Patient Label Here

Birth Child Encounter

Date of birth: dd / mmm / yyyy **Time of Birth**: _____ **Sex**: □ Female □ Male □ Ambiguous □ Unknown

Birth Location: √One □ Hospital □ Home □ Birth Centre □ Nursing Station □ Other

If Birth Centre, name:_____
If Birth Hospital, name:_____

Type of Birth: √One

□ Spontaneous vaginal □ Assisted vaginal (forceps/vacuum) □ Induced or spontaneous labour - C/S □ No labour - C/S

Presentation Type : _____

Birth Order: (Indicate birth order of each baby) Singleton = A Circle A B C D *Complete separate *Birth Child Encounter* for each child

Forceps/Vacuum: □None □Vacuum □Vacuum and Forceps □Unknown

Apgar 1:_____ □ Unknown **Apgar 5**:_____ □ Unknown
Apgar 10:_____ □ Unknown

Delayed Cord Clamping:: □ Ye s □ No □ Unknown
Delayed Cord Clamping Duration: Minutes _____ Seconds _____

Neonatal Resuscitation: □ None □ FFO2 □ CPAP + Air □ CPAP + O2 □ PPV + air □ PPV + O2 □ Intubation for tracheal suction □ Intubation for PPV □ Laryngeal Mask Airway (LMA) □ Chest compression □ Epinephrine □ Narcan/Naloxone □ Volume Expander □ Unknown

Birth Outcome: □ Live Birth **Stillbirth at > 20 wks or > 500 gms:** □ Termination □ – occurred during antepartum period □ Spontaneous – occurred during intrapartum period
Neonatal death: □ No □ Yes □ Yes - with termination of pregnancy If yes, date: dd/mmm/yyyy Time of death: _____ Age at neonatal death: _____Days

Birth Weight:_____gms □ Weight Unknown GA at Birth: _____ weeks _____days □ Head Circumference at Birth_____

Neonatal Transfer to NICU/SCN: □ No transfer □ NICU/SCN other hospital □ NICU/SCN same hospital **If NICU/SCN other hospital - Neonatal Transfer to Hospital**: Name:_____
Reason for Neonatal Transfer: □ Requires higher level of care □ Requires further investigation □ Post Resuscitation □ Observation 4 hours or less (no interventions) □ Other □ Unknown

Neonatal transfer to NICU/SCN Date: dd / mmm / yyyy **Neonatal Transfer to NICU/SCN Time:** _____

Arterial cord blood test status: √One □Done □Not Done □Results Pending □Unsatisfactory Specimen □Unknown Arterial Cord Blood pH: _____
Arterial Cord Blood Base Excess/Deficit:_____
Venous cord blood test status: √One □Done □Not Done □Results Pending □Unsatisfactory Specimen □Unknown Venous Cord Blood pH: _____1__
Venous Cord Blood Base Excess/Deficit _____

Infant Early attachment: √One
□ Yes - skin-to-skin contact with birth mother uninterrupted for at least 1 hour within the first 2 hours post-birth
□ Yes - skin-to-skin contact with birth mother for less than 1 hour within the first 2 hours post-birth
□ Yes - skin-to-skin contact with a person other than the birth mother within the first 2 hours post-birth
□ No skin-to-skin contact within the first 2 hours post-birth
□ Unknown if skin-to-skin positioning took place

If "no skin-to-skin contact within the first 2 hours post-birth" is selected, please complete the following:

Reason for no skin-to-skin (select all that apply):
□ Maternal medical indications
□ Newborn medical indications
□ Maternal choice
□ Reason unknown

Breastfeeding behaviours observed in the first 2 hours post-birth

Baby positioned to breastfeed: □ Yes □ No □ Unknown

If yes, please complete the following:

Baby breastfeeding behaviours observed:
□ Rooting or nuzzling or licking □ Latching □ Sucking □ Swallowing □ None □ Unknown

Neonatal Birth Complications: □ Caput succedaneum □ Cephalohematoma □ Clavicular fracture □ Fracture – other □ Facial nerve injury □ Brachial plexus injury □ Palsy – other □ Birth Injury □ Other □ Unknown

Newborn Congenital Anomalies Identified: □ None □ Suspected or Confirmed

Newborn Congenital Anomalies Suspected: Specify: _____

Newborn Congenital Anomalies Confirmed: Specify:_____

Midwifery Tab

Was the care of the maternal client transferred back to midwifery: □ Yes □ No

Was there Neonatal transport to hospital within approximately 1 hour post-birth? □ Yes □ No □ Unknown
Did EMS attend in birth or the 1st hour post-birth? □ Yes □ No □ Unknown
Was EMS used to transport to hospital? □ Yes □ No □ Unknown

Reason(s) for Transport: □ Respiratory Distress □ Maternal Clinical Indication □ Other neonatal clinical indication □ Other
Primary Reason for Transport:_____ (indicate)
Barrier to Transport: □ None □ Delayed arrival time of EMS □ Delayed Departure of EMS □ Delay on route □ Other

Where there any infant consultations, transfers of care, or use of hospital/outpatient/emergency services within approximately the first hour of birth?
Yes_____ No_____

2 consultation records provided. If additional are needed, please attach to record.

Reason(s) for consultation/transfer of care?

Infant Consult with Physician? Yes_____ No_____
Was rationale for consult due to hospital/physician protocol? Yes__ No____

Infant Transfer of Care? Yes_____ No_____
Was rationale for transfer of care due to hospital/physician protocol? Yes_____ No_____
If Yes,
Was transfer of infant care returned within approximately the first hour of birth? Yes_____ No_____

Infant Outpatient (plus emergency) Hospital Services: Yes_____ No_____