

New York State Perinatal Quality Collaborative

**Scheduled Delivery Form
and
Stillbirth Aggregate Data Log**

Data Collection Field Manual

For DSRIP Project 3.f.i – Perinatal Care

June 2015

**Division of Family Health
New York State Department of Health**



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Table of Contents

General Instructions	1
1. Case Definition:	1
2. Instructions for Monthly Data Collection:	1
3. Instructions for Retrospective Data Collection:	1
4. Monthly Reporting to NYSDOH	1
5. Who to Call for Help:	2
Patient Demographics Section Field Definitions	3
1. Permanent Facility Identifier (PFI)	3
2. Facility Name	3
3a. Sequence Number:	3
‡Medical Record Number	3
3b. System ID:.....	3
4. Admit Date	4
5. Maternal Age:	4
6. Notes:	4
7. Delivery Type Vaginal.....	4
8. Delivery Type Cesarean.....	4
9. Delivery Type Induced Labor	4
10. Patient Ethnicity	5
11. Patient Race.....	5
12. Primary Insurer	6
Clinical Data Section Field Definitions	7
13. Enter the gestational age fields using both week and day measures.	7
a. Final Gestational Age at Delivery Weeks	7
b. Final Gestational Age at Delivery Days	7
14. Was Gestational Age Documented in the Chart:	7
15. Was Gestational Age of less than 39 weeks confirmed by one of the following	7
16. Was fetal lung maturity documented by amniocentesis?	8
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?	8
18. Patient Counseling	9
19. Reason for Scheduled Delivery	9
20. Maternal Reasons for Scheduled Delivery	10
21. Fetal Reasons for Scheduled Delivery	10
22. Psychosocial Reasons for Scheduled Delivery	11
23. Specify (narrative).....	11
24a. When Maternal or Fetal Reason is ‘Other’, was the reason for scheduled delivery reviewed by a designated reviewer or panel?	11
24b. Medically indicated based on review?.....	11
24c. Please explain decision based on review?	12
25. Plurality: Enter the number of infants delivered.	12

26. Was the infant admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours	12
27. If 'Yes': Number of days in NICU for the first birth if single or multiple birth	12
28. If 'Yes': Number of days in NICU for the second birth if multiple birth	12
29. If 'Yes': Number of days in NICU for the third birth if multiple birth	12
Data Collection, Entry and Verification Field Definitions	13
30. Initials of individual completing this form	13
‡ Initials of obstetrician	13
How to Enter Zero Scheduled Deliveries	13

General Instructions

General Instructions for Collecting Data

- 1. Case Definition:** For the purposes of this project, scheduled deliveries are defined as inductions or Cesarean sections prior to the onset of labor between 36 0/7 and 38 6/7 weeks gestational age.

- 2. Instructions for Retrospective Data Collection: Measurement Year 1:** For July 1, 2014, through June 30, 2015, hospitals should review past medical charts and complete a NYSPQC Scheduled Delivery Form for **every** scheduled delivery that occurred between 36 0/7 and 38 6/7 weeks gestational age.

- 3. Instructions for Monthly Data Collection: Measurement Year 2:** Beginning July 1, 2015, hospitals should complete a NYSPQC Scheduled Delivery Form for **every** scheduled delivery that occurred between 36 0/7 and 38 6/7 weeks gestational age as it occurs during the month.

- 4. Monthly Reporting to NYSDOH:** After completing the monthly data collection:
 - a. Enter the scheduled delivery information into the NYSDOH data management electronic tool “*NYS Perinatal Quality Collaborative Scheduled Delivery Form System*” (NYSPQC SDFS). The NYSPQC SDFS will provide data entry and management functions for the data. The NYSPQC SDFS is a web-based application on the NYSDOH Health Commerce System (HCS) and is located at: <https://commerce.health.state.ny.us/>. Instructions for using the HCS are provided in the “New York State Perinatal Quality Collaborative Health Commerce System Scheduled Delivery Form System User Guide”.
 - b. The data collection forms should be entered into the SDFS after completing chart reviews for all scheduled deliveries but no later than the last Wednesday of each subsequent month. Early data submission is encouraged when possible.
 - 1) Measurement Year 1 (July 1, 2014 through June 30, 2015): All retrospective data should be submitted by December 2015.
 - 2) Measurement Year 2 (July 1, 2015 through June 30, 2016): Data is due no later than the last Wednesday of each subsequent month (i.e., data for the month of July will be due the last Wednesday of August).

- c. Reporting zero scheduled deliveries: If your facility has zero scheduled deliveries between 36 0/7 and 38 6/7 weeks of gestational age for the month (regardless of indication), please confirm zero using the “Stillbirth Aggregate Data Log”. Due dates are the same as those for the “Scheduled Delivery Form”.

5. Who to Call for Help:

If you need help completing this form, require additional forms or you need technical assistance with the SDFS, please contact:

New York State Perinatal Quality Collaborative
New York State Department of Health
Room 984, Corning Tower
Albany, NY 12237
Phone: (518) 473-9883
FAX: (518) 474-1420

Email: NYSPQC@health.ny.gov

Patient Demographics Section Field Definitions

A. Patient Demographics					
1. Permanent Facility Identifier (PFI): 1	2. Facility Name: 2		3a. Sequence Number: 3a.	3b. System ID: 3b.	
4. Admit Date (Month and Year): mm/yyyy 4	____ / ____ (mm/yyyy)	5. Maternal Age: 5	____ years	*Medical Record Number:	
Delivery Type				6. NOTES: 6	
7	7. Vaginal:	Spontaneous <input type="checkbox"/>	Operative <input type="checkbox"/>		
8	8. Cesarean:	Primary <input type="checkbox"/>	Repeat <input type="checkbox"/>		
9	9. Induced Labor:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
10	10. Patient ethnicity:	Hispanic <input type="checkbox"/>	Non-Hispanic <input type="checkbox"/>		Ethnicity Unknown <input type="checkbox"/>
11	11. Patient race:	White <input type="checkbox"/>	Black or African American <input type="checkbox"/>	American Indian/ Alaskan Native <input type="checkbox"/>	
		Asian <input type="checkbox"/>	Native Hawaiian/ Other Pacific Islander <input type="checkbox"/>	Some Other Race <input type="checkbox"/>	Race Unknown <input type="checkbox"/>
12	12. Primary Insurer:	Medicaid <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Private <input type="checkbox"/>	Other <input type="checkbox"/>

1. Permanent Facility Identifier (PFI): This is a unique identifier that is assigned to each hospital by the NYSDOH. You can locate this number on the upper right-hand side of your facility's NYSDOH issued operating certificate. The PFI can also be located by browsing the NYSDOH web site at:

http://www.health.ny.gov/statistics/sparcs/reports/compliance/pfi_facilities.htm

Note: This field should not be left blank.

2. Facility Name: Enter the official name of the facility as it appears on the NYSDOH issued Article 28 operating certificate. **Note:** This field should not be left blank.

3a. Sequence Number: Enter a unique site assigned sequence number that will be used in lieu of the medical record number for each delivery. The sequence number should be consecutive and not duplicate another patient's number. The site-assigned sequence number should be recorded on the paper form and the electronic form. Duplicate numbers from the same facility will be rejected. When you assign the Sequence Number, this value should be left padded with zeroes and the value should be padded to create a character number that is 5 characters in length. For example, the first Sequence Number assigned should be "00001" and the next "00002" **Note:** This field should not be left blank.

***Medical Record Number:** Enter the patient's medical record number on the paper form for site use only. **Note:** This field will not be collected on the Health Commerce System electronic form.

3b. System ID: Entering a Sequence Number into the HCS data entry form will prompt the system generation of a System ID that uniquely identifies the electronic record. Please record this number into the System ID field on the paper form after this number is generated on the Health Commerce System. By recording this number, you will be able to specifically identify the electronic record that corresponds to your paper form. **Note:** This field should not be left blank on the paper form.

A. Patient Demographics				
1. Permanent Facility Identifier (PFI): 1	2. Facility Name: 2	3a. Sequence Number: 3a.	3b. System ID: 3b.	
4. Admit Date (Month and Year): mm/yyyy 4	____ / ____ (mm/yyyy)	5. Maternal Age: 5 _____ years	*Medical Record Number:	
Delivery Type			6. NOTES: 6	
7 7. Vaginal:	Spontaneous <input type="checkbox"/>	Operative <input type="checkbox"/>		
8 8. Cesarean:	Primary <input type="checkbox"/>	Repeat <input type="checkbox"/>		
9 9. Induced Labor:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
10 10. Patient ethnicity:	Hispanic <input type="checkbox"/>	Non-Hispanic <input type="checkbox"/>		Ethnicity Unknown <input type="checkbox"/>
11 11. Patient race:	White <input type="checkbox"/>	Black or African American <input type="checkbox"/>	American Indian/ Alaskan Native <input type="checkbox"/>	
	Asian <input type="checkbox"/>	Native Hawaiian/ Other Pacific Islander <input type="checkbox"/>	Some Other Race <input type="checkbox"/>	Race Unknown <input type="checkbox"/>
12 12. Primary Insurer:	Medicaid <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Private <input type="checkbox"/>	Other <input type="checkbox"/>

4. **Admit Date:** Enter the month and year of the maternal date of delivery admission. **Note:** This field should not be left blank.
5. **Maternal Age:** Record the mother's age on the date of delivery admission using years of age as the measure. **Note:** This field should not be left blank.
6. **Notes:** Use this space to write any notes or other miscellaneous documentation about the delivery that qualifies the data input. For example, the note may provide additional documentation about an elective delivery or a delivery where the medical indication is not included on the list of maternal or fetal indications.
7. **Delivery Type Vaginal:** Classify vaginal births as "spontaneous" or "operative". Use "operative" to classify vaginal assisted deliveries that required the use of obstetrical forceps or vacuum extraction and which did not result in Cesarean section to achieve the delivery. Use "spontaneous" to indicate that the birth occurred without the need for forceps, vacuum, or any other instrumentation. **Note:** Vaginal birth must also have field 9. Induced Labor completed as "Yes".
8. **Delivery Type Cesarean:** Classify Cesarean births as "primary" or "repeat". Categorize all Cesarean births that were not preceded by a Cesarean birth as "primary". Categorize all Cesarean births that were preceded by another Cesarean birth as "repeat". **Note:** All Cesarean births recorded on this form must leave field #7 "Delivery Type Vaginal" blank.
9. **Delivery Type Induced Labor:** Check "Yes" if the labor was induced and "No" if the labor was not induced. **Note:** This field should not be left blank.

A. Patient Demographics				
1. Permanent Facility Identifier (PFI): 1	2. Facility Name: 2		3a. Sequence Number: 3a.	3b. System ID: 3b.
4. Admit Date (Month and Year): mm/yyyy 4	____ / ____ (mm/yyyy)	5. Maternal Age: 5	____ years	*Medical Record Number:
Delivery Type				6. NOTES: 6
7 7. Vaginal:	Spontaneous <input type="checkbox"/>	Operative <input type="checkbox"/>		
8 8. Cesarean:	Primary <input type="checkbox"/>	Repeat <input type="checkbox"/>		
9 9. Induced Labor:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
10 10. Patient ethnicity:	Hispanic <input type="checkbox"/>	Non-Hispanic <input type="checkbox"/>	Ethnicity Unknown <input type="checkbox"/>	
11 11. Patient race:	White <input type="checkbox"/>	Black or African American <input type="checkbox"/>	American Indian/ Alaskan Native <input type="checkbox"/>	
	Asian <input type="checkbox"/>	Native Hawaiian/ Other Pacific Islander <input type="checkbox"/>	Some Other Race <input type="checkbox"/>	Race Unknown <input type="checkbox"/>
12 12. Primary Insurer:	Medicaid <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Private <input type="checkbox"/>	Other <input type="checkbox"/>

10. Patient Ethnicity: Enter the ethnicity of the patient as “Hispanic” if the patient indicated Hispanic as her primary, self-identified ethnicity. This would be a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. Enter “Non-Hispanic” if the patient indicated that she is not of Hispanic ethnicity. Enter “Unknown” if the patient did not provide information about her ethnicity. **Note:** This field should not be left blank.

11. Patient Race: Enter the patient self-identified race as follows: **Note:** This field should not be left blank.

- a. **White:** Enter the selection as White for any patient having origins in any of the original people of Europe, the Middle East or North Africa. It includes women who indicate their race as “White” or report entries such as Irish, German, Italian, Near Easterner, Arab or Polish.
- b. **Black or African American:** Enter the selection as Black or African American for any patient having origins in any of the Black racial groups of Africa. It includes people who indicate their race as Black, African American, African American, Afro American, Kenyan, Nigerian or Haitian.
- c. **American Indian and Alaska Native:** Enter the selection as American Indian and Alaska Native for any patient having origins in any of the original women of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- d. **Asian:** Enter the selection as Asian for any patient having origins in any of the original people of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Includes Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese and other Asian.

A. Patient Demographics			
1. Permanent Facility Identifier (PFI): 1	2. Facility Name: 2	3a. Sequence Number: 3a.	3b. System ID: 3b.
4. Admit Date (Month and Year): mm/yyyy 4	_____ / _____ (mm/yyyy)	5. Maternal Age: 5 _____ years	*Medical Record Number:
Delivery Type			6. NOTES: 6
7 7. Vaginal:	Spontaneous <input type="checkbox"/>	Operative <input type="checkbox"/>	
8 8. Cesarean:	Primary <input type="checkbox"/>	Repeat <input type="checkbox"/>	
9 9. Induced Labor:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
10 10. Patient ethnicity:	Hispanic <input type="checkbox"/>	Non-Hispanic <input type="checkbox"/>	
11 11. Patient race:	White <input type="checkbox"/>	Black or African American <input type="checkbox"/>	American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> Some Other Race <input type="checkbox"/> Race Unknown <input type="checkbox"/>
12 12. Primary Insurer:	Medicaid <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Private <input type="checkbox"/> Other <input type="checkbox"/>

- e. **Native Hawaiian and Other Pacific Islander:** Enter the selection as Native Hawaiian and Other Pacific Islander for any patient having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands. Includes women who indicate their race as Native Hawaiian, Guamanian or Charmorro, Samoan and other Pacific Islander.
- f. **Other Race:** Enter the selection as “Other Race” for any patient who has indicated a race not included in the previous categories. Patients who identify as multiracial, mixed, interracial or Hispanic/Latino group (for example, Mexican, Puerto Rican, or Cuban) in the “Some other race” category should be included in this category which includes all other responses not included in the “White”, “Black or African American”, “American Indian and Alaska Native”, “Asian” and “Native Hawaiian and other Pacific Islander” race categories described above.
- g. **Race Unknown:** Enter the selection as “Race Unknown” for a patient who has not provided information on her race.

12. Primary Insurer: Enter the primary insurer category using the selections provided. For “Medicaid” include all Medicaid programs such as Medicaid Managed Care and Family Health Plus. For “Other”, include other government insurance programs such as Child Health Plus, Indian Health Service, CHAMPUS and Tricare for Life.

B. Clinical Data	
13. Final Gestational Age at Delivery:	<input type="text" value="13a"/> weeks <input type="text" value="13b"/> days
14. Was gestational age documented in the chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text" value="14"/>
15. Was gestational age of <u>less than 39 weeks</u> confirmed by one of the following? <ul style="list-style-type: none"> • First or second trimester ultrasound < 20 weeks • Fetal heart tones documented for 30 weeks by Doppler ultrasonography • 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text" value="15"/>
16. Was fetal lung maturity documented by amniocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text" value="16"/>
17. For inductions, was the Bishop Score of cervical status 8 or greater for a <u>primigravida</u> birth mother or 6 or greater for a <u>multigravida</u> birth mother?	<input type="checkbox"/> Score ≥ 8 <u>primigravida</u> , ≥ 6 <u>multigravida</u> <input type="text" value="17"/> <input type="checkbox"/> Determined, did not meet criteria <input type="checkbox"/> Not measured or cannot be calculated

Clinical Data Section Field Definitions

Reporting Clinical Data: Clinical data should reflect the documented care provided to the patient during this hospitalization. All reports for multiple births should be reported as a single delivery.

13. Enter the gestational age fields using both week and day measures.
- Final Gestational Age at Delivery Weeks:** Enter the final gestational age of the child at birth by entering the number of weeks of gestation in whole numbers without any decimal places. This field must not be less than 36^{0/7} weeks or greater than 38^{6/7} weeks. **Note:** This field should not be left blank.
 - Final Gestational Age at Delivery Days:** Enter the final gestational age of the child at birth by entering the days of gestation in whole numbers using a range of 0 to 6. For example: enter 0 days when the gestational age is exactly 36 weeks. When the gestational age is 36 weeks and 2 days, this field would receive the value “2”. **Note:** This field should not be left blank.

14. **Was Gestational Age Documented in the Chart:** Record “Yes” if the gestational age was documented in the chart regardless of the method used to determine the gestational age. Answer “No” if the chart did not document the final gestational age. **Note:** This field should not be left blank.

15. **Was Gestational Age of less than 39 weeks confirmed by one of the following:**
Enter “Yes” if the gestational age was confirmed using one of the following methods:

- First or second trimester ultrasound < 20 weeks
- Fetal heart tones documented for 30 weeks by Doppler ultrasonography
- 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result

Enter “No” if the gestational age was not confirmed by any of these methods. **Note:** This field should not be left blank.

B. Clinical Data	
13. Final Gestational Age at Delivery:	<input type="text" value="13a"/> weeks <input type="text" value="13b"/> days
14. Was gestational age documented in the chart?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox" value="14"/>
15. Was gestational age of less than 39 weeks confirmed by one of the following? <ul style="list-style-type: none"> • First or second trimester ultrasound < 20 weeks • Fetal heart tones documented for 30 weeks by Doppler ultrasonography • 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox" value="15"/>
16. Was fetal lung maturity documented by amniocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox" value="16"/>
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?	<input type="checkbox"/> Score ≥ 8 primigravida, ≥ 6 multigravida <input type="checkbox"/> Determined, did not meet criteria <input type="checkbox" value="17"/> <input type="checkbox"/> Not measured or cannot be calculated

16. Was fetal lung maturity documented by amniocentesis?: Enter “Yes” if the fetal lung maturity was documented by amniocentesis. Enter “No” if the fetal lung maturity was not documented. **Note:** This field should not be left blank.

17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?

1. Enter “Score ≥ 8 primigravida, ≥ 6 multigravida” if the Bishop Score was 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother.
2. Enter “Determined, did not meet criteria” if the Bishop Score was determined, but did not meet these criteria.
3. Enter “Not measured or cannot be calculated” if the Bishop Score was not measured or cannot be calculated because elements are missing.

NOTE: If the actual number of the Bishop Score was not calculated but all of the elements are present in the chart, the reviewer may calculate the Bishop Score as below and enter “Score ≥ 8 primigravida, ≥ 6 multigravida” if ≥ 8 for primigravida and ≥ 6 for multigravida.

Cervix	Score			
	0	1	2	3
Position	Posterior	Midposition	Anterior	-----
Consistency	Firm	Medium	Soft	-----
Effacement	0-30%	40-50%	60-70%	>80%
Dilation	Closed	1-2 cm	3-4 cm	>5 cm
Baby’s Station	-3	-2	-1	+1, +2

Patient Counseling (18b and 18c are <u>only required for RPCs</u> participating in the OB Prenatal Education Project)	
18a. Was there documentation in the medical record that the maternal <u>and</u> fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks were discussed with the mother? 18a	<input type="checkbox"/> Yes <input type="checkbox"/> No
18b. Was there documentation in the medical record of the mother's preferred language? If yes, please specify the language. 18b	<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No
18c. Was patient education provided in the mother's preferred language? 18c	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for Scheduled Delivery	
19. Was there documentation in the medical or prenatal record of the <u>primary</u> reason for scheduled delivery? 19	<input type="checkbox"/> Yes <input type="checkbox"/> No

18. Patient Counseling

- a. Enter "Yes" if the medical record shows documentation of patient counseling to discuss the maternal and fetal/newborn risks and benefits of scheduled delivery. Enter "No" if documentation is not present in the medical record.
- b. Enter "Yes" if the medical record shows documentation of patient's preferred language, and specify the language. Enter "No" if documentation is not present in the medical record.
- c. Enter "Yes" if the medical record shows documentation that patient counseling to discuss the maternal and fetal/newborn risks and benefits of scheduled delivery was delivered in the patient's preferred language. Enter "No" if documentation is not present in the medical record.

19. Reason for Scheduled Delivery: Was there documentation in the medical or prenatal record of a primary reason for scheduled delivery? Enter "Yes" if there was documentation in either the medical or prenatal record of a primary reason for scheduled delivery and "No" if no reason was noted in these records. Record the single maternal, fetal or psychosocial reason in one of fields 20, 21 or 22.

Note: Field 19 should not be left blank. Determine the primary maternal, fetal or psychosocial reason for the scheduled delivery and indicate the category in the appropriate field (#20-22) below.

Which of the following was the **PRIMARY** reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial)
 SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED) 20

20. Maternal Reasons for Scheduled Delivery ***SELECT ONLY ONE***					
Premature rupture of membranes	<input type="checkbox"/>	Prepregnancy hypertension	<input type="checkbox"/>	Hematological condition (specify in #23 below)	<input type="checkbox"/>
Prolonged rupture of membranes	<input type="checkbox"/>	Gestational diabetes	<input type="checkbox"/>	Active genital herpes infection	<input type="checkbox"/>
Chorioamnionitis	<input type="checkbox"/>	Diabetes (Type I/II)	<input type="checkbox"/>	Prior myomectomy	<input type="checkbox"/>
Placental abruption	<input type="checkbox"/>	Heart disease (specify in #23 below)	<input type="checkbox"/>	Prior vertical or "T" incision c-section	<input type="checkbox"/>
Placenta previa/Vasa previa	<input type="checkbox"/>	Liver disease (specify in #23 below)	<input type="checkbox"/>	History of poor pregnancy outcomes (specify in #23 below)	<input type="checkbox"/>
Gestational hypertension	<input type="checkbox"/>	Renal disease (specify in #23 below)	<input type="checkbox"/>	History of fast labor (<3 hrs) and distant from hospital	<input type="checkbox"/>
Preeclampsia/Eclampsia	<input type="checkbox"/>	Pulmonary disease (specify in #23 below)	<input type="checkbox"/>	Other (specify in #23 below)	<input type="checkbox"/>

20. Maternal Reasons for Scheduled Delivery: Check the box next to the *single* primary maternal reason that was documented in the medical records for a scheduled delivery between 36^{0/7} and 38^{6/7} weeks of gestation. When the maternal reason for scheduled delivery includes instructions to specify below, then proceed to field 23 and describe the reason. If the scheduled delivery was due to fetal or psychosocial reasons, leave this section blank and proceed to field 21 or 22.

Note: For Fields 20, 21 and 22, select only one category (maternal, fetal or psychosocial). Additionally, select only one reason within the category. Describe the primary reason in field 23 when indicated.

21. Fetal Reasons for Scheduled Delivery ***SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED*** 21					
Oligohydramnios	<input type="checkbox"/>	Intrauterine growth restriction (<5 th percentile for gestational age)	<input type="checkbox"/>	Fetal demise	<input type="checkbox"/>
Macrosomia—Sono EFW>5,000 gms	<input type="checkbox"/>	Abnormal fetal testing (by NST, Bpp, or continuous wave Doppler)	<input type="checkbox"/>	Other (specify in #23 below)	<input type="checkbox"/>
Major fetal anomaly	<input type="checkbox"/>	Alloimmunization/fetal hydrops	<input type="checkbox"/>		<input type="checkbox"/>

21. Fetal Reasons for Scheduled Delivery: Check the box next to the single primary fetal reason for delivery. When the fetal reason for scheduled delivery includes instructions to specify below, or the fetal reason is "Other" then proceed to field 23 and describe the reason. If "Maternal Reasons for Scheduled Delivery" field has been checked, do not check the "Fetal Reasons for Scheduled Delivery" field. If the scheduled delivery was due to psychosocial reasons, leave this section blank and proceed to field 22 (below).

22. Psychosocial Reasons for Scheduled Delivery				
SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED				
Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)	<input type="checkbox"/>	Patient request—“Elective”	<input type="checkbox"/>	Convenience of patient/doctor (includes scheduling difficulties)
				Other (specify in #23 below)

22. Psychosocial Reasons for Scheduled Delivery: Check the box next to the single primary Psychosocial reason for delivery. If either the “Fetal Reason for Delivery” or “Maternal Reasons for Scheduled Delivery” field have been checked, do not check a “Psychosocial Reasons for Scheduled Delivery” field.

23. Specify (narrative as directed above)

23. Specify (narrative) Please explain the choice made as requested above in fields 20, 21 and 22.

24a. When ‘Other’ is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Review Pending	Results of scheduled delivery review from Q24a: 24b. Medically indicated based on review? <input type="checkbox"/> Yes <input type="checkbox"/> No
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24a. When Maternal or Fetal Reason is ‘Other’, was the reason for scheduled delivery reviewed by a designated reviewer or panel?

When Maternal or Fetal Reason is ‘Other’, Check “Yes” if a designated reviewer or panel reviewed the reason for scheduled delivery to determine if there was a valid medical indication for scheduled delivery that was not included on Question 20. “Maternal Reasons for Scheduled Delivery”; or Question 21. “Fetal Reasons for Scheduled Delivery”; or Question 22. “Psychosocial Reasons for Scheduled Delivery”. Check “No” if the scheduled delivery was not reviewed by a designated reviewer or panel. Check “Review Pending” when the review is not yet completed.

24b. Medically indicated based on review?

If Questions 24a. is checked “Yes” then check “Yes” when the scheduled delivery was medically indicated based upon the review. Check “No” if the scheduled delivery was *not* medically indicated based upon the review. If Question 24a. is checked “Review Pending” then leave Q24b blank to be updated later.

24c. If the answer to question 24a. is "Yes", please explain decision based on review 24c

24c. Please explain decision based on review?

If Questions 24a. is checked "Yes" then please explain the decision based upon the review.
 If Question 24a. is checked "Review Pending" then leave Q24c blank to be updated later.

Infant Outcome	
25. Plurality – please enter the number of infants delivered: ____ 25	
26. Was any infant(s) admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours? 26	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. If 'Yes': Number of days in NICU (Baby #1) 27	__ _ _
28. If 'Yes': Number of days in NICU (Baby #2) 28	__ _ _
29. If 'Yes': Number of days in NICU (Baby #3) 29	__ _ _

25. Plurality: Enter the number of infants delivered.

26. Was the infant admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours: Check "Yes" if any infant born during this delivery was admitted to the NICU. Check "No" if the infant was not admitted or stayed in the NICU for less than 4 hours. If "Yes", respond to questions 25, 26 and 27 if applicable.

Then proceed to Fields 25 through 27 for single or multiple births.

27. If 'Yes': Number of days in NICU for the first birth if single or multiple birth: Enter the number of days in the NICU if the first infant born during this delivery was admitted to the NICU.

28. If 'Yes': Number of days in NICU for the second birth if multiple birth: Enter the number of days in the NICU if the second infant born during this delivery was admitted to the NICU.

29. If 'Yes': Number of days in NICU for the third birth if multiple birth: Enter the number of days in the NICU if the third infant born during this delivery was admitted to the NICU. You may enter "0" in the field if an infant of multiple births is *not* admitted the NICU. (i.e., one infant is admitted and one infant is not).

Data Collection, Entry and Verification Field Definitions

General Instructions:

C. Data collection, entry and verification	
30. Initials of individual completing this form: 30	*Initials of obstetrician:

30. Initials of individual completing this form: Enter the initials of the person who completed the form.

Initials of obstetrician: Enter the initials of the obstetrician who performed the delivery. This information will be used by the site only. **Note:** *This field will not be recorded in the database and will not be transmitted to the NYSDOH.*

How to Enter Zero Scheduled Deliveries

Instructions for Entering Zero Scheduled Deliveries for a Month Using the Stillbirth Aggregate Data Log:

If there are no scheduled deliveries between 36 0/7 and 38 6/7 weeks gestation, use the “*Stillbirth Aggregate Data Log*” to enter zero. In order for NYSDOH to know your facility has had zero scheduled deliveries, as opposed to missing data for the month, please submit the stillbirth aggregate log. The stillbirth log is submitted on a monthly basis. Enter “0” into the field for total of all scheduled deliveries between 36 0/7 and 38 6/7 weeks gestation and check Confirm when Zero Scheduled Deliveries (See form on next page).

A. Patient Demographics					
1. Permanent Facility Identifier(PFI):	2. Facility Name:	3a. Sequence Number:	3b. System ID:		
4. Admit Date (Month and Year): mm/yyyy	____ / ____ (mm/yyyy)	5. Maternal Age: ____ years	*Medical Record Number:		
Delivery Type			6. NOTES:		
7. Vaginal:	Spontaneous <input type="checkbox"/>	Operative <input type="checkbox"/>			
8. Cesarean:	Primary <input type="checkbox"/>	Repeat <input type="checkbox"/>			
9. Induced Labor:	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
10. Patient ethnicity:	Hispanic <input type="checkbox"/>	Non-Hispanic <input type="checkbox"/>		Ethnicity Unknown <input type="checkbox"/>	
11. Patient race:	White <input type="checkbox"/>	Black or African American <input type="checkbox"/>	American Indian/ Alaskan Native <input type="checkbox"/>		
	Asian <input type="checkbox"/>	Native Hawaiian/ Other Pacific Islander <input type="checkbox"/>	Some Other Race <input type="checkbox"/>	Race Unknown <input type="checkbox"/>	
12. Primary Insurer:	Medicaid <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Private <input type="checkbox"/>	Other <input type="checkbox"/>	
B. Clinical Data					
13. Final Gestational Age at Delivery:		____ weeks ____ days			
14. Was gestational age documented in the chart?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
15. Was gestational age of <u>less than 39 weeks</u> confirmed by one of the following?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<ul style="list-style-type: none"> • First or second trimester ultrasound < 20 weeks • Fetal heart tones documented for 30 weeks by Doppler ultrasonography • 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result 					
16. Was fetal lung maturity documented by amniocentesis?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?		<input type="checkbox"/> Score ≥8 primigravida, ≥6 multigravida <input type="checkbox"/> Determined, did not meet criteria <input type="checkbox"/> Not measured or cannot be calculated			
Patient Counseling (18b and 18c are <u>only</u> required for RPCs participating in the OB Prenatal Education Project)					
18a. Was there documentation in the medical record that the maternal <u>and</u> fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks were discussed with the mother?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
18b. Was there documentation in the medical record of the mother's preferred language? If yes, please specify the language.			<input type="checkbox"/> Yes, _____ <input type="checkbox"/> No		
18c. Was patient education provided in the mother's preferred language?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for Scheduled Delivery					
19. Was there documentation in the medical or prenatal record of the <u>primary</u> reason for scheduled delivery?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Which of the following was the <u>PRIMARY</u> reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial) ***SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED)***					
20. Maternal Reasons for Scheduled Delivery ***SELECT ONLY ONE***					
Premature rupture of membranes	<input type="checkbox"/>	Pregnancy hypertension	<input type="checkbox"/>	Hematological condition(specify in #23 below)	<input type="checkbox"/>
Prolonged rupture of membranes	<input type="checkbox"/>	Gestational diabetes	<input type="checkbox"/>	Active genital herpes infection	<input type="checkbox"/>
Chorioamnionitis	<input type="checkbox"/>	Diabetes(Type I/II)	<input type="checkbox"/>	Prior myomectomy	<input type="checkbox"/>
Placental abruption	<input type="checkbox"/>	Heart disease (specify in #23 below)	<input type="checkbox"/>	Prior vertical or "T" incision c-section	<input type="checkbox"/>
Placenta previa/Vasa previa	<input type="checkbox"/>	Liver disease(specify in #23 below)	<input type="checkbox"/>	History of poor pregnancy outcomes(specify in #23 below)	<input type="checkbox"/>
Gestational hypertension	<input type="checkbox"/>	Renal disease(specify in #23 below)	<input type="checkbox"/>	History of fast labor (<3 hrs) and distant from hospital	<input type="checkbox"/>
Preeclampsia/Eclampsia	<input type="checkbox"/>	Pulmonary disease(specify in #23 below)	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Placenta Accreta	<input type="checkbox"/>	Other (specify in #23 below)	<input type="checkbox"/>		

	3. Sequence Number (from front of form):
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21. Fetal Reasons for Scheduled Delivery *SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED*****

Oligohydramnios	<input type="checkbox"/>	Intrauterine growth restriction (< 5 th percentile for gestational age)	<input type="checkbox"/>	Fetal demise	<input type="checkbox"/>
Macrosomia–Sono EFW>5,000 gms	<input type="checkbox"/>	Abnormal fetal testing (by NST, BPP, or continuous wave Doppler)	<input type="checkbox"/>	Mono-Di Twins	<input type="checkbox"/>
Major fetal anomaly	<input type="checkbox"/>	Alloimmunization/fetal hydrops	<input type="checkbox"/>	Other (specify in #23 below)	<input type="checkbox"/>

22. Psychosocial Reasons for Scheduled Delivery

SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED

Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)	<input type="checkbox"/>	Patient request – “Elective”	<input type="checkbox"/>	Convenience of patient/doctor (includes scheduling difficulties)	<input type="checkbox"/>
				Other (specify in #23 below)	<input type="checkbox"/>

23. Specify (narrative as directed above)

24a. When ‘Other’ is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel? Yes No Review Pending

Results of scheduled delivery review from Q24a:
24b. Medically indicated based on review? Yes No

24c. If the answer to question 24a. is “Yes”, please explain decision based on review

Infant Outcome

25. Plurality – please enter the number of infants delivered: _____	
26. Was any infant(s) admitted to the Neonatal Intensive Care Unit (NICU) <u>for more than 4 hours</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. If ‘Yes’: Number of days in NICU (Baby #1)	_ _ _ _
28. If ‘Yes’: Number of days in NICU (Baby #2)	_ _ _ _
29. If ‘Yes’: Number of days in NICU (Baby #3)	_ _ _ _

C. Data collection, entry and verification

30. Initials of individual <i>completing</i> this form:	*Initials of obstetrician:
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D. Optional Data Collection (for site use only)

31. Optional Field for Data Collection(#1)	
32. Optional Field for Data Collection(#2)	
33. Optional Field for Data Collection(#3)	
34. Optional Field for Data Collection(#4)	
35. Optional Field for Data Collection(#5)	

Stillbirth Aggregate Data Log

Count of Total Stillbirths, Live Births and Deliveries Each Month

36 0/7 to 38 6/7 Weeks

PFI	Facility Name	Admit Year (yyyy)	Admit Month (1-12)	Total Stillbirths	Total Live Births	Total Deliveries	36 0/7 to 38 6/7 Weeks			
							Total Stillbirths	Total Live Births	Total All Deliveries	Total All Scheduled Deliveries
										<input type="checkbox"/>
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