BUMPES

A study of position during the late stages of labour in women with an epidural

Study number:

You and your child's health at one year

Thank you for completing this questionnaire

If you would like help completing this questionnaire, please contact us by telephone or email at:

[redacted]

Section 5: Hospital visits for you

The following section asks about your use of hospital services **following discharge home from hospital after the birth of your first child**. *Please answer all questions as fully as possible.*

5.1 **Have you been admitted to hospital in the past year?** Yes ☐ No ☐

If Yes, please provide details for each individual admission.

Hospital admission 1

a) Reason:

b) Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital: ☐☐ days

c) Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had:

Hospital admission 2

a) Reason:

b) Did you stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you stayed in hospital: ☐☐ days

c) Did you have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you had:

If you have had more than 2 admissions, please enter them on the back page.

5.2 **Have you attended an outpatient clinic in a hospital for your health since the birth of your first child?** Yes ☐ No ☐

If Yes, please provide details for each individual visit. *Please do not include visits to antenatal clinics.*

Outpatient Clinic attendance

Type of clinic	Attended *(please tick)*	Number of times	Reason
Perineal care clinic	Yes ☐		
Gynaecological	Yes ☐		
Surgical	Yes ☐		
Other *(please specify)*	Yes ☐		
Other *(please specify)*	Yes ☐		
Other *(please specify)*	Yes ☐		

If you have had more than 3 "Other" clinic visits, please enter them on the back page.

Section 6: Your first child's health

The following question asks about your first child's use of hospital services **following discharge home from hospital after birth.** *Please answer all questions as fully as possible.*

6.1 **Has your first child been admitted to hospital in the past year?** Yes ☐ No ☐

If Yes, please provide details for each individual admission.
(If more than 4 visits use the back page)

Hospital admission 1

a) Reason:

b) Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital: ☐☐ days

c) Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had:

Hospital admission 2

a) Reason:

b) Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital: ☐☐ days

c) Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had:

Hospital admission 3

a) Reason:

b) Did your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days your child stayed in hospital: ☐☐ days

c) Did your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation your child had:

If your child had more than 3 admissions, please enter them on the back page.

6.2 **Has your first child attended an outpatient clinic in the last year?** Yes ☐ No ☐

If Yes, please provide details for each individual visit.

Outpatient Clinic attendance

Type of clinic	Attended *(please tick)*	Number of times	Reason
Orthopaedic	Yes ☐		
Paediatric	Yes ☐		
Hearing	Yes ☐		
Eye	Yes ☐		
Dermatology	Yes ☐		
Other *(please specify)*	Yes ☐		
Other *(please specify)*	Yes ☐		

If your child had more than 2 "Other" outpatient visits, please enter them on the back page.

Section 7:

The following questions ask about your child's development. You might find it helpful to refer to the red book (Child Health Record) and comments made by your health visitor and doctor.

7.1 **Has your first child been diagnosed with cerebral palsy?** Yes ☐ No ☐

7.2 **Has your first child been diagnosed with any other major health problem?** Yes ☐ No ☐

If Yes, please specify:

8.1 **What date did you finish completing this questionnaire?** D D / M M / Y Y

8.2 **What is your date of birth:** D D / M M / Y Y

Thank you for completing this questionnaire

Please return it to us in the FREEPOST envelope provided.
No stamp is required.

Please only use this page to provide *additional* information to questions 5.1, 5.2, 6.1 and 6.2 *if necessary*.

Additional hospital admissions (5.1 or 6.1 continued)

Additional hospital admission

Additional hospital admission for: You ☐ Your child ☐

a) Reason:

b) Did you/your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you/your stayed in hospital: ☐ days

c) Did you/your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you/your had:

Additional hospital admission

Additional hospital admission for: You ☐ Your child ☐

a) Reason:

b) Did you/your child stay overnight in hospital? Yes ☐ No ☐

If Yes, please give number of days you/your stayed in hospital: ☐ days

c) Did you/your child have an operation? Yes ☐ No ☐

If Yes, please tell us what operation you/your had:

Additional outpatient clinic attendance (5.2 or 6.2 continued)

Additional attendance

Additional outpatient clinic addition for: You ☐ Your child ☐

Type of clinic	Attended *(please tick)*	Number of times	Reason
Please specify	Yes ☐		

Additional attendance

Additional outpatient clinic addition for: You ☐ Your child ☐

Type of clinic	Attended *(please tick)*	Number of times	Reason
Please specify	Yes ☐		

UCL Comprehensive Clinical Trials Unit

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