Post Birth Data Collection Form M (Mother)

INFANT STUDY

INFANT Study number:

Please complete firmly in **black** ballpoint pen

Please complete this form for all women who received a higher level of care (e.g. ICU/HDU care) OR who had surgery OR a procedure in theatre following their delivery.

Mother's surname: _____

Surgery/Procedure

1. **Did this woman undergo any surgery/procedure in theatre following her delivery (not including a caesarean section)?** Yes ☐ No ☐

If Yes, *please give details below*:

Date of surgery	Type of surgery	Hospital of surgery (If not hospital of delivery)
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		
D D / M M / Y Y		

Higher Level Of Care & Investigations

2. **Did this woman receive a higher level of care following her delivery?** *(e.g. ICU/HDU care) including HDU care on the delivery suite post delivery.* Yes ☐ No ☐

If Yes, what type of higher level of care did this woman receive? *(please tick all that apply)*

High Dependency Unit or Area
(this includes if the HDU care was on the delivery suite post delivery) . . . . . ☐

Intensive Care Unit . . . . . ☐

Specialist unit e.g. dialysis unit . . . . . ☐

Type of specialist unit *(please state)*: _____

Please give details of length of stay and reasons for admission to higher level of care:

Type of Unit	Date & time of admission	Date & time of discharge	Main reason for admission	Treatment(s) received *(e.g. ventilation, dialysis etc)*
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		
	D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)		

STUDY OFFICE USE ONLY:
First Entry: ☐ Second Entry: ☐

INFANT Study number: ☐☐☐☐☐☐

3. **Did this woman undergo any of the following investigations after trial entry prior to her discharge from hospital or death?** *(please tick all that apply)*

Ultrasound	☐	If ticked, how many?	☐
MRI	☐	If ticked, how many?	☐
CT-scan	☐	If ticked, how many?	☐
X-ray	☐	If ticked, how many?	☐

OUTCOME – *Please complete **either** box A, B or C*

A. Discharge Home

4. **Was the woman discharged home?** Yes ☐ No ☐

5. **Date of discharge home:** D D / M M / Y Y

B. Transfer

6. **Was the woman discharged to another hospital?** Yes ☐ No ☐

Date of transfer: D D / M M / Y Y

If Yes, please give details of where the woman was transferred to: _____

_____

Please describe how the woman was transferred:

Ambulance ☐

Helicopter ☐

Own transport ☐

Other (*please specify*): _____

C. Death

7. **Did this woman die?** Yes ☐ No ☐

Date of death: D D / M M / Y Y

If Yes, has a cause of death been identified? Yes ☐ No ☐

If Yes, please provide details: _____

_____

Has a post-mortem been performed? Yes ☐ No ☐

Name: *(please PRINT)* _____ **Date:** D D / M M / Y Y

[redacted] [redacted] [redacted]