National Mortality Review Committee | Perinatal and Maternal Mortality Review

Rapid reporting form for a perinatal death – mother

Please use the *Guidelines for the completion of the mother and baby forms following a perinatal death March 2016 Version 10* to help you complete this form. You can obtain these guidelines from www.otago.ac.nz/pmmrc. Please contact your local coordinator for assistance with logging in.

Both the mother and the baby National Mortality Review Committee forms need to be completed by the lead maternity carer or other clinician for any baby who dies from 20 weeks gestation (ie, ≥20^{0}, or **if gestation is unknown** a birth weight ≥400 g), including all terminations, to before 28 completed days of life (ie, up to midnight on the 27th day).

This mother form can be submitted electronically before you submit the baby form. If you are submitting written forms, please courier this and the mother form to the address at the end of the form. We understand that you may not know the answer to some questions, but please answer as many as possible. Compulsory entries are marked with two asterisks (**).

Please complete within 48 hours of the baby's death if possible.

Personally identifiable information (of the mother, baby or lead maternity carer) collected on this form will be kept confidential. The information included in reports by the National Mortality Review Committee is grouped and non-identifiable.

Place patient label here if available

**How many perinatal losses are linked to this pregnancy: .....

**Mother's NHI: ..... Date of birth: _____ /_____ /_____
DD MM YYYY

First name: ..... Surname: .....

Mother's other name(s): .....

Usual residential address at time of delivery

Property/house name .....

Flat/unit number .....

Street number/rapid number (rural) .....

Street name .....

Suburb/locality .....

Town/city .....

Country (if not New Zealand) .....

Postcode .....

Ethnicity (select all that apply)

- ☐ New Zealand European
- ☐ Māori
- ☐ Samoan
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (please state).....

What is the country of birth?

- ☐ New Zealand
- ☐ Australia
- ☐ England
- ☐ China
- ☐ India
- ☐ South Africa
- ☐ Samoa
- ☐ Cook Islands
- ☐ Other (please state) .....

Source of ethnicity information (select all that apply)

- ☐ Woman
- ☐ Family/whānau
- ☐ DHB patient registration form
- ☐ LMC notes
- ☐ Clinical notes
- ☐ NHI details
- ☐ Other (please state) .....
  .....

Maternal height: ____ cm

(If not available, please measure height and weight.)

Maternal weight ____ kg (earliest measured in pregnancy)

Obstetric history

Previous pregnancies (Do not include index pregnancy in parity. Multiple births are counted as one.)

Gravidity ____ Parity: ____ ☐ Unknown

Please complete for each pregnancy. See footnotes for codes for each section.

Date of delivery	Place of birth	Gestation (weeks)	Pregnancy outcome[1]	Delivery method[2]	Birth weight	SGA <10th centile	Complications[3]

[1]Pregnancy outcome: LB, live born; SM, spontaneous miscarriage; TOP, termination of pregnancy; E, ectopic pregnancy; SB, stillbirth; END, early neonatal death (<7 days age); LND, late neonatal death (7–27 days); CYD, Child and Youth Death (28 days–24 years); U, unknown.

[2]Delivery method: NVD, normal vaginal delivery; OV, operative vaginal delivery; VB, vaginal breech; CS, Caesarean section; U, unknown.

[3]Complications: NIL, no complications; HE, hyperemesis; APH, ante partum haemorrhage/abruption; CxS, cervical stitch; GDM, gestational diabetes; PET, pre-eclampsia; Other, please comment in summary section; U, unknown.

All the following questions relate to this pregnancy

Has the mother experienced family violence during this pregnancy?

☐ No

☐ Not asked

☐ Unknown

☐ Yes

If yes, was she offered referral to relevant support services?

☐ Yes ☐ Yes, but declined ☐ No ☐ Unknown

Does the mother have a history of infertility for >12 months before this pregnancy?

☐ Yes ☐ No ☐ Unknown

Fertility treatment for this pregnancy (select all that apply)

☐ Artificial insemination – donor

☐ Artificial insemination – husband/partner

☐ Clomiphene citrate

☐ Follicle-stimulating hormone

☐ Intra-cytoplasmic sperm injection

☐ In vitro fertilisation (number of embryos transferred: _____)

☐ Surgery to increase fertility

☐ Insulin sensitisers, eg, metformin

☐ Letrozole

☐ Other (please state).....

Was treatment in New Zealand?

☐ Yes ☐ No ☐ Unknown

If overseas, where: .....

Intended place of birth

☐ Home

☐ Birthing unit

☐ Hospital level 1

☐ Hospital level 2

☐ Hospital level 3

☐ Other

☐ Unknown

☐ Not registered

☐ Name of place/unit/hospital.....

.....

Actual place of birth

☐ Home

☐ Birthing unit

☐ Hospital level 1

☐ Hospital level 2

☐ Hospital level 3

☐ Other

☐ Unknown

☐ Fetus still in utero

☐ Name of unit/hospital.....

.....

If the intended place of birth was different to the actual place of birth, when was the mother transferred to the actual place of birth?

☐ Before labour ☐ In labour ☐ Unknown

Lead maternity carer

Please select the mother's lead maternity carer (LMC) at time of first registration and at birth (select one in each column)[1]

	LMC at booking	LMC at birth
Not registered	☐	☐
Self-employed midwife	☐	☐
DHB care	☐	☐
General practitioner	☐	☐
Obstetrician (private)	☐	☐
Unknown	☐	☐

Please indicate who was clinically responsible for the woman's care at the time of the birth (select one)

☐ No care

☐ Self-employed midwife

☐ DHB care

☐ General practitioner

☐ Obstetrician (private)

☐ Unknown

If clinical responsibility is different to 'LMC at booking, when did this transfer of clinical responsibility occur?

☐ Antenatal ☐ Intrapartum

Antenatal procedures **(select all that apply)**

☐ Scan at ≤22 weeks gestation (how many scans: _____)

☐ 1st trimester screening (MSS1)

☐ 2nd trimester screening (MSS2)

☐ Anatomy scan: gestation of first anatomy scan: ____ weeks ____days

gestation of second anatomy scan: ____ weeks ____ days

☐ Chorionic villus sampling

☐ Cervical suture

☐ Amniocentesis

☐ Doppler studies

☐ Growth scan

☐ External cephalic version *(list continues over page)*

[1] For 'LMC at booking' to be different to 'LMC at birth', a new registration must have been completed.

☐ Fetocide

☐ Amnioreduction

☐ Fetoscopic laser treatment

☐ Traditional massage

☐ Other (please state).....

☐ No antenatal procedures

☐ Unknown

Smoking

Smoking at first registration with an LMC (cigarettes)

☐ Yes ☐ No ☐ Unknown

Smoking status at birth (cigarettes)

☐ Never smoked

☐ Current non-smoker

☐ Stopped before this pregnancy

☐ Stopped <16 weeks gestation

☐ Stopped ≥16 weeks gestation

☐ Previous status unknown

☐ Current smoker

How many cigarettes per day: ____ ☐ Unknown

☐ Smoking status unknown

Smoking cessation support

☐ No

☐ Yes – by LMC/clinician only

☐ Yes – referred to external agent

☐ Offered but declined

☐ Unknown

Maternal use of alcohol and other drugs

☐ Yes (please complete the section below) ☐ No ☐ Unknown

	During first trimester	Month before birth	Describe *(list continues over page)*
Alcohol	☐	☐	.....
Amphetamine/P	☐	☐	.....
Cocaine	☐	☐	.....
Ecstasy	☐	☐	.....
Hallucinogens	☐	☐	.....
Herbal highs	☐	☐	.....
Synthetic cannabis	☐	☐	.....

Marijuana	☐	☐	.....
Opiates	☐	☐	.....
Methadone	☐	☐	.....
Petrol/paint/glue	☐	☐	.....

Other (please state) .....

Antenatal visits before fetal death/or delivery

Total number of visits from antenatal record: ____ ☐ Unknown

Gestation at first antenatal visit with LMC: ____ weeks ☐ Unknown

Gestation at first antenatal visit with any health provider: ____ weeks ☐ Unknown

Mother's clinical history (including any diagnoses made in this pregnancy; please answer all questions; list continues over page)

Asthma	☐ Yes	☐ No	☐ Unknown
Diabetes	☐ Yes	☐ No	☐ Unknown
	☐ Type 1 diabetes		
	☐ Type 2 diabetes		
	☐ Impaired glucose tolerance		
Epilepsy	☐ Yes	☐ No	☐ Unknown
Heart condition	☐ Yes	☐ No	☐ Unknown
	☐ Congenital heart condition		
	☐ Rheumatic heart disease		
	☐ Coronary artery disease		
	☐ Other cardiac condition (please state)		
Thyroid abnormality	☐ Yes	☐ No	☐ Unknown
	☐ Hypothyroidism		
	☐ Hyperthyroidism		
	☐ Other (please state).....		
Inflammatory bowel disease	☐ Yes	☐ No	☐ Unknown
Systemic lupus erythematosus	☐ Yes	☐ No	☐ Unknown
Other autoimmune disorder	☐ Yes	☐ No	☐ Unknown
Mental health disorder	☐ Yes	☐ No	☐ Unknown
	☐ Depression		
	☐ Psychotic disorder		
	☐ Other (please state).....		
Renal disease	☐ Yes	☐ No	☐ Unknown
Venous thromboembolism	☐ Yes	☐ No	☐ Unknown

Blood disorder ☐ Yes ☐ No ☐ Unknown

☐ Anaemia

☐ Thalassaemia trait

☐ Thrombophilia

☐ Other (please state).....

Hypertension ☐ Yes ☐ No ☐ Unknown

☐ Chronic/essential hypertension

☐ Secondary hypertension

Cervical surgery ☐ Yes ☐ No ☐ Unknown

Urinary tract infection ☐ Yes ☐ No ☐ Unknown

Uterine abnormality ☐ Yes ☐ No ☐ Unknown

Uterine surgery ☐ Yes ☐ No ☐ Unknown

Other (please state).....

Diabetes in pregnancy

Was the mother screened for diabetes in pregnancy ☐ Yes ☐ No ☐ Unknown ☐ Declined

Gestational diabetes confirmed ☐ Yes ☐ No ☐ Unknown

Laboratory results

HbA1c at booking _____ mmol/mol Date ___/___/____

HbA1c at ≥20 weeks (record highest result) _____ mmol/mol Date ___/___/____

Polycose (record highest result) ____ . ____ mmol/L Date ___/___/____

Glucose tolerance test (record highest result)

Fasting ___ . ___ mmol/L 2 hr ___ . ___ mmol/L Date ___/___/____

Was this a multiple pregnancy?

☐ Yes ☐ No ☐ Unknown

Number of fetuses/babies at first ultrasound in pregnancy: _____

Total number of babies born in this delivery, including stillbirths: _____

Was a fetal reduction performed?

☐ Yes (please describe):.....

☐ No

☐ Unknown

Select the type of multiple:

☐ Dichorionic diamniotic

☐ Monochorionic diamniotic

☐ Monoamniotic

☐ Other multiple – please describe chorionicity

☐ Unknown

Please write the NHI of all fetuses/babies

☐ First NHI .....

☐ Second NHI.....

☐ More than two (please add all NHI):.....

.....

Was there any vaginal bleeding related to this pregnancy? (Please complete both)

Before 20 weeks	☐ Yes	☐ No	☐ Unknown
After 20 weeks	☐ Yes	☐ No	☐ Unknown

Did the mother have any of these obstetric conditions in this pregnancy? (Select all that apply)

Hypertension	☐ Yes	☐ No	☐ Unknown
	☐ Gestational hypertension		
	☐ Pre-eclampsia		
	☐ Pre-eclampsia with chronic hypertension		
	☐ Eclampsia		
	☐ Chronic hypertension		
	☐ Unspecified		
Preterm labour	☐ Yes	☐ No	☐ Unknown
Prolonged rupture of membranes	☐ Yes	☐ No	☐ Unknown
	☐ Preterm rupture <37 weeks gestation		
	☐ Term rupture ≥37 weeks gestation		
Cholestasis of pregnancy	☐ Yes	☐ No	☐ Unknown
Confirmed maternal infection	☐ Yes	☐ No	☐ Unknown
	☐ Pyelonephritis		
	☐ Lower urinary tract infection		
	☐ Other infection:.....		
Trauma	☐ Yes	☐ No	☐ Unknown
	☐ Vehicular		
	☐ Violent personal injury or assault		
	☐ Other, eg, falls:		

Other obstetric condition
☐ Yes (please state) .....
☐ No
☐ Unknown

Surgery in pregnancy
☐ Yes (state type of surgery): .....
☐ No
☐ Unknown

Was fetal growth restriction suspected before fetal demise?

☐ No ☐ Yes, but no scan performed

☐ Yes, and confirmed by scan ☐ Yes, but normal growth on scan

☐ Unknown

Was a customised growth chart generated for this woman antenatally?

☐ Yes ☐ No ☐ Unknown

Was folic acid taken:

Pre-pregnancy? ☐ Yes ☐ No ☐ Unknown

In the first trimester? ☐ Yes ☐ No ☐ Unknown

Was there consultation with an obstetrician during pregnancy?

☐ Obstetrician was lead maternity carer ☐ No ☐ Unknown

☐ Yes (choose reasons for obstetrician consultation below)

- ☐ Prolonged pregnancy (>41 weeks)
- ☐ Age of mother
- ☐ Breech
- ☐ Recurrent miscarriage
- ☐ Mother's request
- ☐ Stillbirth (this pregnancy)
- ☐ Previous stillbirth
- ☐ Suspected size of fetus ☐ large fetus ☐ small fetus
- ☐ Previous intrauterine growth restriction
- ☐ Previous Caesarean section
- ☐ Renal
- ☐ Cardiac
- ☐ Hypertension
- ☐ Prolonged rupture of membranes
- ☐ Cholestasis
- ☐ Other medical (please state) .....
- ☐ Surgery in pregnancy
- ☐ Significant infection
- ☐ Multiple pregnancy
- ☐ Antepartum haemorrhage
- ☐ Diabetes
- ☐ Unstable lie
- ☐ Fetal abnormality
- ☐ Raised BMI
- ☐ Other reason (please state) .....

Was the mother referred to any other healthcare services (apart from midwifery and obstetrics) during pregnancy?

☐ Yes ☐ No ☐ Unknown

- ☐ Medical (including MFM, non-obstetric specialists)
- ☐ Mental health
- ☐ Drug and alcohol
- ☐ Social
- ☐ Other service (please state) .....

Induction

☐ Yes ☐ No ☐ Unknown

Medication/method used

- ☐ Balloon
- ☐ Cervidil
- ☐ Misoprostol (dose: ____ mcg)
- ☐ Mifegyne
- ☐ PG gel 1 mg
- ☐ PG gel 2 mg
- ☐ PGE2 tablets
- ☐ Oxytocin
- ☐ Artificial rupture of membranes (time: __:__ 24-hr clock; date: ___/___/___)
- ☐ Other (please state) .....

Reason for induction

- ☐ Post dates
- ☐ Pre-eclampsia
- ☐ APH
- ☐ Diabetes
- ☐ Maternal request
- ☐ Intrauterine fetal death
- ☐ Intrauterine growth restriction
- ☐ Fetal abnormality
- ☐ Prolonged rupture of membranes
- ☐ Other (please state).....

Augmentation

☐ Yes ☐ No ☐ Unknown

Medication/method

- ☐ Artificial rupture of membranes (time: __:__ 24-hr clock; date: ___/___/___)
- ☐ Oxytocin
- ☐ Other (please state).....

Analgesia in labour

☐ Yes ☐ No ☐ Unknown

- ☐ Opiate
- ☐ Nitrous oxide
- ☐ Epidural
- ☐ TENS (transcutaneous electrical nerve stimulation)
- ☐ Unknown
- ☐ Other (please state) .....

Bath or pool during labour

Did part of labour occur in bath/pool?	☐ Yes	☐ No	☐ Unknown
Was the baby born in bath/pool?	☐ Yes	☐ No	☐ Unknown

Mode of birth (select one for each baby/fetus this pregnancy)

	First baby/ fetus	Second baby/ fetus
Normal vaginal delivery	☐	☐
Vaginal breech (also answer 'a')	☐	☐
Operative vaginal delivery (also answer 'b')	☐	☐
Caesarean section (also answer 'c')	☐	☐
Unknown/not stated	☐	☐

Were there more than two babies/fetuses? ☐ Yes ☐ No ☐ Unknown

[a]Breech

When was breech diagnosed? ☐ Before labour ☐ During labour

Mode of delivery: ☐ Assisted ☐ Extraction ☐ Spontaneous

Was an anaesthetic administered?

☐ Yes ☐ No ☐ Unknown

- ☐ General
- ☐ Spinal
- ☐ Epidural
- ☐ Local
- ☐ Other (please state) .....

[b]Operative vaginal delivery

Mode of delivery

☐ Forceps low	☐ Ventouse low
☐ Forceps mid-cavity	☐ Ventouse mid
☐ Forceps mid-cavity with rotation	☐ Ventouse mid-rotation

Was an anaesthetic administered?

☐ Yes ☐ No ☐ Unknown

- ☐ General
- ☐ Spinal
- ☐ Epidural
- ☐ Local
- ☐ Other (please state) .....

[c]Caesarean

Were forceps tried first?

☐ Forceps/ventouse attempted before Caesarean

☐ Forceps/ventouse not attempted before Caesarean

Type of Caesarean section

☐ **Planned** – no labour ☐ **Unplanned** – during labour

☐ **Planned** – during labour ☐ **Unplanned** – no labour

Was an anaesthetic administered?

☐ Yes ☐ No ☐ Unknown

☐ General

☐ Spinal

☐ Epidural

☐ Local

☐ Other (please state) .....

Maternal outcome

☐ Alive and generally well

☐ Alive but with serious morbidity, eg, admitted to ICU, hysterectomy or stroke

☐ Dead (Please add further details if morbidity or mortality has occurred)

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Placenta

Placenta weight: ___ gm ☐ Placenta not weighed ☐ Unknown

Placental examination

☐ Not examined

☐ Normal

☐ Some abnormalities (select all that apply)

☐ Retroplacental clot

☐ Gritty/calcified

☐ Circumvallate placenta

☐ Other (please state) .....

Umbilical cord examined?

☐ Yes ☐ No ☐ Unknown

Any problems with cord? (Select all that apply)

☐ True knot: ☐ tight knot ☐ loose knot

☐ Cord round neck: ☐ tight around ☐ loose around

☐ Cord round limbs or body: ☐ tight around ☐ loose around

☐ Torsion/spring-like cord (eg, hypercoiled)

☐ Marginal/velamentous insertion

☐ Abnormal cord thickness ☐ thin cord ☐ thick cord

☐ Meconium stained

☐ Tear in cord

☐ Two vessels

☐ Other abnormality (please state) .....

Summary

Please provide any other information you consider relevant or may have contributed to the outcome but that was not covered in these questions.

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.....

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Form completed by

Name: .....

Designation: .....

Phone .....

Email .....

Date .....

LMC name and address if different to clinician completing the form

Name: .....

Phone .....

Email .....

Date .....

Please courier the completed form to:

National Coordinator Perinatal and Maternal Mortality Review

Level 9, Accuro House, 17–21 Whitmore St, Wellington 6011

If you have questions, please contact your local Perinatal and Maternal Mortality Review coordinator

National Mortality Review Committee | Perinatal and Maternal Mortality Review

Rapid reporting form for a perinatal death – baby

Please use the *Guidelines for the completion of the mother and baby forms following a perinatal death March 2016 Version 10* to help you complete this form. You can obtain these guidelines from www.otago.ac.nz/pmmrc. Please contact your local coordinator for assistance with logging in.

Both the mother and the baby National Mortality Review Committee forms need to be completed by the lead maternity carer or other clinician for any baby who dies from 20 weeks gestation (ie, ≥20^0, or **if gestation is unknown** a birth weight ≥400 g), including all terminations, to before 28 completed days of life (ie, up to midnight on the 27th day).

This baby form can be submitted electronically **after** you have submitted the mother form. If you are submitting written forms, please courier this and the mother form to the address at the end of the form.

Please complete within 48 hours of the baby's death if possible

Personally identifiable information (of the mother, baby or lead maternity carer) collected on this form will be kept confidential. The information included in reports by the National Mortality Review Committee is grouped and non-identifiable.

Place patient label here if available

Mother's NHI: ..... Baby's NHI: .....

Mother's first name: ..... Surname:.....

Mother's other name(s):.....

Baby's first name: ..... Surname:.....

Baby's other name(s):.....

Baby's sex: ☐ Male ☐ Female ☐ Indeterminate ☐ Unknown

Baby's ethnicity (select all that apply)

☐ New Zealand European ☐ Māori

☐ Samoan ☐ Cook Island Māori

☐ Tongan ☐ Niuean

☐ Chinese ☐ Indian

☐ Other (please state).....

Source of ethnicity information (select all that apply)

☐ Parents ☐ LMC notes

☐ Family/whānau ☐ Clinical notes

☐ DHB patient registration form ☐ NHI details

☐ Other (please state) .....

Live or stillbirth (select one) ☐ Stillbirth ☐ Live birth ☐ Unknown

Was this birth the result of a termination of pregnancy?

☐ Yes ☐ No ☐ Unknown

Date of birth: _____ /_____ /_____ Time of birth __:__ hrs (use 24-hour clock)
DD MM YYYY

Gestation at birth: ____ weeks ____ days ☐ Unknown

Best estimate of gestational age based on:

☐ Ultrasound in first trimester ☐ Ultrasound ≤20 weeks gestation

☐ Ultrasound >20 weeks gestation ☐ Last menstrual period

☐ Clinical examination at birth

Baby's birthweight: _____ g ☐ Unknown

If this was a multiple pregnancy, what was the birth order of the deceased fetus/baby?

☐ First ☐ Second

☐ Other (please state) .....

When did death occur?

☐ Antepartum ☐ Intrapartum – first stage

☐ Neonatal ☐ Intrapartum – second stage

☐ Unknown ☐ Intrapartum – unknown

If stillbirth, estimated gestational age at time of fetal death: __ weeks __ days ☐ Unknown

Place of death for live-born babies:

☐ Home ☐ Hospital (please also answer the next question)

☐ Other (please state).....

Area of hospital where baby died

☐ Delivery suite ☐ Postnatal ward ☐ Neonatal unit

☐ Children's ward ☐ Operating theatre ☐ Antenatal ward

☐ Emergency department ☐ SCBU

☐ Other (please state).....

Baby examination

Were any external abnormalities noted on external examination of the baby?

☐ No

☐ Yes (please state).....

.....

Post-mortem examination

Was a post-mortem examination discussed or offered to parents/whānau?

☐ Yes ☐ No ☐ Unknown

If not, why not?.....

.....

.....

Was the pānui/information for whānau/families about post-mortem examination provided to the whānau? (Note: it is available in te reo Māori, Samoan, Hindi and Chinese at www.hqsc.govt.nz/resources/resource-library/panuiinformation-for-whanaufamilies-about-post-mortem-examination-brochure)

☐ Yes ☐ No ☐ Unknown

Who discussed or offered the post-mortem? (Select all that apply)

☐ Fetal medicine specialist ☐ Paediatric/neonatal SMO

☐ Perinatal pathologist ☐ Paediatric registrar

☐ Obstetric SMO ☐ Paediatric SHO

☐ Obstetric registrar ☐ Midwife LMC

☐ Obstetric SHO ☐ Midwife core

☐ Other (please state).....

If a post-mortem was discussed or offered, was consent given?

☐ Unknown

☐ Yes: What type of post-mortem examination was consented to?

☐ Full post-mortem ☐ Limited post-mortem ☐ External post-mortem

☐ No (describe the reasons why not) .....

.....

Was the death referred to the coroner?

☐ Yes ☐ No ☐ Unknown

Did the coroner take jurisdiction?

☐ Yes ☐ No ☐ Unknown

If neonatal death, what was the date and time of death:

Date: _____ /_____ /_____ Time: __:__ hrs (use 24-hour clock)
DD MM YYYY

Apgar scores

1 minute .....

5 minutes..... (If the score for 5 minutes is <9, complete the next three)

10 minutes.....

15 minutes.....

20 minutes.....

Cord gases

☐ Not taken		Arterial	Venous
pH		__ . __ __	__ . __ __
Base deficit	+/−	__ __ . __	__ __ . __
CO_2		__ __ . __	__ __ . __
Lactate		__ __ . __	__ __ . __

Was the baby resuscitated at birth?

☐ Yes – resuscitated and transferred to another clinical area

☐ Yes – baby unable to be resuscitated

☐ No

☐ Unknown

Were maternal corticosteroids given antenatally?

☐ Yes, course started at gestation: __ weeks __ days

☐ No ☐ Unknown

Was the course of corticosteroids completed?

☐ Yes ☐ No ☐ Unknown

Was the baby transferred from their place of birth before their death?

☐ Unknown

☐ Yes, the baby was transferred to:

- ☐ Neonatal intensive care unit (NICU)/special care unit (SCU)
- ☐ Special care baby unit (SCBU)
- ☐ Postnatal ward
- ☐ Home
- ☐ Died in transfer
- ☐ Tertiary services
- ☐ Other (please state) .....

.....

☐ No, the baby was not transferred because:

- ☐ Died at place of birth
- ☐ Died in birthing unit/theatre
- ☐ Other (please state) .....

.....

Summary

Please provide any other information you consider relevant or that may have contributed to the outcome but was not covered in these questions.

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Form completed by

Name: .....

Designation: .....

Phone: .....

Email: .....

Date .....

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