recorded in Item 38 should be recorded here. Usually this will also mean the most difficult presentation.
- The type of presentation during labor should be recorded. This is not necessarily the same as the presentation at delivery. If a malpresentation is corrected either spontaneously or by version or rotation so that delivery is normal vertex, then the malpresentation should be recorded.
- Frank breech, also known as single breech or pelvic presentation.
- Footling breech, also known as incomplete breech. Note that both double footling (both feet or knees are prolapsed into the vagina) and single footling (one foot or knee is prolapsed into the vagina) are included in this category.
- Complete breech, also known as double breech, full breech or flexed breech.
- Transverse lie refers to oblique and "back-up" and "back-down" transverse lies.
- Compound presentation means that more than one part, such as the arm and vertex, presented.
- Cord prolapse should be recorded in Item 41.

36. Anesthetic administered: 0) none or psychoprophylaxis only 1) analgesic, systemic or inhalation 2) local 3) paracervical/pudendal 4) spinal/epidural 5) general 6) 1 and 2 or 1 and 3 7) other combination 8) other _____ 52

- None includes patients who deliver by "natural childbirth." It does not include the use of hypnosis which should be recorded as 8) other.
- Analgesic includes drugs such as meperidine (Demerol®), diazepam (Valium®), or self-administered nitrous oxide that are given either orally, by injection, or by inhalation; to temporarily diminish discomfort, awareness, or the sensation of pain.
- Local means that a drug is directly injected into the area to be anesthetized. For example, a drug is injected into the perineum for repair of a laceration or episiotomy or to perform an episiotomy.
- Paracervical/pudendal anesthetic means that a drug such as lidocaine is injected around the paracervical area or the pudendal



- **Frank breech**, also known as single breech or pelvic presentation



- **Footling breech**, also known as incomplete breech. Note that both double footling (both feet or knees are prolapsed into the vagina) and single footling (one foot or knee is prolapsed into the vagina) are included in this category



- **Complete breech**, also known as double breech, full breech or flexed breech

nerve, for example, to block the nerve supply to an anatomic region.

- Spinal/epidural anesthetic means that a drug such as lidocaine is injected into the subarachnoid space (spinal fluid) or into the epidural space to produce regional anesthesia. This includes caudal anesthesia.
- General anesthesia refers to inhalation or intravenous administration of drugs which cause the patient to lose consciousness.
- Other combination (code 7) should not be used if any other code is appropriate.

37 Episiotomy: 0) none 1) midline 2) midline, with extension 3) midline, with hematoma 4) mediolateral 5) mediolateral, with extension 6) mediolateral, with hematoma 8) other

 53

- Episiotomy refers to a surgical incision of the perineum performed just before delivery to prevent undue stretching or tearing of the perineum. Do not include surgical repair of perineal tears.
- Midline (or median) episiotomy refers to a posterior incision through the perineal body itself.
- Mediolateral episiotomy refers to an incision starting at the midline but proceeding laterally.
- Extensor refers to spontaneous enlarging of the episiotomy. Do not include the situation where the original episiotomy was inadequate and the birth attendant intentionally extends it.
- Hematoma refers to a collection of coagulated or liquid blood at the episiotomy site, which may spontaneously drain or be surgically evacuated.
- An anterior episiotomy to deliver women who have been "circumcised" should be recorded as 8) other

38 Type of delivery: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other

 54

- Spontaneous delivery is one in which the birth attendant does not assist beyond holding the baby, or in which the birth attendant facilitates the delivery manually. Do not include major manual maneuvers such as rotation or version.
- Outlet forceps (low forceps) delivery means that the forceps are applied when the scalp is or has been visible at the introitus without separating the labia, the skull has reached the pelvic floor, and the sagittal suture is in the anteroposterior diameter of the pelvis.
- Vacuum extractor refers to the use of a cup from which the air is partially evacuated after it has been placed over the infant's head.
- Mid- or high forceps delivery means that the forceps are applied when the head is engaged (mid-forceps) or not engaged (high forceps), but the conditions for outlet forceps delivery have not been met. Any forceps delivery requiring artificial rotation beyond 45°, regardless of the station from which the extraction is begun, is designated mid-forceps delivery.
- Manual rotation means a major manual maneuver such as rotation beyond 45°. Do not include either internal or external version in this code. These should be coded as 8) other.
- Breech extraction includes all maneuvers to assist the delivery of the baby including manual maneuvers to deliver the head. If the infant is delivered with no assistance from the birth attendant, the delivery should be recorded as 0) spontaneous. If forceps are applied to the aftercoming head, the delivery should be recorded as 1) outlet forceps.
- Cesarean section includes classical, low transverse, and extra-peritoneal cesarean section, and other abdominal methods of delivery. However, if there is uterine rupture and the infant is delivered by laparotomy, write 8 (other) in the box and describe the situation in the space provided. Do not record it as a cesarean section.

- Destructive procedures include craniotomy, embryotomy, decapitation, and any procedure which involves deliberate mutilation and death of the fetus, whether the fetus was alive or dead before the procedure.
- Other includes such situations as internal or external version or symphysiotomy. It also includes laparotomy for uterine rupture as mentioned above. Any method of delivery that cannot be accommodated by codes 0-7 should be recorded as 8, and details given in the space provided.

39 Primary injury during labor and/or delivery: 0) none 1) vulva 2) vagina 3) perineum 4) cervix 5) uterus 6) rectum 7) bladder 8) other

 55

- Record the appropriate number in the box. Record only maternal injuries in this item; record fetal injuries in Item 47 (code 7).
- If more than one part is injured, record the part receiving the most serious and/or extensive damage. Thus a fourth degree perineal tear should be recorded as 6) rectum.
- Urethral injuries should be recorded under 7) bladder, not 1) vulva

40 Primary complication of labor and/or delivery: 0) none 1) prolonged/obstructed labor 2) placenta previa 3) placenta abruptio 4) hypotonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other

 56

- If there is more than one complication, use the following principles to decide which one is primary and which one should be recorded in Item 41 (Secondary complication of labor and/or delivery).
- Record the clinically most important condition, that is, the potentially most hazardous one, in Item 40.
- If, of the two or more conditions, one threatens the mother and one the fetus, record the one that threatens the mother in Item 40 and the one that threatens the fetus in Item 41.
- If both a symptom and a diagnosed condition are to be recorded, record the diagnosed condition in Item 40 and the symptom in Item 41.

EXAMPLES:

- For hemorrhage and retained products, record retained products in Item 40 and hemorrhage in Item 41.
- For placenta previa and hemorrhage, record placenta previa in Item 40 and hemorrhage in Item 41.
- For hypotonic uterine contractions and prolonged labor, record hypotonic contractions in Item 40 and prolonged labor in Item 41.
- For obstructed labor and prolonged labor, record the obstruction in Item 40 and the prolonged labor in Item 41 even though both have the same code number.
- If cord prolapse is the only complication, record C in Item 40, and 2 in Item 41.
- **NOTE:** Placenta previa, placenta abruptio, and obstructed labor are always to be recorded as the primary complications and should not be recorded in Item 41. Prolonged labor is, however, a result of such things as obstructed labor, or uterine dysfunction and should usually be recorded in Item 41 with the cause— abnormal uterine contractions, obstructed labor, etc.—recorded in Item 40.
- Do not record a complication in Item 41 when the response to Item 40 is 0 except in the case of cord prolapse.
- Prolonged labor is defined for this study as active labor of more than 18 hours.
- Obstructed labor is the lack of adequate progress of labor because of cephalo-pelvic disproportion, the presence of pelvic masses, or fetal size, shape, abnormalities, or presentation.

- Placenta previa is the implantation of the placenta in the lower uterine segment. The placenta encroaches on or covers (completely or partially) the internal cervical os. Placenta previa is classified as marginal, partial, or total, and all forms should be recorded here
- Placenta abruptio is the complete or partial detachment of the normally implanted placenta from the uterine wall at 20 completed weeks or more of gestation
- Record placenta abruptio in both its complete and incomplete forms and also situations where only the placental margin is involved (marginal sinus rupture).
- Hypotonic uterine contractions (hypoactive uterine inertia) are those which are less than normal in intensity and/or frequency for that stage of labor.
- Hypertonic uterine contractions (hyperactive uterine inertia) are those which exceed the normal pattern of intensity and/or frequency for that stage of labor.
- Hemorrhage is the loss from the vascular space of more than 500 ml of blood irrespective of the etiology or whether it is external or internal blood loss. Record the etiology of the blood loss in the space provided, if it is not adequately recorded in Item 39 (maternal injury)
- Retained products is the failure to completely expel the placenta and membranes within one hour of the delivery of the fetus or failure to expel the second twin within 12 hours of the first infant.
- If the placenta is removed manually or surgically within one hour of delivery, do *not* code as retained products
- Any complication that occurs that cannot be accommodated by the above codes should be described in the space provided, and 8 written in the box
- Cord prolapse is the descent of the umbilical cord through the cervical os in advance of the presenting part. This category includes occult cord prolapse in which the cord descends alongside of the presenting part.

41 Secondary complication of labor and/or delivery: 0) none 1) prolonged labor 2) cord prolapse 4) hypotonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other _____ 57

- Follow the instructions for Item 40
- Do NOT report a secondary complication if you did not report a primary complication, except in the case of cord prolapse.

42 Duration of labor (in completed hours) 0) none 1) <2 2) 2-6 3) 7-12 4) 13-18 5) 19-24 6) 25-48 7) over 48 58

- The onset of labor is defined as the time at which contractions occur at 10-minute intervals and are of 30 seconds' duration. If this time is unknown, use the time at which the patient became aware she was in labor. If she does not know the exact number of hours, the birth attendant should make the best possible estimate.
- If there is no labor, as in the case of some elective cesarean sections, write 0 in the box. If the response to Item 34 is 0, the response to this item must also be 0

43 Attendant at delivery: 0) none 1) nurse 2) qualified midwife 3) student nurse/midwife 4) paramedic 5) medical student 6) general physician 7) OB/GYN physician 8) other _____ 59

- Record the appropriate number in the box.
- If more than one person attends the birth, record the person primarily responsible for the delivery.
- Midwife is defined as a nurse who has had special obstetrical training. Do not include untrained midwives.

- If the birth attendant was a student nurse or student midwife, write 3 in the box; if it was a medical student, write 5 in the box. Medical student is defined as a person who has not yet received a medical degree (MD, MB, ChB, etc.).
- Paramedic refers to any person with medical training who is not a nurse, midwife, physician, or medical student.
- General physician refers to any person who has a medical degree and no specialized training in obstetrics and gynecology.
- OB/GYN physician refers to any person who has a medical degree and has or is receiving specialized training in obstetrics and gynecology
- Other includes any person who was the primary birth attendant and fits into none of the above categories, such as a social worker, a policeman, or a relative of the patient.

Pregnancy Outcome Items 44-52

44 Birth weight (gm; 9988 or more = 9988) 60-62

- **NOTE:** Do NOT estimate weight.
- Record in grams the infant's weight within one hour of delivery. Do not include the weight of cord clamps, swaddlings, etc. A conversion table from pounds and ounces to grams is given in Appendix D. Record the weight of all infants including those stillborn. In the case of multiple births, the weight of the infant whose delivery is recorded in Item 3B should be recorded here.
- If weighing scales are not available or the infant was not weighed for some other reason, write 9 in each of the four boxes.

EXAMPLES:

- For twins, when the spontaneously delivered firstborn weighs 1504 grams and the forceps delivered secondborn weighs 1753 grams, record 1753 in the boxes.
- If the weight equals or exceeds 9988 grams record 9988.

45 Sex of infant(s) born at this delivery 63
 number of males (write number of each) number of females 64

- Record the number of infants of each sex delivered, both live births and stillbirths. For example, if one male child is delivered, write 1 in box 63 and 0 in box 64.
- **NOTE:** If either of these two boxes is blank, the entire form will be rejected and returned to the Contributor.

NOTE: Items 46 and 47 refer to Item 38 delivery.

46. Apgar score: 9) not done at 1 minute (8 or more = 8) at 5 minutes 65 66

- The Apgar score is a system of numerical evaluation which describes the status of the infant at one minute and five minutes after birth. A score of zero indicates a severely jeopardized infant; higher scores, up to a maximum of 10, indicate progressively better conditions. The score should be given by someone other than the one who delivers the infant so that each measurement can be obtained objectively. The one-minute and five-minute intervals after birth must be timed.
- Each sign is given a score and the total of the five scores is the Apgar score. Record this number in the box. If the score is 8, 9 or 10, write 8 in the box.

APGAR SCORE

Sign	Criteria and Values			Score
	2	1	0	
Heart rate	≥ 100	< 100	absent to auscultation	
Respiration	yelling	irregular, inadequate	none	
Muscle tone	well flexed	some tone	flaccid	
Reflexes-sharp slap on feet	cry	grimace	none	
Color	pink all over	blue hands and feet	pale, blue	
			Total	

For Items 47-48, use the following codes: 0) normal or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other (for codes 2, 3, 7 and 8, specify)

47. Primary fetal/neonatal condition, specify 67

- If the infant is normal and liveborn, or is stillborn with no apparent pathology, write **0** in the box. Please do *NOT* code a stillbirth **8** in this box. We can learn from question 49 whether the infant is liveborn or stillborn.
- Fetal distress during labor includes such indications as deceleration of heart rate to less than 100 beats per minute or a fetal scalp pH of less than 7.2. Write the indication of fetal distress in the space provided.
- Minor malformations are those which do not threaten fetal survival, such as polydactyly, syndactyly, pes equinovarus, and luxation of the hip joint. Specify the malformation in the space.
- Major malformations are those which threaten the life and normal development of the newborn such as hydrocephaly, myelomeningocele, cleft palate, and congenital metabolic error. Specify the malformation in the space.
- Respiratory distress syndrome (or pulmonary syndrome or hyaline membrane disease) is characterized by expiratory grunting, labored respiration, thoracic/abdominal retraction, cyanosis and/or cardiac failure accompanied by metabolic disorder. Record only respiratory distress that requires treatment.
- Isoimmunization, is the condition produced in the fetus as a result of exposure to maternal antibodies (for example, Rh, Hr, A-B, and those designated in other blood classification systems).
- Do not include physiological icterus of the newborn or cases in which the mother has antibody titers that do not produce changes in the fetus/neonate that require therapy.
- Icterus (yellow sclera) is considered pathological when the serum bilirubin level is 8.0 mg/100 ml serum.
- Neonatal sepsis is a systemic response to any infection.
- Trauma means mechanical injury occurring during delivery such as a laceration from use of forceps or a broken clavicle (whether accidental or intentional to facilitate delivery). On the line provided, specify all details when trauma occurs. Do not include destructive procedures used to deliver the fetus and recorded in Item 38.
- If the infant's neonatal condition is not covered by any of the above conditions, write **8** in the box and describe the condition in the space provided.

48. Secondary fetal/neonatal condition, specify 68

- Follow the instructions for Item 47
- Do *NOT* report a secondary condition if you have not reported a primary condition.

49. Death of fetus/newborn 0) none 1) antepartum, one 2) antepartum, two or more 3) intrapartum, one 4) intrapartum, two or more 5) postpartum, one 6) postpartum, two or more 7) combination 8) other 69

- Record in this box the appropriate code for the number of fetal and neonatal deaths that occur before the mother is discharged from the hospital.
- If there is a multiple birth of three or more infants and more than one dies, write in the margin how many died.
- Antepartum means before the onset of labor.
- Intrapartum means during labor and before the infant is completely expelled from the mother.
- Postpartum means after the infant is completely expelled and separated from the mother until mother's discharge from the hospital.
- **NOTE:** Codes 2, 4, 6 and 7 cannot exist for a single delivery. If these responses are used with a single delivery, the entire form will be rejected and returned to the Contributor.

50. Primary puerperal condition 0) normal 1) fever requiring treatment 2) bleeding requiring treatment 3) urinary tract infection 4) mastitis 5) phlebitis 6) dehiscence 7) death (complete Death Report) 8) other 70

- Write **0** in the box if the postpartum status is normal.
- Record the appropriate code if postpartum complications occur.
- Bleeding refers to bleeding occurring 24 hours or more after delivery.
- Urinary tract infection includes all infections of the urinary tract from the kidney to the urethra.
- Mastitis refers to inflammation of the breast. Do not include normal engorgement of the breast even if accompanied by transitory fever.
- Phlebitis refers to any venous inflammation or clotting in the venous system of the legs or lower pelvis and includes superficial or deep phlebitis.
- Dehiscence refers to the separation or gaping of the incision including episiotomy and cesarean section incisions.
- If the mother dies, complete a Death Report (Appendix F) and attach it to the Maternity Record.

51. Maternal blood transfusion during hospitalization: 0) none 1) yes, before delivery 2) yes, during delivery 3) yes, after delivery 4) 1 and 2 5) 1 and 3 6) 2 and 3 7) 1, 2 and 3 71

- This item refers to the transfusion of whole blood or packed red blood cells, not the administration of plasma, saline, glucose, or other intravenous fluids.

52. Number of nights hospitalized this admission before delivery: (8 or more = 8) 72

- This refers to the number of nights the patient was hospitalized during this admission for delivery before the delivery of the infant. For instance, if she is admitted in false labor on the 4th, sent home on the 5th, readmitted on the 8th in labor, and delivered on the 9th, the number of nights hospitalized before delivery is one night (the 8th).

Special Studies Items 53-55

The Contributor may decide to include on this form up to three additional items which are recorded in the Special Studies section. All questions, codes, and definitions are at his own discretion, although the IFRP may make recommendations. The IFRP must approve the use of all Special Studies before the study is initiated.

SPECIAL STUDIES	
53 _____	73
54 _____	74
55 _____	75

Additional Information Items 56-59

COMPLETE THESE ITEMS AT TIME OF DISCHARGE

56 Number of nights hospitalized this admission after delivery (8 or more = 8) 76

- This is the number of times the clock passes midnight while the patient is in the hospital after she has delivered. If the patient was delivered on one day and was released on the next day, record one night of hospitalization even if the patient was in the hospital for less than 24 hours. Similarly, if the patient was delivered early in the morning of one day and was released before midnight on the same day, record 0 nights of hospitalization even though she was in hospital for almost 24 hours (and possibly longer than the patient in the previous example).
- In answering this question, include any nights that the patient is hospitalized after delivery for reasons not related to the delivery such as sterilization.

57 Female sterilization: 0) none 1) before this delivery 2) at cesarean section 3) immediately after delivery 4) same day 5) 1-2 days later 6) 3-4 days later 7) 5-9 days later 8) 10 or more days later 77

- Write 0 in the box if the patient was not sterilized during her hospitalization for delivery. If the patient was sterilized before delivery, write 1 in the box. If the patient was sterilized during a cesarean section, write 2 in the box. Otherwise, write in the box the code corresponding to the number of days after delivery the patient was sterilized. Immediately after delivery is defined as within two hours of delivery.
- Any operation which causes permanent sterilization should be recorded here. However, if the patient is not sterilized during the admission in which she delivered, even if she intends to return or does return after discharge for such an operation, do not record it in this item.
- If an operation which produces permanent sterilization was performed but not for contraceptive purposes (for instance, hysterectomy following a ruptured uterus), it should be recorded in this item.
- If the patient died before discharge, write 9 in the box.

58 Number of additional children wanted (8 or more = 8) 78

- An effort should be made to obtain a realistic statement of the number wanted. If the patient wants more children, but does not know how many, write 8 in the box. If she wants as many as possible or whatever God sends, write 8 in the box.
- If the patient died before discharge, write 9 in the box.

59 Contraceptive method planned or provided: 0) none 1) IUD 2) orals/injectables 3) female sterilization 4) male sterilization 5) condom 6) withdrawal/rhythm 7) foam/diaphragm/jelly 8) other 79

- Record in the box the number corresponding to the method of fertility control used by the patient at her discharge or the method she plans to use after discharge. If at discharge she is not using any method of fertility control, record the method she plans to use.
- Use the definitions given in Item 25.
- If the response is "other," specify the method used or planned.
- If the patient intends to contracept but has not decided what method to use, write 9 (unknown) in the box.
- If the patient died before discharge, write 9 in the box.
- If the response to Item 57 is 1 through 8, the response to this item must be 3.
- If the patient is sterilized during this admission, write 3 in the box.

Recorder's name _____ 80

- The person who completes the Maternity Record should write his/her name legibly on this line.

INTERNATIONAL FERTILITY RESEARCH PROGRAM
MATERNITY RECORD

PATIENT IDENTIFICATION

1 Hospital or clinic no. _____ 2 Admission date _____ day month year

3 Patient's name _____ family _____ first _____ maiden _____ Husband's name _____

4 Address _____

STUDY IDENTIFICATION

5 Center name _____ and number _____

6 Study number _____ 9 0 3

7 Patient order number _____

8 Delivery date _____ day month year

9 Registration status: 0) not booked 1) picked patient's choice 2) referred by physician 3) referred by midwife 4) emergency 8) other _____

PATIENT CHARACTERISTICS

10 Residence: 1) urban 2) rural 3) urban slum 4) rural slum _____

11 Patient's status: 1) private 2) not private 8) other _____

12 Patient's age (completed years) _____

13 Patient's education (School year completed): 0) 0 1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 11) 11 12) 12 13) 13 14) 14 15) 15+ _____

14 Marital status: 1) never married 2) currently married 3) divorced 4) separated 5) widowed 6) consensual union 8) other _____

15 Age at first marriage union (completed years) _____

OBSTETRIC HISTORY (not including this pregnancy)

16 Total live births _____

17 Children now living: number of males (8 or more = 8) _____ number of females _____

18 Duration of breast feeding of last live birth (in months): 0) did not breast feed 1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 11) 11 12) 12 13) 13 14) 14 15) 15 16) 16 17) 17 18) 18 19) 19 20) 20 21) 21 22) 22 23) 23 24) 24 25) 25 26) 26 27) 27 28) 28 29) 29 30) 30 31) 31 32) 32 33) 33 34) 34 35) 35 36) 36 37) 37 38) 38 39) 39 40) 40 41) 41 42) 42 43) 43 44) 44 45) 45 46) 46 47) 47 48) 48 49) 49 50) 50 51) 51 52) 52 53) 53 54) 54 55) 55 56) 56 57) 57 58) 58 59) 59 60) 60 61) 61 62) 62 63) 63 64) 64 65) 65 66) 66 67) 67 68) 68 69) 69 70) 70 71) 71 72) 72 73) 73 74) 74 75) 75 76) 76 77) 77 78) 78 79) 79 80) 80 81) 81 82) 82 83) 83 84) 84 85) 85 86) 86 87) 87 88) 88 89) 89 90) 90 91) 91 92) 92 93) 93 94) 94 95) 95 96) 96 97) 97 98) 98 99) 99 100) 100 _____

19 Number of stillbirths (8 or more = 8) _____

20 Number of infant deaths (less than 12 completed months 8 or more = 8) _____

21 Number of spontaneous abortions (8 or more = 8) _____

22 Number of induced abortions (8 or more = 8) _____

23 Outcome of last pregnancy: 0) not previously pregnant 1) live birth full term still living 2) live birth full term deceased 3) live birth premature still living 4) live birth premature deceased 5) stillbirth 6) induced abortion 7) spontaneous abortion 8) other _____

24 Number of months since last pregnancy ended (98 or more = 98) _____

25 Contraceptive method mainly used before conception: 0) none 1) IUD 2) orals/injectables 3) female sterilization 4) male sterilization 5) condom 6) withdrawal/rhythm 7) foam/diaphragm/jelly 8) other _____

MEDICAL DATA

26 Number of antenatal visits (8 or more = 8) _____

27 Primary antenatal condition (see code list) _____

28 Hospitalization required during this pregnancy: 0) no 1) yes for condition indicated in Item 27 2) yes for condition other than the one indicated in Item 27 specify condition _____

29 Tobacco smoking during pregnancy: 0) none During part of pregnancy (cigarettes/day): 1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 11) 11 12) 12 13) 13 14) 14 15) 15 16) 16 17) 17 18) 18 19) 19 20) 20 21) 21 22) 22 23) 23 24) 24 25) 25 26) 26 27) 27 28) 28 29) 29 30) 30 31) 31 32) 32 33) 33 34) 34 35) 35 36) 36 37) 37 38) 38 39) 39 40) 40 41) 41 42) 42 43) 43 44) 44 45) 45 46) 46 47) 47 48) 48 49) 49 50) 50 51) 51 52) 52 53) 53 54) 54 55) 55 56) 56 57) 57 58) 58 59) 59 60) 60 61) 61 62) 62 63) 63 64) 64 65) 65 66) 66 67) 67 68) 68 69) 69 70) 70 71) 71 72) 72 73) 73 74) 74 75) 75 76) 76 77) 77 78) 78 79) 79 80) 80 81) 81 82) 82 83) 83 84) 84 85) 85 86) 86 87) 87 88) 88 89) 89 90) 90 91) 91 92) 92 93) 93 94) 94 95) 95 96) 96 97) 97 98) 98 99) 99 100) 100 Throughout pregnancy (cigarettes/day): 1) 1 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 11) 11 12) 12 13) 13 14) 14 15) 15 16) 16 17) 17 18) 18 19) 19 20) 20 21) 21 22) 22 23) 23 24) 24 25) 25 26) 26 27) 27 28) 28 29) 29 30) 30 31) 31 32) 32 33) 33 34) 34 35) 35 36) 36 37) 37 38) 38 39) 39 40) 40 41) 41 42) 42 43) 43 44) 44 45) 45 46) 46 47) 47 48) 48 49) 49 50) 50 51) 51 52) 52 53) 53 54) 54 55) 55 56) 56 57) 57 58) 58 59) 59 60) 60 61) 61 62) 62 63) 63 64) 64 65) 65 66) 66 67) 67 68) 68 69) 69 70) 70 71) 71 72) 72 73) 73 74) 74 75) 75 76) 76 77) 77 78) 78 79) 79 80) 80 81) 81 82) 82 83) 83 84) 84 85) 85 86) 86 87) 87 88) 88 89) 89 90) 90 91) 91 92) 92 93) 93 94) 94 95) 95 96) 96 97) 97 98) 98 99) 99 100) 100 4) 1 10 5) 11 20 6) 21 or more 8) cigars/pipes etc _____

30 Number of previous cesarean sections _____

31 Estimated duration of pregnancy (menstrual age in completed weeks) _____

32 Hemoglobin at admission for delivery (to nearest gm): 1) < 5 gm 2) 6 gm 3) 7 gm 4) 8 gm 5) 9 gm 6) 10 gm 7) 11 gm 8) 12 gm 9) not done _____

33 Rupture of membranes: Spontaneous: 1) < 24 hrs before delivery 2) 24 hrs before delivery Artificial: 3) < 24 hours before delivery 4) 24 hrs before delivery 5) during cesarean section _____

34 Type of labor: 0) no labor 1) spontaneous 2) spontaneous, augmented with artificial rupture of membranes (ARM) 3) spontaneous, augmented with drugs 4) spontaneous, augmented with ARM and drugs 5) induced, with ARM 6) induced, with drugs 7) induced, with ARM and drugs 8) other _____

For multiple births, code information for the most difficult delivery in Items 35, 38, 44, 45, 47 and 48 and complete a separate Multiple Birth Record for each infant

35 Type of presentation during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other _____

36 Anesthetic administered: 0) none or psychoprophylaxis only 1) analgesic systemic or inhalation 2) local 3) paracervical/pudendal 4) spinal/epidural 5) general 6) 1 and 2 or 1 and 3 7) other combination 8) other _____

37 Episiotomy: 0) none 1) midline 2) midline with extension 3) midline with hematoma 4) mediolateral 5) mediolateral with extension 6) mediolateral with hematoma 8) other _____

38 Type of delivery: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other _____

39 Primary injury during labor and/or delivery: 0) none 1) vulva 2) vagina 3) perineum 4) cervix 5) uterus 6) rectum 7) bladder 8) other _____

40 Primary complication of labor and/or delivery: 0) none 1) prolonged/obstructed labor 2) placenta previa 3) placenta abruptio 4) hypotonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other _____

41 Secondary complication of labor and/or delivery: 0) none 1) prolonged labor 2) cord prolapse 4) hypotonic uterine contractions 5) hypertonic uterine contractions 6) hemorrhage 7) retained products 8) other _____

42 Duration of labor (in completed hours): 0) none 1) < 2 2) 2 3) 3 4) 4 5) 5 6) 6 7) 7 8) 8 9) 9 10) 10 11) 11 12) 12 13) 13 14) 14 15) 15 16) 16 17) 17 18) 18 19) 19 20) 20 21) 21 22) 22 23) 23 24) 24 25) 25 26) 26 27) 27 28) 28 29) 29 30) 30 31) 31 32) 32 33) 33 34) 34 35) 35 36) 36 37) 37 38) 38 39) 39 40) 40 41) 41 42) 42 43) 43 44) 44 45) 45 46) 46 47) 47 48) 48 49) 49 50) 50 51) 51 52) 52 53) 53 54) 54 55) 55 56) 56 57) 57 58) 58 59) 59 60) 60 61) 61 62) 62 63) 63 64) 64 65) 65 66) 66 67) 67 68) 68 69) 69 70) 70 71) 71 72) 72 73) 73 74) 74 75) 75 76) 76 77) 77 78) 78 79) 79 80) 80 81) 81 82) 82 83) 83 84) 84 85) 85 86) 86 87) 87 88) 88 89) 89 90) 90 91) 91 92) 92 93) 93 94) 94 95) 95 96) 96 97) 97 98) 98 99) 99 100) 100 _____

43 Attendant at delivery: 0) none 1) nurse 2) qualified midwife 3) student nurse/midwife 4) paramedic 5) medical student 6) general physician 7) OB/GYN physician 8) other _____

44 Birth weight (gm): 9988 or more = 9988 _____

45 Sex of infant(s) born at this delivery: number of males (write number of each) _____ number of females _____

46 Apgar score: 9) not done at 1 minute (8 or more = 8) _____ at 5 minutes _____

For Items 47-48 use the following codes: 0) normal or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) sepsis/meningitis 6) neonatal sepsis 7) trauma 8) other (for codes 2, 3, 7 and 8 specify)

47 Primary fetal/neonatal condition specify _____

48 Secondary fetal/neonatal condition specify _____

49 Death of fetus/newborn: 0) none 1) antepartum, one 2) antepartum, two or more 3) intrapartum, one 4) intrapartum, two or more 5) postpartum, one 6) postpartum, two or more 7) combination 8) other _____

50 Primary perinatal condition: 0) normal 1) fever requiring treatment 2) bleeding requiring treatment 3) urinary tract infection 4) mastitis 5) phlebitis 6) disseminated 7) death (complete Death Report) 8) other _____

51 Maternal blood transfusion during hospitalization: 0) none 1) yes before delivery 2) yes during delivery 3) yes after delivery 4) 1 and 2 5) 1 and 3 6) 2 and 3 7) 1 2 and 3 _____

52 Number of nights hospitalized this admission before delivery (8 or more = 8) _____

SPECIAL STUDIES

53 _____

54 _____

55 _____

Complete these items at time of discharge.

56 Number of nights hospitalized this admission after delivery (8 or more = 8) _____

57 Female sterilization: 0) none 1) before this delivery 2) at cesarean section 3) immediately after delivery 4) same day 5) 1-2 days later 6) 3-4 days later 7) 5-9 days later 8) 10 or more days later _____

58 Number of additional children wanted (8 or more = 8) _____

59 Contraceptive method planned or provided: 0) none 1) IUD 2) orals/injectables 3) female sterilization 4) male sterilization 5) condom 6) withdrawal/rhythm 7) foam/diaphragm/jelly 8) other _____

Recorder's name _____

PLEASE AIRMAIL TO International Fertility Research Program, Research Triangle Park, North Carolina 27709 USA

ANTENATAL CONDITIONS

(Refer to manual, item 27)

Numbers in parentheses refer to codes in WHO International Classification of Diseases 9th edition

- 00 None
99 Unknow.
- Hemorrhage per vagina**
01 Threatened abortion (640.0)
02 Placenta previa (641.0, 641.1)
03 Placenta abruptio, premature separation (641.2)
04 Rupture of the marginal sinus (641.8)
05 Antepartum hemorrhage associated with coagulation defects (641.3)
06 Other and unspecified antepartum hemorrhage per vagina (641.8, 641.9)
- Hypertensive disorders**
07 Preexisting hypertension (642.0)
08 Preexisting hypertension with superimposed pre-eclampsia or eclampsia (642.7)
09 Hypertension of this pregnancy (642.3)
10 Pre-eclampsia (642.4, 642.5)
11 Eclampsia (642.6)
12 Other hypertensive disorders and isolated symptoms of pre-eclampsia (642.0, 646.1, 646.2), specify
- Amniotic cavity and genitourinary tract disorders and infections**
13 Infection of amniotic cavity (658.4)
14 Lower urinary tract infections (646.6)
15 Acute pyelitis/pyelonephritis (590.1)
16 Chronic pyelitis/pyelonephritis (590.0)
17 Nephritis, nephrotic syndrome and nephrosis (580-583, 591)
18 Pelvic inflammatory disease (614.8, 614.9)
19 Urinary-genital tract fistula (619.0)
20 Other infections or disorders (646.6, 647.2), specify
- Cardiovascular and respiratory disorders**
21 Varicose veins of legs, vulva and vagina (671.0, 671.1)
22 Phlebitis or thrombophlebitis (671.2)
23 Phlebothrombosis (671.3)
24 Congenital cardiovascular disorders (745-747)
25 Rheumatic heart disease (390-398)
26 Acute respiratory conditions (460-466, 480-487)
27 Chronic obstructive lung disease and allied conditions, nontubercular (490-496)
28 Other cardiovascular and respiratory disorders (648.6, 460-519.9), specify
- Blood disorders**
29 Iron deficiency anemia (280)
30 Other deficiency anemias (282-283)
31 Sickle-cell anemia (282.6)
32 Thalassemia (282.4)
33 Other anemias and blood disorders (285), specify
- Diseases and disorders of pelvic organs**
34 Tumors of the body of the uterus (654.1)
35 Incompetent cervix (654.5)
36 Ovarian cysts and benign ovarian tumors (620.0, 620.1, 620.2, 620.8)
37 Other abnormality of shape or position of uterus and neighboring structures (654.4)
38 Other and unspecified abnormality of cervix, vagina and vulva (654.6-654.9)
- Fetal problems**
39 Rhesus isoimmunization (656.1)
40 ABO and other isoimmunization (656.2)
41 Fetal distress (656.3)
42 Intrauterine death (656.4)
43 Intrauterine growth retardation (656.5)
44 Previous malposition, successfully converted to cephalic (652.1)
45 Other known or suspected fetal condition affecting management of pregnancy (655, 656.6, 656.8, 656.9)
- Fetopelvic disproportion**
46 Abnormal or contracted pelvis (653.0-653.4)
47 Large or abnormal fetus (653.5-653.7)
- Other complications of pregnancy**
48 Hyperemesis gravidarum (643)
49 Threatened premature labor (644.0)
50 Polyhydramnios (657)
51 Oligohydramnios (658.0)
52 Other complications of pregnancy (640-646, 650-679), specify
- Infectious and parasitic disease**
53 Rubella (647.5)
54 Other viral diseases except respiratory (647.6), specify
55 Tuberculosis (647.3)
56 Malaria (647.4)
57 Syphilis (647.0)
58 Gonorrhoea (647.1)
59 Bilharzia (schistosomiasis) (120)
60 Gastrointestinal parasites (12J-129), specify
61 Other bacterial infections or parasitic diseases (001-136.8), specify
- Gastrointestinal disorders**
62 Appendicitis (540-542)
63 Noninfective ileitis and colitis (555-558)
64 Cholecystitis and cholelithiasis (574.0-574.5, 575.0, 575.1)
65 Rectovaginal fistula (E19.1)
66 Other gastrointestinal disorders (531-579.9), specify
- Malignant neoplasms**
67 Breast (174)
68 Cervix (180)
69 Lymphatic and hematopoietic (200-208)
70 Other (140-208.9), specify
- Benign neoplasms**
71 Other neoplasms (210-229) (except as in code 34), specify
- Neurologic disorders**
72 Cerebral palsy (343)
73 Encephalitis (062-065)
74 Epilepsy (345)
75 Paraplegia (344.1)
76 Other neurologic disorders (320-359), specify
- Endocrine disorders**
77 Hyperthyroidism (240-242)
78 Hypothyroidism (243-244)
79 Diabetes mellitus, preexisting (250)
80 Diabetes mellitus, gestational (648.0)
81 Parathyroid disorders (252)
82 Adrenal disorders (255)
83 Other endocrine disorders (240-258.9)
- Mental disorders**
84 Psychosis (290-299), specify
85 Neurosis (301-316), specify
86 Mental retardation (317-319)
87 Alcohol dependence (303)
88 Drug dependence (304)
89 Pica (307.5), specify
- Malnutrition**
90 Avitaminosis (264-269.2)
91 Other malnutrition (260-269)
- Musculoskeletal system disorders and injuries**
92 Bone and joint disorders of back, pelvis and lower limbs (part of 711-719, 720-724; part of 725-738)
93 Internal injury to chest and pelvis (860-869)
94 Trauma involving abdominal injury (868)
95 Other musculoskeletal disorders and injuries (part of 710-739 and 800-999), specify
- Poisoning**
96 Poisoning and toxic effects (960-989), specify
- Other disorders**
98 Other, specify

INSTRUCTIONS FOR THE SHIPPING CONTROL SHEET FOR MATERNITY RECORD STUDIES

Completed forms should be sent each month to the International Fertility Research Program. A Shipping Control Sheet (SCS) should be mailed *with* each package of forms sent. Please complete the SCS as follows:

Center Number Record the number assigned to your Center.

Shipping Date Record the date on which the forms are being sent.

Enclosure Information

1. **Shipment Number**—To help ensure that no shipments are misplaced or lost, each shipment of forms should be numbered consecutively within each specific study. If a break in the shipment number sequence is noted, the Contributor will be notified and attempts made to locate the missing shipment. If a shipment cannot be located, the Contributor's duplicate copies may be used to obtain the data.
2. **Study Number**—List the appropriate study number vertically in this column. Several studies may be listed on one Shipping Control Sheet. However, each separate package mailed should include a Shipping Control Sheet listing the contents of that package.

Enter the total number of each type of form sent in the appropriate column. Blank columns have been left to allow for a tally of any special forms that may be used.

Supplies Needed

The IFRP recommends that a large enough supply of forms be maintained by the Contributor, to cover a two to three month period. Since Center's volume may vary at different times throughout the study, this section is intended to help ensure against depleting the supply of forms during the study.

Address Change

If there is a change of contact person or address, please note the change at the bottom of the SCS.

**CONVERSION CHART:
Hemoglobin in percentages to grams per 100 ml
(for Item 32)**

Percent of normal		gm %	IFRP code	Percent of normal		gm %	IFRP code
18-21%	=	3 grams	code 1	58-63%	=	10 grams	code 6
22-28%	=	4 grams		64-69%	=	11 grams	code 7
29-34%	=	5 grams		70-75%	=	12 grams	code 8
35-40%	=	6 grams	code 2	76-81%	=	13 grams	
41-46%	=	7 grams	code 3	82-87%	=	14 grams	
47-51%	=	8 grams	code 4	88-93%	=	15 grams	
52-57%	=	9 grams	code 5	94-98%	=	16 grams	

Appendix D

CONVERSION CHART: Ounces to grams
ounces

lb	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		28	57	85	113	142	170	198	227	255	283	312	340	369	397	425
1	454	481	510	539	567	595	624	652	680	709	737	765	794	822	850	879
2	907	936	964	992	1021	1049	1077	1106	1134	1162	1191	1219	1247	1276	1304	1332
3	1361	1389	1417	1446	1474	1503	1531	1559	1588	1616	1644	1673	1701	1729	1758	1786
4	1814	1843	1871	1899	1928	1956	1984	2013	2041	2070	2098	2126	2155	2183	2211	2240
5	2268	2296	2325	2353	2381	2410	2438	2466	2495	2523	2551	2580	2608	2637	2665	2693
6	2722	2750	2778	2807	2835	2863	2892	2920	2948	2977	3005	3033	3062	3090	3118	3147
7	3175	3204	3232	3260	3289	3317	3345	3374	3402	3430	3459	3487	3515	3544	3572	3600
8	3629	3657	3685	3714	3742	3771	3799	3827	3856	3884	3912	3941	3969	3997	4026	4054
9	4082	4111	4139	4167	4195	4224	4252	4281	4309	4337	4366	4394	4422	4451	4479	4508
10	4536	4564	4593	4621	4649	4678	4706	4734	4763	4791	4819	4848	4876	4904	4933	4961
11	4989	5018	5046	5074	5103	5131	5160	5188	5216	5245	5273	5301	5330	5358	5386	5415
12	5443	5471	5500	5528	5556	5585	5613	5642	5670	5698	5727	5755	5783	5812	5840	5868
13	5897	5925	5953	5982	6010	6038	6067	6095	6123	6152	6180	6208	6237	6265	6294	6322
14	6350	6379	6407	6435	6464	6492	6520	6549	6577	6605	6634	6662	6690	6719	6747	6775
15	6803	6832	6861	6889	6918	6946	6974	7002	7031	7059	7087	7116	7144	7172	7201	7229
16	7257	7286	7314	7343	7371	7399	7428	7456	7484	7513	7541	7569	7598	7626	7654	7683
17	7711	7739	7768	7796	7824	7853	7881	7909	7938	7966	7994	8023	8051	8080	8108	8136

Definitions of antenatal conditions

The numbers in parentheses following the conditions listed on the back of the form refer to the codes of the *International Classification of Diseases published by the World Health Organization (9th edition, World Health Organization, Geneva, 1977)*.

00 None. If the patient's antenatal condition is normal and satisfactory, write 00 in the boxes

99 Unknown. If the patient's antenatal condition is unknown and cannot be presumed normal and satisfactory, write 99 in the boxes

Hemorrhage per vagina

01 Threatened abortion (640.0). Bleeding of uterine origin occurring before the 20th completed week of gestation, with or without uterine colic, without expulsion of the products of conception, and without dilatation of the cervix.

02 Placenta previa (641.0 and 641.1). Only placenta previa diagnosed antenatally should be recorded. If the condition is not diagnosed until the onset of labor, this should be recorded under Item 40, code 2. Placenta previa is the implantation of any part of the placenta in the lower uterine segment. The term expresses the anatomic relationship between the placental site and the lower uterine segment. The placenta encroaches on or covers (completely or partially) the internal cervical os. This code includes low-lying placenta, marginal, partial, and total placenta previa with or without hemorrhage.

03 Placenta abruptio (premature separation) (641.2). Abruptio placenta is the complete or partial detachment of the normally implanted placenta from the uterine wall at 20 weeks or more of gestation. The condition may occur with placenta previa. It is characterized by severe abdominal pain, hemorrhage, and often shock. It is also called premature separation of the placenta, placental abruption, accidental hemorrhage, or ablatio placenta.

04 Rupture of the marginal sinus (641.8). Observed defect in the venous sinus which surrounds the margin or edge of the placenta.

05 Antepartum hemorrhage associated with coagulation defects (641.3). Includes antepartum bleeding associated with or attributed to afibrinogenemia, hypofibrinogenemia, or hyperfibrinolysis.

06 Other and unspecified antepartum hemorrhage per vagina (641.3 and 641.9). Any other bleeding of uterine origin that is of other or unknown etiology or that is attributable to trauma should be included in this category.

Hypertensive disorders

07 Preexisting hypertension (642.0). Includes malignant, essential, or chronic hypertension which complicates the pregnancy, delivery, and/or puerperium and which existed before the onset of pregnancy. Any preexisting hypertension that is secondary to heart and/or renal disease should be coded under heart or renal disease (codes 15-17, 21-25).

08 Preexisting hypertension with superimposed preeclampsia or eclampsia (642.7). Superimposed eclampsia or preeclampsia is the development of eclampsia or preeclampsia in a patient with chronic hypertensive vascular or renal disease, or benign essential hypertension. Preeclampsia and eclampsia are defined below.

09 Hypertension of this pregnancy (642.3). This is the development of hypertension during this pregnancy in a previously normotensive patient when there is no evidence of either hypertensive vascular disease or preeclampsia.

10 Preeclampsia (642.4 and 642.6). Preeclampsia or preeclamptic toxemia is defined as the development of hypertension with proteinuria or edema or both and which is attributed to the pregnancy. Includes both mild and severe cases.

11 Eclampsia (642.6). Eclampsia is characterized by convulsions in a patient with preeclampsia that cannot be attributed to a condition such as epilepsy.

12 Other hypertensive disorders and isolated symptoms of preeclampsia (642.9, 646.1, 646.2). Specify on the Maternity Record the details of any condition coded here.

Amniotic cavity and genitourinary tract disorders and infections

13 Infection of amniotic cavity (658.4). Includes amnionitis, chorioamnionitis, membranitis, and placentitis.

14 Lower urinary tract infection (646.6). Includes cystitis, urethritis, any inflammatory disease, or infection without a specified site in lower urinary tract.

15 Acute pyelitis/pyelonephritis (590.1). Nonchronic ascending infection from the bladder involving ureters, renal pelvis, and kidney due to local bacterial infection.

16 Chronic pyelitis/pyelonephritis (590.0). Chronic or recurring inflammation of the renal parenchyma and pelvis.

17 Nephritis, nephrotic syndrome, and nephrosis (580-583, 590). Inflammation of the kidneys, nephropathy, or degeneration of renal tubular epithelium. Nephrotic syndrome is characterized by edema, massive proteinuria, and hypoalbuminemia.

18 Pelvic inflammatory disease (614.8, 614.9). Includes infections of internal genitalia caused by pathogens other than gonococcus and tuberculosis. If the inflammation is due to gonorrhoea, use code 58; if it is due to tuberculosis, use code 55.

19 Urinary-genital tract fistula (619.0). Includes vesicovaginal and urethrovaginal fistulas as well as the rarer cervicovesical, uterovesical, ureterovaginal, and uteroureteric fistulas. This code covers all fistulas present in this pregnancy, as well as those previously repaired. Rectovaginal fistulas should be recorded under code 65.

20 Other infections or disorders (646.6, 647.2). Includes any infections or disorders of the genitourinary tract which may complicate pregnancy or labor. Specify condition on Maternity Record form.

Cardiovascular and respiratory disorders

21 Varicose veins of legs, vulva or vagina (671.0, 671.1). Includes any abnormally lengthened, dilated, and sacculated superficial veins in legs, vulva, or vagina.

22 Phlebitis or thrombophlebitis (671.2). This condition is defined as inflammation of vein and/or the formation of a thrombus after inflammation of the wall of a vein.

23 Phlebothrombosis (671.3). Formation of a thrombus in a deep vein of legs or pelvis in the absence of a preexisting inflammation.

24 Congenital cardiovascular disorders (746-747). Any anomaly or disorder of the cardiovascular system present from birth which complicates pregnancy or delivery, such as atrioventricular septal defects.

25 Rheumatic heart disease (390-398). Includes acute rheumatic fever with heart involvement as well as chronic rheumatic heart diseases such as rheumatic pericarditis, diseases of the mitral valve, aortic valve, and other endocardial structures.

26 Acute respiratory conditions (460-456, 480-487). Includes any respiratory condition which complicates pregnancy or delivery. Pneumonia and influenza should always be included in this code. Tuberculosis is coded 55.

27 Chronic obstructive lung disease and allied conditions, non-tubercular (490-496). Includes chronic bronchitis, emphysema, asthma, bronchiectasis, as well as pneumoconiosis due to external agents such as asbestos or silicates. Also includes pleurisy, lung abscess, and other diseases of the lung, not including tuberculosis which is recorded under code 55.

28 Other cardiovascular and respiratory disorders (648.6, 460-519.9). Includes any disease or disorder of the cardiovascular and respiratory systems not specified above. Specify conditions on the Maternity Record.

Blood disorders

29 Iron deficiency anemia (280). This condition is characterized by small, pale red blood cells, low reticulocyte activity, and depleted iron reserves. Serum iron concentration is below 60µg/100 ml.

- 30 Other deficiency anemias (282-283).** Includes folic acid deficiency, megaloblastic anemia, and other deficiency anemias (except iron deficiency) either acquired or hereditary
- 31 Sickle cell anemia (282.6).** This condition is a form of hemolytic anemia that occurs almost exclusively in Blacks. Do not include the presence of sickle cell trait without anemia and/or crisis in this code
- 32 Thalassemia (282.4).** Any one of the group of chronic familial anemias occurring in populations bordering on the Mediterranean or in Blacks. These anemias are characterized by the production of abnormally thin blood cells
- 33 Other anemias and blood disorders (285).** Includes only conditions that cannot be more specifically identified in the above list. Specify the anemia or disorder on the Maternity Record

Diseases and disorders of pelvic organs

- 34 Tumors of the body of the uterus (654.1).** Includes uterine fibroids present during pregnancy and any other benign tumor of the uterus. Malignant tumors are coded 70
- 35 Incompetent cervix (654.5).** This condition can be inferred from a painless dilation and effacement of the cervix, usually in the second trimester or from a history of repeated relatively painless and bloodless second trimester abortions. If the condition is diagnosed, this code should be used regardless of whether surgical repair has been done
- 36 Ovarian cysts and benign ovarian tumors (620.0, 620.1, 620.2, 620.8).** Includes follicular cysts, corpus luteum cysts, dermoid cysts, cystadenomas, and other or unspecified cysts or tumors of the ovary present during pregnancy
- 37 Other abnormality of the shape or position of uterus and neighboring structures (654.4).** Includes cystocele, rectocele, enterocele, pelvic repair and prolapse of a gravid uterus. Previous repair of these conditions should be included
- 38 Other or unspecified abnormalities of the cervix, vagina and vulva (654.6-654.9).** This code should be used if the condition or etiology of the condition is not more specifically listed elsewhere in these codes. Benign tumors should be recorded under code 71, malignancies should be recorded under codes 68 to 70, and conditions resulting from venereal disease should be recorded under codes 57 to 58

Fetal problems

- 39 Rhesus isoimmunization (656.1).** The presence of anti-Rh antibody in a woman carrying an Rh positive infant. This should be coded only if the condition was diagnosed antenatally. If this condition is diagnosed after delivery, write 5 in Item 47
- 40 ABO and other isoimmunization (656.2).** Includes all those immunologic disorders resulting from an immune reaction by the mother against a blood group factor present on the red cells of the fetus except for the Rh blood group which is coded above. This should be coded only if the condition was diagnosed antenatally
- 41 Fetal distress (656.3).** Use the code only if abnormal fetal acid-base balance is detected, if fetal heart rate is over 160 beats per minute or less than 120 beats per minute, if a late or variable deceleration pattern of bradycardia is detected, or if fetal monitoring detects any other fetal manifestation of distress
- 42 Intrauterine death (656.4).** Use the code only if the fetus dies after 20 weeks' gestation but before termination of the pregnancy
- 43 Intrauterine growth retardation (656.5).** Also called "light for dates," "placental insufficiency," and "small for dates"
- 44 Previous malposition successfully converted to cephalic (652.1).** Use this code for any delivery in which breech, transverse lie, brow, or face or any other malpresentation is successfully converted to occiput presentation
- 45 Other known or suspected fetal condition affecting management of pregnancy (655, 656.6, 656.8, 656.9).** Any diagnosed or suspected condition of the fetus requiring special observation or obstetrical care or termination of the pregnancy after 20 weeks' gestation.

Fetopelvic disproportion

- 46 Abnormal or contracted pelvis (653.0-653.4).** Any abnormality of the bony pelvis in which a major diameter of inlet, mid pelvis, or outlet is compromised so that vaginal delivery of a fetus is not possible
- 47 Large or abnormal fetus (653.5-653.7)** Use this code for cephalopelvic disproportion of fetal origin. The fetus may be abnormally formed (i.e., hydrocephalic) or normally formed but too large for the proportions of the maternal pelvis

Other complications of pregnancy

- 48 Hyperemesis gravidarum (643)** Excessive vomiting requiring care at less than 22 weeks of gestation. Do not use this code for vomiting occurring later in pregnancy
- 49 Threatened premature labor (644.0)** False labor at less than 37 weeks' gestation
- 50 Polyhydramnios (657)** An excessive amount of amniotic fluid. The normal volume of amniotic fluid ranges from 800 to 1200 ml
- 51 Oligohydramnios (658.0)** Deficient amount of amniotic fluid. The normal volume of amniotic fluid ranges from 800 to 1200 ml
- 52 Other complications of pregnancy (640-646, 650-679).** Any disease or disorder of the fetus or mother requiring special observation or care which cannot be coded more specifically elsewhere. Specify the condition on the Maternity Record

Infectious and parasitic diseases

- 53 Rubella (647.5)** Often called German or three day measles. Code only if the disease is diagnosed during pregnancy
- 54 Other viral diseases except respiratory (647.6).** This code should be used for diseases caused by any viral agent if the disease is not specified elsewhere in this list. Viral diseases of the genitourinary tract, respiratory system, or gastrointestinal system should be recorded using codes 20, 28, or 66
- 55 Tuberculosis (647.3).** Includes all active infections by *Mycobacterium tuberculosis* human or bovine, in any tissue or organ of the body. Do not include inactive or healed tuberculosis
- 56 Malaria (647.4).** Sometimes called marsh fever, paludal fever, or jungle fever. Code if the patient has chronic or acute attacks at any time during her pregnancy
- 57 Syphilis (647.0).** Code if the patient exhibits treated or untreated positive serology or primary (chancres), secondary (condylomata lata), or tertiary (gummata) symptoms of the infectious process of *Treponema pallidum*
- 58 Gonorrhea (647.1).** Any infection of the genitalia or other parts of the body caused by *Neisseria gonorrhoeae* present during any part of the pregnancy
- 59 Bilharzia (Schistosomiasis) (120).** A blood fluke disease caused by schistosoma, a genus of trematode worm
- 60 Gastrointestinal parasites (120-129).** Includes gastrointestinal infestation by any type of trematode (except schistosoma), echinostoma, cestode, trichinella, filaria, ascaris, ancylostoma, or other intestinal helminths
- 61 Other bacterial infections or parasitic diseases (001-136.8).** Includes diseases caused by bacteria or parasites not specified in another code. If the disease involves the genitourinary tract, cardiovascular or respiratory system, or gastrointestinal system, use code 20, 28, 60, or 66

Gastrointestinal disorders

- 62 Appendicitis (540-542).** Use this code only if the inflammation of the vermiform appendix required removal of the appendix. Include all appendectomies done during the pregnancy.
- 63 Noninfective ileitis and colitis (555-558).** Inflammation of the ileum or colon not capable of being transmitted.
- 64 Cholecystitis and cholelithiasis (574.0-574.5, 575.0, 575.1).** Inflammation of the gall bladder or a condition in which concretions are present in the gall bladder or bile duct.
- 65 Rectovaginal fistula (619.1).** An abnormal passage between the rectum and vagina. Code if patient ever had a fistula.

- 66 Other gastrointestinal disorders (531-579.9).** Includes diseases of the esophagus, stomach, small bowel, and large bowel. Includes all functional disorders as well as bacterial, viral, and parasitic diseases of the gastrointestinal system not specified elsewhere. Specify the condition on the Maternity Record.

Malignant neoplasms

- 67 Breast (174).** Any malignant neoplasm (carcinoma or sarcoma) of breast diagnosed before or during pregnancy.
- 68 Cervix (180).** Any malignant neoplasm (carcinoma or sarcoma) occurring in the cervix diagnosed before or during pregnancy.
- 69 Lymphatic or hematopoietic (200-208).** Includes lymphosarcoma, reticulosarcoma, Hodgkin's disease, neoplasm of lymphoid and histiocytic tissue, multiple myeloma, and leukemias.
- 70 Other malignant neoplasms (140-208.9).** Includes any cancers not specified above.
- 71 Benign neoplasms (210-229).** Any nonmalignant tumor present during the pregnancy at any site except the uterus and ovaries. For benign uterine tumors, use code 34. For benign ovarian tumors, use code 36.

Neurologic disorders

- 72 Cerebral palsy (343).** Any defect of motor power and coordination related to damage to the brain, not including hereditary spastic paraplegia or Vogt's disease.
- 73 Encephalitis (062-065).** Any viral disease causing inflammation of the brain.
- 74 Epilepsy (345).** A disorder of the central nervous system characterized by paroxysmal attacks of brain dysfunction, either petit mal or grand mal convulsions.
- 75 Paraplegia (344.1).** A paralysis of both legs during all or any part of the pregnancy.
- 76 Other neurological disorders (320-359).** Includes any disease or disorder of the nervous system not specifically listed above including meningitis, multiple sclerosis, spinocerebellar disease, anterior horn cell disease, diseases of the spinal cord, autonomic nervous system, and central nervous system, muscular dystrophy, and other degenerative diseases.

Endocrine disorders

- 77 Hyperthyroidism (240-242).** A disorder also called thyrotoxicosis caused by an above-normal increase in circulating thyroid hormone. Graves's disease, Plummer's disease, and goiter are included.
- 78 Hypothyroidism (243-244).** A disorder caused by an above-normal decrease in circulating thyroid hormone. This includes both congenital and acquired hypothyroidism.
- 79 Diabetes mellitus, preexisting (250).** Code for diabetic patients with any manifestation of the disease diagnosed before this pregnancy.
- 80 Diabetes mellitus, gestational (648.0).** The presence of an abnormal glucose tolerance test that reverts to normal values following delivery. This code should be used when diabetes is first diagnosed during the pregnancy.
- 81 Parathyroid disorders (252).** Code for hyperparathyroidism and hypoparathyroidism manifested during pregnancy.
- 82 Adrenal disorders (255).** Includes Cushing's syndrome, hyperaldosteronism, adrenogenital disorders, corticoadrenal overactivity, corticoadrenal insufficiency, other adrenal hypofunctions, medulloadrenal hyperfunction, and other adrenal disorders if the disorder originates from the adrenal or is pituitary-induced.
- 83 Other endocrine disorders (240-258.9).** Includes any disorders diagnosed before or during pregnancy which are not specified elsewhere in this list. Specify the disorder on the Maternity Record.

Mental disorders

- 84 Psychosis (290-299).** Any mental disorder in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. It does include alcoholic and drug psychosis. Specify the type of psychosis on the Maternity Record.
- 85 Neurosis (301-316).** Mental disorder without demonstrable organic basis in which the patient may have considerable insight and does have unimpaired reality testing. The principal manifestations include excessive anxiety, hysterical symptoms, obsessional phobias, and compulsive symptoms and depression. Specify the type of neurosis.
- 86 Mental retardation (317-319).** A condition of arrested or incomplete mental development which is especially characterized by subnormal intelligence. This should reflect the individual's current level of functioning without regard to the nature or cause of the disorder.
- 87 Alcohol dependence (303).** A psychic and usually physical state resulting from taking alcohol, characterized by behavioral and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Use code 84 for alcoholic psychosis.
- 88 Drug dependence (304).** A psychic and sometimes physical state resulting from taking a drug characterized by behavioral and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. Use code 84 for drug psychosis.
- 89 Pica (307.5).** A craving for unusual substances not normally considered to be food. Specify the substance.

Malnutrition

- 90 Avitaminosis (264-269.2).** A deficiency disease state resulting from an inadequate supply of one or more vitamins in the diet. Use this code if there is any physical evidence of a deficiency.
- 91 Other malnutritations (260-269).** Includes any deficiency disease state resulting from an inadequate supply of any nutritional element, except vitamins.

Musculoskeletal system disorders and injuries

- 92 Bone and joint disorders of back, pelvis and lower limbs (part of 711-719, 720-724; part of 726-738).** Includes any arthropathy, osteopathy, or other disorder of back, pelvis, and lower limbs.
- 93 Internal injury to chest and pelvis (860-869).** Includes traumatic injuries of internal organs due to crushing, blast, laceration, puncture, tear, or traumatic rupture, with or without an open wound.
- 94 Trauma involving abdominal injury (868).** Includes any traumatic injury of the abdomen involving internal viscera with or without an open wound.
- 95 Other musculoskeletal disorders and injuries (part of 710-739 and 800-999).** Includes any disorders or injuries not specifically listed above. Specify the condition on the Maternity Record.

Poisoning

- 96 Poisoning and toxic effects (960-989).** Includes effects, diagnosed during pregnancy, which result from drugs or biological substances given in error or from overdoses of such substances or from exposure to or ingestion of nonmedicinal substances. Do not include adverse effects ("hypersensitivity," "reaction") resulting from correct substances properly administered.

Other disorders

- 98 Other, specify.** Do not use this code if the condition is more specifically described elsewhere on this list.

**INTERNATIONAL FERTILITY RESEARCH PROGRAM
MULTIPLE BIRTH RECORD**

Complete a separate form for each infant born in a multiple birth.

IDENTIFICATION OF MOTHER:	1 Hospital or clinic no _____	2 Admission date _____
	day month year	
3 Mother's name _____	Father's name _____	
4 Address _____		

STUDY IDENTIFICATION

5 Center name _____ and number

 1-3

6 Study number

 4-6

7 Maternity Record study number

 7-9

8 Mother's patient order number on Maternity Record

 10-14

9 Delivery date:

--	--

 day

--	--	--	--

 month

--	--	--	--

 year 15-20

14 Birth weight (grams)

--	--	--	--	--

 25-28

15 Sex of this infant: 1) male 2) female 3) indeterminate

 29-31

16 Apgar score 9) not done at 1 minute (8 or more = 8) at 5 minutes

 30-31

For items 17-18, use the following codes (0 may be coded for both items. No other codes should be repeated):
 0) normal or stillbirth with no apparent pathology 1) fetal distress during labor 2) minor malformation 3) major malformation 4) respiratory distress syndrome 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other

MEDICAL DATA

10 Number of births this delivery

--

 21

11 Birth sequence of this infant: 1) first 2) second 3) third 4) fourth 5) fifth 6) sixth

--

 22

12 Presentation of this infant during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other, specify _____

--

 23

13 Type of delivery this infant: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other, specify _____

--

 24

17 Primary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____

--

 32

18 Secondary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____

--

 33

19 Fetal/neonatal death: 0) none 1) antepartum 2) intrapartum 3) postpartum

--

 34

3

 80

Recorder's name: _____

PLEASE AIRMAIL TO: International Fertility Research Program, Research Triangle Park, North Carolina 27709 USA

INSTRUCTIONS FOR COMPLETING THE MULTIPLE BIRTH RECORD

The Multiple Birth Record should be completed whenever there is a multiple birth. Complete a separate Multiple Birth Record for each baby. Fill in only one Maternity Record for the mother.

Identification of the Mother Items 1-4

- This information in the upper box is not mailed to the IFRP. The information should be the same as that on the mother's Maternity Record.

Study Identification Items 5-9

5 Center name _____ and number 1-3

- Write the name of the Center on the line. Fill in the unique three-digit number assigned to the Center in the three boxes on the right

6 Study number 4-6

- The study number for the Multiple Birth Record will be assigned by the IFRP. All Multiple Birth Records will have the same study number, unless a special study is undertaken

7 Maternity Record study number 7-9

- This is the same three-digit number found in Item 6 of the Maternity Record

8 Mother's patient order number on Maternity Record 10-14

- This is the same five-digit number found in Item 7 on the Maternity Record.

9 Delivery date:
day month year 15-20

- This is the same date found in item 8 of the Maternity Record
- Note that Items 5-9 MUST MATCH EXACTLY the appropriate items on the Maternity Record, or the computer will reject the entire form.

Medical Data Items 10-19

10. Number of births this delivery: 21

- Write in the box the number of infants delivered; write **2** if twins were born, **3** if triplets, etc.
- **0** or **1** should never be written in this box.

11. Birth sequence of this infant: 1) first 2) second 3) third 4) fourth 5) fifth 6) sixth 22

- Write in the box the order in which the infant was born in this delivery. If the infant was the second of triplets, write **2** in the box.
- Do not take into account the number of children the mother has borne before this delivery. Count only the present delivery.

12. Presentation of this infant during labor: 0) vertex, occiput anterior 1) vertex, occiput transverse or posterior 2) frank breech 3) footling breech 4) complete breech 5) brow/face 6) transverse lie 7) compound 8) other specify _____ 23

- See Item 35 of the instructions for the Maternity Record for definitions of the various presentations (especially breech presentations)
- The response to this item is not necessarily the same as the one to Item 35 of the Maternity Record, since that refers only to the presentation of the infant who was the most difficult to deliver

13. Type of delivery this infant: 0) spontaneous 1) outlet forceps 2) vacuum extractor 3) mid- or high forceps 4) manual rotation 5) breech extraction 6) cesarean section 7) destructive procedure 8) other specify _____ 24

- See Item 38 of the instructions for the Maternity Record for definitions of the methods of delivery
- The response to this item is not necessarily the same as the one to Item 38 of the Maternity Record, since that refers only to the method of delivery of the infant who was the most difficult to deliver

• **EXAMPLE:** The first twin is in vertex position and is satisfactorily delivered spontaneously. The second twin is in the breech position and is delivered by cesarean section. The correct coding is as follows

Item	First twin	Second twin
10	2	2
11	1	2
12	0	2
		(or 3 or 4)
13	0	6

14 Birth weight (grams) 25-28

- Record birth weight in grams within one hour of delivery.
- Do not estimate weight.
- Do not include clothing, swaddling, etc.
- If the baby was not weighed, write **9999** in the boxes.
- The response to this item is not necessarily the same as the one to Item 44 on the Maternity Record, since that refers only to the most difficult delivery.
- Record birth weight of this infant only, not total weight of all infants born this delivery.

15 Sex of this infant: 1) male 2) female 3) indeterminate 29

- If this infant is a male, write **1** in the box. Write **2** in the box if it is a female.
- If the sex of the baby cannot be determined (because of maceration or congenital ambiguity), write **3** in the box.

16 Apgar score: 30
 9) not done 31
 at 1 minute (8 or more = 8) at 5 minutes

- See Item 46 of the Maternity Record for instructions on how to derive the Apgar score.

- Write the score for **this baby** at one minute and at five minutes in the appropriate box.
- If the baby dies before the evaluation is made, write **9** in the box.
- If the score is 8, 9 or 10, write **8** in the box

• **For Items 17-18, use the following codes**

(0 may be coded for both items. No other codes should be repeated):

- 0) normal, or stillbirth with no apparent pathology
 1) fetal distress during labor 2) minor malformation
 3) major malformation 4) respiratory distress syndrome
 5) isoimmunization 6) neonatal sepsis 7) trauma 8) other

17 Primary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____ 32

• For definition of the conditions, see instruction for Items 47-48 of the Maternity Record

- Record in this item the *primary* condition of this infant. If the infant has more than one condition, record the most severe (clinically most significant) in this item, and the less severe, or secondary condition, in Item 18.

18 Secondary fetal/neonatal condition (if coded 2, 3, 7 or 8, specify) _____ 33

- Follow the directions for Item 17 above

19 Fetal/neonatal death: 0) none 1) antepartum
 2) intrapartum 3) postpartum 34

- The response to the item should be consistent with that of Item 49 on the Maternity Record. This item refers to only one infant, however, and Item 49 on the Maternity Record refers to all the infants born at this delivery.

- See the instructions for Item 49 of the Maternity Record for definitions of the terms.

Recorder's name: _____

- The name of the person completing this form should be written **legibly** on the line.

- Attach the two or more completed Multiple Birth Records to the appropriate Maternity Record, and mail them with the regular monthly shipment to the International Fertility Research Program.

Index

A

Ablatio placenta. *See* Placenta abruptio.
 Abortion, induced, 1
 definition of, 5
 as outcome of last pregnancy, 5
 Abortion, spontaneous, 1
 definition of, 5
 as outcome of last pregnancy, 5
 threatened, 17
 Admission
 date of, 3
 emergency, 3
 Adrenal disorders, 19
 Adrenogenital disorders, 19
 Afibrinogenemia, 17
 See also Blood disorders.
 Aftercoming head, forceps to, 8
 Age, of patient, 4
 at marriage, 4
 gestational. *See* Gestational age.
 Alcoholism, 19
 Amnionitis, 17
 Amniotic cavity, infection of, 17
 Amniotomy, 6, 7
 Analgesia, 7
 Analysis, 2
 Anemia, 17, 18
 Anesthesia, 7, 8
 Antenatal
 conditions, 6
 visits, 6
 Aortic valve, diseases of, 17
 Apgar score, 9, 10
 Appendicitis, 18
 Arthropathy, 19
 Asthma, 17
 Attendant at delivery, 9
 Augmented labor, 6
 Avitaminosis, 19

B

Bilharzia, 18
 Bilirubin, level of, 10
 Birth, definition of, 1. *See also* Live birth,
 Multiple birth, Stillbirth.
 Birth attendant. *See* Attendant at delivery.
 Birthweight, 9
 conversion of pounds and ounces
 to grams, 16
 distinction between spontaneous abortion
 and stillbirth, 5
 Bladder, injury to, 8
 Bleeding
 ante partum, 17
 intra partum, 8
 post partum, 10
 Blood disorders, 17, 18
 Booked, 3
 Bowel, 19
 Boxes (on form), 2
 Breast
 inflammation of, 10
 malignant neoplasm of, 19
 Breastfeeding, 5

Breech

 delivery, 8
 extraction, 8
 presentation, 7
 Bronchiectasis, 17
 Bronchitis, 17

C

Carcinoma, 19
 Cardio-vascular disorders, 17
 Cathartics, 6
 Caudal anesthesia, 8
 Cephalo-pelvic disproportion (CPD), 8, 18
 Cerebral palsy, 19
 Cervix
 abnormality of, 18
 incompetent, 18
 injury to, during delivery, 8
 malignancy of, 19
 Cesarean section
 at this delivery, 8
 dehiscence of wound, 10
 number of previous, 6
 rupture of membrane during, 6
 sterilization during, 11
 Children
 additional wanted, 11
 now living, 5
 Cholecystitis, 18
 Cholelithiasis, 18
 Chorioamnionitis, 17
 Cigarettes, 6
 "Circumcision" (female), 8
 Clinic identification number, 3
 Coagulation defects, 17.
 See also Blood disorders.
 Coitus interruptus, 5
 Colitis, 18
 Complication
 of delivery, 2
 of fetus, 10
 of labor, 8, 9
 of neonate, 10
 of pregnancy, 6, 17-19
 of puerperium, 2, 10
 Compound presentation, 7
 Condom, 5, 11
 Confidentiality, 1
 Congenital malformation, 10
 Contraception
 before this pregnancy, 5
 after this delivery, 11
 Convulsions, 17
 Cord prolapse, 7, 8, 9
 Corpus luteum cyst, 18
 Corrections, to responses, 2
 Corticoadrenal
 overactivity, 19
 insufficiency, 19
 Craniotomy, 8
 Cushing's syndrome, 19
 Cystadenoma, 18
 Cystitis, 17
 Cystocele, 18

D

Date
 of admission, 3
 of delivery, 3
 conversion to Western calendar, 3
 recording of, 3
 Death
 of infant born this delivery, 2, 10
 of previous live-born infant, 5
 intrauterine, 18
 Death, maternal
 before delivery, 1
 completion of form after, 10
 inclusion in records, 1
 recording of, 10
 Death Report, 1, 10, 20
 Degenerative diseases, 19
 Dehiscence, 10
 Delivery
 complication of, 2, 8, 9
 date of, 3
 forceps, 8
 multiple. *See* Multiple births.
 premature/mature in previous pregnancy, 5
 type of, 2, 8
 Depo-Provera, 5
 Depression, 19
 Dermoid cyst, 18
 Destructive procedure, 8, 10
 Diabetes mellitus, 19
 Diaphragm, 5, 11
 Douche, 5
 Drug dependence, 19

E

Eclampsia, 17
 Ectopic pregnancy, 5
 Edema, 17
 Education, of patient, 4
 Embryotomy, 8
 Emergency admission, 3
 Emphysema, 17
 Encephalitis, 19
 Endocardial structures, diseases of, 17
 Endocrine disorders, 19
 Enema, 6
 Enterocoele, 18
 Epidural anesthesia, 8
 Epilepsy, 17, 19
 Episiotomy
 type of, 8
 dehiscence of, 10
 repair of, 8
 Esophagus, 19
 External version, 8

F

False labor, 1, 10
 Fetal condition, 10
 Fetal distress, 10, 18
 Feto-pelvic disproportion, 8, 18
 Fetus, large or abnormal, 18
 Fistula, 17, 18

- Foam, spermicidal, 5, 11
 Folic acid deficiency, 18
 Follicular cyst, 18
 Forceps, 8
 Form
 checking of, 2
 completion of, 1, 2
 corrections to, 2
 original copy batching of, 2
 separation of, 2
 shipping of, 2, 14, 15
 supplies of, 15
 Forms
 Death Report, 20
 Maternity Record, 12, 13
 Multiple Birth Record, 21
 Shipping Control Sheet, 14
- G**
 Gall bladder, 18
 Gastrointestinal disorders, 18, 19
 General anesthesia, 8
 German measles, 18
 Gestational age, 6
 as distinction between spontaneous
 abortion and stillbirth, 5
 Goiter, 19
 Gonorrhea, 17, 18
 Grand mal, 19
 Graves's disease, 19
- H**
 Hematocrit, 6
 Hematoma with episiotomy, 8
 Hematopoietic neoplasm, 19
 Hemoglobin, 6
 conversion of percent of normal to
 gms/100 ml, 16
 Hemolytic anemia, 18
 Hemorrhage
 definition of, 9
 antepartum, 17
 intrapartum, 8
 postpartum, 10
 High forceps delivery, 8
 Hodgkin's disease, 19
 Hospital Abortion Record, 1
 Hospital identification number, 3
 Hospitalization
 during pregnancy, 6
 before delivery, 10
 after delivery, 11
 Hyaline membrane disease, 10
 Hydrocephaly, 18
 Hyperaldosteronism, 19
 Hyperemesis, 18
 Hyperfibrinolysis, 17.
 See also Blood disorders.
 Hypertension, 17
 Hyperthyroidism, 19
 Hypertonic uterine contractions, 8
 defined, 9
 Hypnosis, 7
 Hypoalbuminemia, 17
 Hypofibrinogenemia, 17.
 See also Blood disorders.
- Hypothyroidism, 19
 Hypotonic uterine contractions, 8
 defined, 9
 Hysterectomy, 11
 Hysteria, 19
- I**
 Icterus, of the newborn, 10
 Identification
 of center (clinic, hospital), 2, 3
 of patient, 3
 of study, 3
 Immunologic disorders, 18
 Induced labor. *See* Labor
 Injectables, 5, 11
 Infectious diseases, 18
 Influenza, 17
 Ileitis, 18
 Inconsistencies in data, 1, 2
 Induced abortion. *See* Abortion, induced.
 Induced labor, 6, 7
 Infant death, definition of, 5
 Inhalation anesthesia, 7
 Injury
 fetal, 10
 maternal, 8
 Internal version, 8
 International Classification of Diseases
 (ICD), 17
 International Federation of Gynaecology
 and Obstetrics (FIGO), 1
 International Fertility Research Program
 (IFRP), 1-3, 6, 11
 Intrauterine death, 18
 Intrauterine device (IUD), 5, 11
 Intrauterine growth retardation (IUGR), 18
 Isoimmunization, 10, 18
- J**
 Jelly, spermicidal, 5, 11
- K**
 Kidney, disorders of, 17
- L**
 Labor
 complication of, 8
 duration of, 9
 false, 1, 10
 induced, 6, 7
 obstructed, 8, 9
 onset of, 9
 prolonged, 8, 9
 spontaneous, 6, 7
 type of, 2, 6
 Lactation, 5
 Laparotomy, for delivery and uterine repair
 previcus, 6
 this delivery, 8
 Last menstrual period (LMP), 6
 Leukemia, 19
 "Light for dates," 18
- Live birth
 definition of, 4, 5
 as outcome of last pregnancy, 5
 as outcome of this pregnancy, 10
 number of previous, 4, 5
 Local anesthesia, 7
 Lung abscess, 17
 Lymphatic neoplasm, 19
 Lymphosarcoma, 19
- M**
 Malaria, 18
 Malformation, 10
 Malnutrition, 19
 Malposition, 7, 18
 Marginal sinus, rupture of, 9
 Marital status, 4
 Mastitis, 10
 Maternal injury, 8
 Maternity Record, 12, 13
 purpose of, 1
 Mature birth, 1
 Medulloadrenal hyperfunction, 19
 Megaloblastic anemia, 18
 Membranes
 infection of, 17
 rupture of, 6
 Meningitis, 19
 Mental disorders, 19
 Mental retardation, 19
 Midforceps delivery, 8
 Midwife
 delivery by, 9
 referral by, 3
 Miscarriage. *See* abortion, spontaneous.
 Mitral valve, diseases of, 17
 Molar pregnancy, 1, 5
 Multiple birth, 1, 3, 7, 9, 10
 Multiple Birth Record, 21-24
 Multiple sclerosis, 19
 Muscular dystrophy, 19
 Musculoskeletal disorders, 19
 Myeloma, 19
- N**
 "Natural childbirth," 7
 Neonatal condition, 10
 Necplasms, 19
 Nephritis, 17
 Nephrosis, 17
 Nephrotic syndrome, 17
 Nervous system, diseases of, 19
 Neurologic disorders, 19
 Neurosis, 19
 Nurse, 9
- O**
 Obstetric history, 4-5
 Obstructed labor. *See* Labor.
 Oligohydramnios, 18
 Onset of labor. *See* Labor.
 Oral contraception, 5, 11
 Osteopathy, 19
 Outcome of pregnancy
 previous pregnancy, 5
 this pregnancy, 9-11

- Outlet forceps, 8
Ovary, cysts or tumors of, 18
Oxytocics, 6
- P**
- Paracervical block, 7-8
Paramedic, 9
Paraplegia, 19
Parasitic diseases, 18
Parathyroid disorders, 19
Patient
 characteristics of, 4
 confidentiality, 1
 inclusion of, 1
 order number, 1-2
 status of, 4
Pelvic inflammatory disease (PID), 17
Pelvic organs, disorders of, 18
Pelvic repair, 18
Pelvis, contracted, 18
Perineal tear, 8
Perineum, 8
 injury to, 8
Petit mal, 19
pH, of fetal scalp, 10
Phlebitis,
 during pregnancy, 17
 postpartum, 11
Phlebothrombosis, 17
Phobia, 19
Physician
 delivery by, 9
 referral by, 3
Pica, 19
Pills, 5
Pituitary-induced disorders, 19
Placenta
 expulsion of, 9
 infection of, 17
 insufficiency of, 18
 low-lying, 17
 manual removal of, 9
 premature separation of, 17
 retention of, 8, 9
Placenta abruptio
 antenatal diagnosis of, 6, 17
 definition of, 9, 17
 recording of, 9
Placenta previa
 antenatal diagnosis of, 6, 17
 definition of, 9, 17
 recording of, 9
Pleurisy, 17
Plummer's disease, 19
Pneumonia, 17
Pneumoconiosis, 17
Poisoning, 19
Polyhydramnios, 18
Preeclampsia, 17
Pregnancy
 complications of, 6, 17-19
 duration of, 6
 ectopic, 5
 hospitalization, 6
 interval (months since last pregnancy), 5
 molar, 1, 5
Pregnancy
 outcome of last pregnancy, 5
 outcome of this pregnancy, 9-11
Premature
 birth, as outcome of last pregnancy, 5
 births, inclusion of, 1
 definition of, 5
 labor, threatened, 18
 rupture of membranes, 6
 separation of placenta, 17
Presentation
 during labor, 7
 at delivery, 7
Private patient, 4
Prolonged labor, 8, 9
Proteinuria, 17
Psychoprophylaxis, 7
Psychosis, 19
Pudendal block, 7-8
Puerperal condition, 2, 10
Pulmonary syndrome, 10
Pyelitis, 17
Pyelonephritis, 17
- Q**
- Queries, 1
- R**
- Recorder, 11
Rectocele, 18
Rectum, injury to, 8
Registration status, 3
Rejected records, 1, 2, 6, 9
Renal disease, 17
Renal parenchyma, 17
Reports, 1
Residence, of patient, 4
Respiratory disorders, 17
Respiratory distress syndrome, 10
Retained products, 8
 defined, 9
Retained twin, 9
Reticular sarcoma, 19
Rheumatic heart disease, 17
Rheumatic pericarditis, 17
Rh isoimmunization, 18
Rhythm, 5, 11
Rotation, 7
Rubella, 8
Rupture
 of the marginal sinus, 9, 17
 of the membranes, 6
 of the uterus, 6, 8, 11
- S**
- Safe period, 5
Sarcoma, 19
Scalp pH, 10
Schistosomiasis, 18
Separation
 of the form, 2
 of the placenta (premature), 17
Sepsis, neonatal, 10
Septal defects, 17
Sex, of infant, 2, 9
Shipping Control Sheet, 14
Shipping the forms, 2, 15
Sickle cell anemia, 18
Skeletal disorders, 19
"Small for dates," 18
Smoking, 6
Special studies, 11
Spermicides, 5, 11
Spinal anesthesia, 8
Spinal cord, diseases of, 19
Spinocerebellar disease, 19
Spontaneous labor, 6
Sterilization, female
 at this admission, 11
 before this pregnancy, 5, 6
Sterilization, male
 after this delivery, 11
 before this pregnancy, 5
Stillbirth
 as outcome of last pregnancy, 5
 as outcome of this pregnancy, 10
 definition of, 5
 inclusion of, 1
Stomach, 19
Student, 9
Supply of forms, 15
Symphysiotomy, 8
Syphilis, 18
Systemic contraception, 5, 11
- T**
- Term delivery, as outcome of last pregnancy, 5
Thalassemia, 18
Thrombophlebitis, 17
Thyrototoxicosis, 19
Toxemia, 17
Transfusion, blood, maternal, 10
Transverse lie, 7
Trauma, 19
Tuberculosis, 17, 18
Twins
 recording data on delivery of, 7-10
 retention *in utero* of, 9
- U**
- Umbilical cord, presenting, 9
Unknown responses, 1, 2
Urether, injury to, 8
Urethritis, 17
Urinary tract infection (UTI)
 antepartum, 17
 postpartum, 10
Uterine bleeding, 17
Uterine dysfunction, 9
Uterine fibroids, 18
Uterine inertia, 9
Uterine rupture
 in previous pregnancy, 6
 in this pregnancy, 8, 11
Uterine tumor, benign, 18
Uterus
 abnormality of, 18
 injury to, 8
 prolapse of, 18

V

Vacuum extractor, 8

Vagina

 abnormality of, 18

 injury to, 8

 varicosity of, 17

Varicose veins, 17

Vasectomy. *See* Sterilization, male

Venereal diseases, 18

Version, 7, 8

Viability, 1, 5

Viral diseases, 18, 19

Vogt's disease, 19

Vulva

 abnormality of, 18

 injury to, 8

 varicosity of, 17

W

Weekend deliveries, 1

Withdrawal, 5, 11

World Health Organization (WHO), 13