NATIONAL

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

DATA ABSTRACTION FORMS

National Fetal and Infant Mortality Review Program

NATIONAL FETAL–INFANT MORTALITY REVIEW PROGRAM

We extend our sincerest thanks to the members of the **NFIMR Data Abstraction Forms Task Force** for carefully reviewing the existing data abstraction forms and generously sharing their expertise, insights and materials, which contributed to this revision:

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The National Fetal and Infant Mortality Review Program is a partnership between ACOG and federal MCHB.

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The National Fetal and Infant Mortality Review Program is a collaborative effort between The American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau, Health Services and Resource Administration.
Grant #U08MC00136
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FETAL– INFANT MORTALITY REVIEW PROGRAM

LIST OF FORMS

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FETAL– INFANT MORTALITY REVIEW PROGRAM

Pregnancy Course/Prenatal Care Records

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

1. **Did the mother receive prenatal care?**
   - ❒ Yes
   - ❒ No

   If no, go to question 32

2. **Race of mother**
   - ❒ White
   - ❒ Black
   - ❒ Other *(specify)*

   _____

3. **Hispanic ethnicity?**
   - ❒ Yes
   - ❒ No

   If yes, specify
   - ❒ Mexican, Mexican-American, Chicano
   - ❒ Cuban
   - ❒ Puerto Rican
   - ❒ Central/South American
   - ❒ Other, Hispanic *(specify)*

   _____

4. **Country of Birth?**
   - ❒ U.S.A.
   - ❒ Outside of U.S.A. *(specify)*

   _____
   - ❒ Not documented in record

5. **What was the mother's marital status at prenatal registration?**
   - ❒ Single
   - ❒ Married
   - ❒ Separated
   - ❒ Divorced
   - ❒ Widowed

6. **Age at registration for prenatal care?**

   _____yrs.

7. **What was the primary language spoken at prenatal registration?**
   - ❒ English
   - ❒ Spanish
   - ❒ Other *(specify)*

   _____
   - ❒ Not documented

8. **Is there any documentation that the mother received assisted reproductive technology (ART) to conceive this pregnancy?**
   - ❒ Yes
   - ❒ No

   If yes, check all that apply
   - ❒ Fertility drugs, *(specify)*

     _____
   - ❒ In vitro fertilization
   - ❒ Artificial insemination
   - ❒ Egg donation
   - ❒ Sperm donation
   - ❒ Other *(specify)*

     _____
   - ❒ Type of ART not documented in record

   Abstractor please note: *In some states, this information may also be found on birth certificate.*

9. **Where did the mother receive prenatal care during pregnancy? *(Check all that apply)***
   - ❒ Private Provider's office
   - ❒ County or City Health Department
   - ❒ Managed Care Organization
   - ❒ Clinic at work
   - ❒ Clinic at school
   - ❒ Clinic in a hospital
   - ❒ Hospital emergency room
   - ❒ Other episodic, or as needed care provider
   - ❒ Community/Neighborhood Health Center
   - ❒ Other *(specify)*

     _____

10. **What was the payor source at registration for prenatal care? *(Check all that apply)***
    - ❒ Managed Care Organization (MCO)
    - ❒ Private Insurance
    - ❒ Medicaid
    - ❒ Self pay
    - ❒ Military *(specify)*

      _____
    - ❒ Other *(specify)*

      _____

11. Who was the most frequent provider of prenatal care?

❒ Nurse Practitioner
❒ Obstetrician
❒ Nurse–Midwife
❒ Perinatologist
❒ Family Physician
❒ Other *(specify)*

_____

12. _____ weeks gestation at initial provider visit

a. Was there any discrepancy in size versus dates noted at any time during the pregnancy?

❒ Yes
❒ No

If yes, explain

_____

_____

_____

_____

13. Please provide pregnancy history information below in reverse chronological order, most recent pregnancy first.

Pregnancy	Year of Delivery	Gestational Age	Birth Weight	Pregnancy Outcome (See key below)	Comments/ Complications
1					
2					
3					
4					
5					
6					
7					
8					

Pregnancy Outcome

A Live birth, still living
B Live birth, deceased
C Preterm
D Elective Abortion
E Spontaneous Abortion
F Ectopic
G IUFD

a. Pregnancy History Summary

TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

14. Please check which of the following laboratory tests were ordered at the initial visit, the results of those tests, and whether or not treatment or follow-up was arranged.

	Results	Treatment/Follow-Up	
		Yes	No
❒ HCT/HGB			
❒ ABO Blood Type			
❒ D (Rh) Type			
❒ Antibody Screen			
❒ Gonorrhea Culture			
❒ Chlamydia Culture			
❒ Group B Strep Culture			
❒ Serologic Test for Syphilis			
❒ Urine Culture			
❒ Pap Smear			
❒ Sickle Prep or Equivalent			
❒ Rubella Titer			
❒ Hepatitis B Surface Antigen			
❒ Urine Toxicology (drug screen) *If abnormal, specify drug(s) found* _____			
❒ HIV positive*			
❒ Other *(specify)* _____			
❒ Other *(specify)* _____			

*** If the mother is HIV positive, the abstractor may wish to collect additional data. Contact NFIMR for more information.**

15. Were any of the following laboratory tests done, the results of those tests and whether or not treatment was prescribed.

❒ Yes
❒ No

If yes, check all that apply

	Results	Treatment	
		Yes	No
❒ AFP Screening (Amniotic fluid)			
❒ AFP Screening (Serum)			
❒ Amniocentesis			
❒ Genetic			
❒ Maturity (L/S ratio)			
❒ Culture for:			
❒ Gardnerella Vaginitis			
❒ Mycoplasma H.-Ureaplasma			
❒ Other *(specify)* _____			
❒ GTT			
❒ Genetic Counseling			
❒ Hepatitis C			
❒ Karotyping			
❒ Prepartal Fetal Monitoring/Non-Stress Test			
❒ Sonography			
❒ TORCH			
❒ Urine C&S			
❒ Other *(specify)* _____			

16. Is there written documentation that the mother was asked about any of the following topics *at the initial visit?*

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Current medications (prescription, non-prescription, herbal) please *(specify)* _____		
❒ Domestic violence/family violence		
❒ Environmental and occupational exposures *(specify)*_____ _____		
❒ Nutritional abnormalities such as anorexia, bulimia, etc		
❒ Other *(specify)* _____		

17. Was the mother screened for use of alcohol, tobacco or other drugs *at the initial visit*?

❒ Yes
❒ No

If yes, please state type and amounts of use: (Check all that apply)

❒ Cigarettes – number _____/day
❒ Alcohol – number of drinks _____/week
❒ Heroin
❒ Amphetamines
❒ Cannabis _____/day
❒ Methadone _____ mg/day
❒ Methamphetamines
❒ Cocaine/Crack
❒ Hallucinogens *(specify)*

_____

❒ Other *(specify)*

_____

18. Did medical, nursing, social work or other personnel identify any of these psychosocial or lifestyle problems listed below at any time during prenatal course?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the mother requiring continuing medical care (Lupus, Diabetes, HIV, hypertension, etc) *please specify* _____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other		
❒ Other		

19. Did a medical, nursing or social work personnel develop a plan of care for any of the above problems?

❒ Yes
❒ No

If yes, describe

_____

_____

_____

_____

_____

_____

_____

_____

_____

20. Was the mother referred for any other additional social support services during the pregnancy?

❒ Yes
❒ No

If yes, check all that apply

❒ Alcohol Cessation Program
❒ Child Protective Services
❒ Mental Health Services
❒ Drug Treatment Program
❒ Methadone Maintenance Program
❒ Family Planning
❒ On-going Case Management
❒ Food Stamps
❒ PHN Home Assessment/Follow-up
❒ Financial Planning
❒ Public Assistance
❒ Genetic Evaluation/Counseling
❒ Smoking Cessation Program
❒ Homemaker/Home Health Aide
❒ Unemployment Office
❒ Housing Authority
❒ Medicaid
❒ Other *(specify)*

_____

21. Nutrition Pre-pregnancy Weight (history)

_____kgm ❒ Not Recorded

a. Total Pregnancy observed Weight Gain _____kgm during _____weeks

b. Height _____cm

c. BMI_____

22. Was a nutritional assessment documented in the chart?

❒ Yes
❒ No

23. Was a referral to a dietitian ordered?

❒ Yes
❒ No

If yes, did the dietitian see the mother?

❒ Yes
❒ No

24. Was the mother enrolled in WIC?

❒ Yes
❒ No

25. At any time during the prenatal period were any of the following topics documented in writing as having been discussed?

(Abstractor: These are topics suggested in the AAP/ACOG Guidelines for Perinatal Care)

❒ Yes
❒ No

If yes, check all that apply

Early Pregnancy

❒ Routine prenatal tests
❒ Domestic violence
❒ HIV Testing
❒ Seat belt use
❒ Risk factors identified by prenatal history
❒ Childbirth classes/hospital facilities
❒ Anticipated course of prenatal care
❒ Nutrition and weight gain counseling

Early Pregnancy, cont.

❒ Toxoplasmosis precautions (cats/raw meat)
❒ Sexual activity
❒ Exercise
❒ Environmental/work hazards
❒ Travel
❒ Tobacco (Ask, Advise, Assess, Assist, and Arrange)
❒ Alcohol Cessation
❒ Illicit/recreational drugs
❒ Use of any medications (Including supplements, vitamins, herbs, or OTC drugs)
❒ Indications for ultrasound

Mid Pregnancy

❒ Signs and symptoms of preterm labor
❒ Abnormal lab values
❒ Influenza vaccine
❒ Selecting a pediatrician
❒ Postpartum family planning/tubal sterilization

Late Pregnancy

❒ Anesthesia/analgesia plans
❒ Postterm counseling
❒ Fetal movement monitoring
❒ Circumcision
❒ Labor signs
❒ Breast or bottle feeding
❒ VBAC counseling
❒ Postpartum (perinatal) depression
❒ Signs and symptoms of pregnancy induced hypertension
❒ Newborn car seat

26. Did this mother have any significant medical problems predating this pregnancy?

❒ Yes
❒ No

If yes, check all that apply

❒ **Cardiovascular Disease**
❒ Bacterial Endocarditis
❒ Class I or II
❒ Hypertension
❒ Class III or IV
❒ Other *(specify)*

_____

❒ **Urologic Disease**
❒ Acute Pyelonephritis
❒ Renal Disease (*specify*)

_____

❒ Other *(specify)*

_____

❒ Other

❒ **Endocrinologic/Metabolic**
❒ Diabetes: Class_____
❒ Gestational
❒ Thyroid *(specify)*

_____

❒ Other *(specify)*

_____

❒ **Respiratory Disease**
❒ Active Tuberculosis
❒ Asthma
❒ Other *(specify)*

_____

❒ **Neuro/psychiatric**
❒ Eating Disorders (Anorexia, Bulimia)
❒ Emotional Disorder (*specify*)

_____

❒ Psychiatric Illness (*specify*)

_____

❒ Seizure Disorder
❒ Hx of Perinatal Related Depression
❒ Other *(specify)*

_____

❒ **Hematologic**
❒ Folic Acid Deficiency
❒ Rh Sensitized
❒ Hemolytic Anemia
❒ Sickle Cell Disease
❒ Iron Deficiency Anemia
❒ Other *(specify)*

_____

❒ **Gastrointestinal**
❒ Cirrhosis
❒ Hepatitis *(specify type)*

_____

❒ Other *(specify)*

_____

❒ **Trauma/Physical Injury** *(specify)*

_____

❒ **Immunologic**
❒ HIV/AIDS
❒ Lupus
❒ Other *(specify)*

_____

❒ **Gynecological**
❒ Chlamydia
❒ Condyloma
❒ Herpes
❒ Degenerating Myoma
❒ Incompetent Cervix
❒ Gonorrhea
❒ Syphilis
❒ Group B Strep
❒ Other Sexually Transmitted Infection(s)

(specify) _____
❒ Other *(specify)*

_____

27. Did the mother develop any new significant medical or obstetric problems during this pregnancy?
❒ Yes
❒ No

If yes, check all that apply
❒ **Cardiovascular Disease**
❒ Bacterial Endocarditis
❒ Hypertension
❒ Class I or II
❒ Class III or IV
❒ Other *(specify)*

_____

❒ **Urologic Disease**
❒ Cystitis
❒ Acute Pyelonephritis
❒ Other Renal Disease *(specify)*

_____

❒ Other *(specify)*

_____

❒ **Endocrinologic/Metabolic**
❒ Diabetes: Class _____
❒ Gestational Diabetes
❒ Thyroid *(specify)*

_____

❒ Other *(specify)*

_____

❒ **Respiratory Disease**
❒ Active Tuberculosis
❒ Asthma
❒ Other *(specify)*

_____

❒ **Neuro/psychiatric**
❒ Eating Disorders (Anorexia, Bulimia)
❒ Emotional Disorder *(specify)*

_____

❒ Psychiatric Illness *(specify)*

_____

❒ Seizure Disorder
❒ Perinatal Depression
❒ Other *(specify)*

_____

❒ **Hematologic**
❒ Rh Sensitized
❒ Iron Deficiency Anemia
❒ Sickle Cell Disease
❒ Folic Acid Deficiency
❒ Hemolytic Anemia
❒ Other *(specify)*

_____

❒ **Gastrointestinal**
❒ Cirrhosis
❒ Hepatitis *(specify type)*

_____

❒ Other *(specify)*

_____

❒ **Trauma/Physical Injury** *(specify)*

_____

❒ **Immunologic**
❒ HIV/AIDS
❒ Lupus
❒ Other *(specify)*

_____

❒ **Gynecological**
❒ Herpes
❒ Chlamydia
❒ Degenerating Myoma
❒ Gonorrhea
❒ Group B Strep
❒ Herpes
❒ Incompetent Cervix
❒ Syphilis
❒ Other Sexually Transmitted Infection(s)

(specify) _____
❒ Other *(specify)*

_____

28. Was a prenatal risk assessment done at the initial provider visit?
❒ Yes
❒ No

a. What system was used to assess risk?
❒ Creasy
❒ Hollister
❒ Healthy Start
❒ Popras
❒ None
❒ Other *(specify)*

_____

b. What level of risk was assessed at the first visit?
❒ Low
❒ Moderate
❒ High
❒ Very High
❒ Risk level not documented

29. Was a prenatal risk assessment done at 28 weeks gestation?

❒ Yes
❒ No
❒ Not applicable—mother already delivered

a. What system was used to assess risk?

❒ Creasy
❒ Hollister
❒ Healthy Start
❒ Popras
❒ None
❒ Other *(specify)*

_____

b. What level of risk was assessed at 28 weeks?

❒ Low
❒ Moderate
❒ High
❒ Very High
❒ Risk level not documented

30. Number of Prenatal Appointments Given

_____ 1st Trimester
_____ 2nd Trimester
_____ 3rd Trimester

31. Number of Prenatal Appointments Missed

_____ 1st Trimester
_____ 2nd Trimester
_____ 3rd Trimester

a. Check all documented methods used to follow-up on missed appointment

❒ Letter
❒ Not known
❒ Telephone call
❒ No method of follow-up noted
❒ Outreach worker/public health nurse home visit
❒ Other *(specify)*

_____

32. Hospital Visits or Emergency Department Visits during this Pregnancy

Visit	Gestations Age (weeks)	Chief Complaint	Treatment
1			
2			
3			

Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____

ABSTRACTOR'S NOTES: (Add any information here that will help you summarize the case. If additional information was found on other records such as WIC or PHN home visit, etc, please make a note of the data source in the abstraction form and on the case review summary.)

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

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FETAL– INFANT MORTALITY REVIEW PROGRAM

Maternal Labor, Delivery & Postpartum Records

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

1. Level of Hospital of Birth *(Check one)*

❒ 1°
❒ 2°
❒ 3°
❒ Unknown

2. What was the payor source for the delivery? *(Check all that apply)*

❒ Military *(specify)*

_____

❒ Private Insurance
❒ Medicaid
❒ Managed Care Organization (MCO)
❒ Self pay
❒ Other *(specify)*

_____

3. Was the mother accompanied by a support person during labor and delivery?

❒ Yes
❒ No

If yes, what was the relationship of the support person to the mother?

_____

_____

4. Admission Information

a. Maternal Status on Admission

❒ Blood pressure _____ / _____
❒ Pulse _____
❒ Respirations _____
❒ Temperature _____ C_
❒ Cervical Dilation ___ cm
❒ Membranes
❒ Frequency of contractions
  ❒ Q _____min
❒ Duration of contractions _____

b. Fetal Status on Admission

❒ Heart rate _____

5. Continued labor status

❒ None
❒ Spontaneous
❒ Induced
❒ Augmented

6. Labor Duration

a. First Stage

❒ Normal (3–20 hrs)
❒ Abnormal (<3 hrs, >20 hrs)
❒ Unknown

Comments

_____

_____

_____

b. Second Stage

❒ Normal (0–2 hrs)
❒ Abnormal (>2 hrs)
❒ Unknown

Comments

_____

_____

_____

7. Did the mother develop any significant medical or obstetric problems during this labor and delivery or in the postpartum period?

❒ Yes
❒ No

If yes, check all that apply

❒ **Cardiovasclar**
❒ Hypertension
❒ Hypotension
❒ Other *(specify)*

_____

❒ **Endocrinologic/Metabolic**
❒ Diabetes
  Class _____
❒ Pregnancy related

_____

❒ Thyroid *(specify)*

_____

❒ Other *(specify)*

_____

❒ **Gastrointestinal**
❒ Hepatitis *(specify)*

_____

❒ Liver Failure
❒ Other *(specify)*

_____

❒ **Hematologic**
❒ Nonuterine hemorrhage
❒ HELLP syndrome
❒ Other *(specify)*

_____

❒ **Infection**
❒ Fetal sepsis
❒ Group B Strep
❒ Maternal sepsis
❒ New diagnoses of HIV positive status
❒ Genital herpes
❒ Other STD *(specify)*

_____

❒ Other infection *(specify)*

_____

❒ **Neuro/psychiatric**
❒ Drug withdrawal symptoms *(specify)*

_____

_____

❒ Eclampsia related seizures
❒ Emotional disorder *(specify)*

_____

❒ Other *(specify)*

_____

❒ **Respiratory**
❒ Asthma
❒ Pneumonia
❒ Other *(specify)*

_____

❒ **Trauma/Physical Injury**
❒ Yes
❒ No

If yes, specify

_____

_____

❒ **Urinary Tract**
❒ Cystitis
❒ Pyelonephritis
❒ Other *(specify)*

_____

❒ **Obstetric Problems *(Check all that apply)***
❒ Abnormal placenta or cord *(specify)*

_____

❒ Macrosomia
❒ Abruptio
❒ Malpresentation
❒ Accreta/Percreta
❒ Manual removal of retained placenta
❒ Amniotic fluid embolism
❒ Multiple pregnancy
❒ Cervical/Vaginal laceration
❒ Oligohydramnios
❒ Chorioamnionitis
❒ Polyhydramnios
❒ Cord accident
❒ Postmaturity
❒ Failure to progress
❒ Praevia
❒ Fetal demise
❒ Pregnancy Induced Hypertension/ Pre-eclampsia
❒ Fetal distress
❒ Premature labor
❒ Fetal growth retardation
❒ Previous C-section
❒ Force dystocia
❒ Uterine rupture
❒ Gross Meconium
❒ 4° Extension of episiotomy
❒ Hemorrhage (> 500 cc)
❒ Other *(specify)*

_____

_____

_____

8. Was the mother referred to any other providers for medical consultation during labor and delivery?

❒ Yes
❒ No

If yes, specify

_____

_____

_____

9. Did the mother receive any anesthesia during labor or delivery?

❒ Yes
❒ No

If yes, check all that apply

❒ Epidural
❒ Paracervical block
❒ General inhalation
❒ Pudendal block
❒ Paracervical block
❒ Spinal
❒ Local perineal infiltration
❒ Other *(specify)*

_____

10. Fetal Heart Rate

a. What was the fetal heart rate pattern during the last hour before delivery? *(Check all that apply)*

Rate/Pattern

❒ Normal (120-160/min.)
❒ Bradycardia (<120/min.)
❒ Tachycardia (>160/min.)
❒ Loss of baseline variability
❒ Late decelerations
❒ Variable decelerations

b. If the heart rate was not normal, what intervention(s) is documented?

_____

_____

_____

_____

c. Electronic Monitoring?

❒ Yes
❒ No

If yes, indicate method(s) used

❒ Internal monitoring
❒ External monitoring

11. Mode of delivery *(Check all that apply)*

❒ Forceps
❒ Repeat C-section
❒ Vacuum extraction
❒ Spontaneous vaginal delivery
❒ Vaginal birth after previous C-section
❒ Primary C-section
❒ Other *(specify)*

_____

12. If the mother had a C-Section, forceps delivery, or vacuum extraction, what were the indications for that procedure?

_____

_____

_____

_____

_____

_____

13. What time did the mother deliver? (Use military time)

_____

a. What was the day of the week?

_____

DELIVERY DATA ON INFANT-RECORDED IN MOTHER'S CHART

If fetal death or stillbirth occurred, skip to item 18.

If mother delivered more than one infant, please duplicate this page and complete the form for each infant.

Fetal/Infant I.D. #: _____

14. Apgar Scores
- ❒ 1 minute _____
- ❒ 5 minutes _____
- ❒ 10 minutes _____

15. Birth Weight _____

Gestational Age _____

Sex
- ❒ Male
- ❒ Female

16. Cord blood gases done?
- ❒ Yes
- ❒ No

If yes, specify results

pH _____
pCO2 _____
pO2 _____
Base Excess_____

17. Were any neonatal resuscitation measures required/attempted in the delivery room?
- ❒ Yes
- ❒ No

a. *If yes, check all that apply*
- ❒ Physical stimulation
- ❒ Bag & Mask
- ❒ ET Suction
- ❒ Intubation
- ❒ Respiratory meds
- ❒ Ext. cardiac massage
- ❒ Cardiac meds
- ❒ Other *(specify)*

_____

- ❒ Oxygen blow by

_____

b. If assisted ventilation, was it
- ❒ < 5 minutes
- ❒ > 5 minutes & < 30 minutes
- ❒ > 30 minutes

c. Was surfactant treatment given in delivery room?
- ❒ Yes
- ❒ No

18. Were there other infant problems not classified by above scheme?
- ❒ Yes
- ❒ No

If yes, specify

_____
_____
_____

COMMENTS: (Add any information here that will help you summarize the delivery information about the infant that was included in the mother's record.)

POSTPARTUM

19. Was the mother referred to any other providers for medical consultation during the postpartum hospital stay? (internist, etc)

❒ Yes
❒ No

If yes, specify

_____

20. If the mother did not receive prenatal care (PNC), was a notation made of the mother's reason(s) for not seeking services?

❒ Yes
❒ No

If yes, check all that apply

❒ Financial
❒ Limited/absent availability of service
❒ Other reasons *(specify)*

_____

21. What was the duration of postpartum stay?

_____ hours

22. Did the mother sign herself out of the hospital against medical advice (AMA)?

❒ Yes
❒ No

23. Were any of the following topics discussed during the postpartum stay?

❒ Yes
❒ No

If yes, check all that apply

❒ Breastfeeding
❒ Bottle feeding
❒ Infant care
❒ SID/Safe Sleep Risk Reduction education
❒ Parenting skills
❒ Family Planning
❒ Maternal signs and symptoms that warrant medical attention
❒ Infant signs and symptoms that warrant medical attention
❒ Where to go for care in case of infant emergency
❒ Where to go for care in case of maternal emergency

24. Did medical, nursing or social work personnel identify any of the psychosocial or lifestyle problems listed below during labor/delivery/postpartum hospital stay?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the mother requiring continuing medical care (Lupus, Diabetes, HIV, hypertension, etc) *please specify* _____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other *(specify)* _____		
❒ Other *(specify)* _____		

25. Was the mother referred for any other specific support services at any time during her hospital stay?

❒ Yes
❒ No

If yes, check all that apply

❒ Alcohol Treatment Program
❒ Mental Health Services
❒ Child Protective Services
❒ Methadone Maintenance Program
❒ Family Planning
❒ Ongoing Case Management
❒ Financial Planning
❒ Other Drug Treatment Program
❒ Food Stamps
❒ PHN Home Assessment/Follow-up
❒ Genetic Evaluation/Counseling
❒ Smoking Cessation Program
❒ Group Shelter
❒ Unemployment Office
❒ Housing Authority
❒ WIC
❒ Medicaid
❒ Other *(specify)*

_____

26. If the fetus or infant died, is there any documentation of counseling or bereavement support for the mother?

❒ Yes
❒ No

If yes, specify

_____

_____

_____

_____

27. Is a maternal discharge plan documented in the records?

❒ Yes
❒ No

28. Was a postpartum follow-up visit scheduled for the mother?

❒ Yes
❒ No
❒ Mother instructed to call to make an appointment

If yes, please specify the location for postpartum visit

❒ Clinic at hospital
❒ Clinic at work or school
❒ Community Health Center
❒ County or City Health Department
❒ Hospital emergency room, other episodic, or as needed care provider
❒ Managed care organization (MCO)
❒ Private provider's (MD, CNM) office
❒ Other *(specify)*

_____

29. If yes, how many weeks after the delivery was the visit scheduled? _____wks

30. Were any immunizations given?

❒ Yes
❒ No

If yes, check all that apply

❒ Anti-D Immune Globulin
❒ Rubella
❒ Other *(specify)*

_____

31. Maternal HGB/HCT at discharge

_____

32. Was the mother discharged with any medications?

❒ Yes
❒ No

If yes, specify

_____

_____

_____

_____

ABSTRACTOR'S NOTES: (Add any information that will help you summarize this case.)

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

NATIONAL

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Newborn Assessment Record

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

1. **Estimated gestational age (EGA) at birth**
   _____ wks

   Please specify how EGA was determined

   _____

   _____

   _____

2. **Weight at admission** _____ gms

   Head circumference _____ cm

   Crown-heel length _____ cm

   Temperature _____ C

   Respirations _____ /Min

   Heart Rate _____ /Min

3. **Disposition from delivery room**
   - ❒ Normal newborn nursery
   - ❒ Rooming in
   - ❒ Observation/special care nursery
   - ❒ Other *(specify)*

   _____

4. **What was the payor source for this hospitalization? *(Check all that apply)***
   - ❒ Military (*specify*)

   _____
   - ❒ Self pay
   - ❒ Managed care organization (MCO)
   - ❒ Private Insurance
   - ❒ Medicaid
   - ❒ Other (*specify*) _____

   _____

5. **Were any birth defects noted during nursery stay?**
   - ❒ Yes
   - ❒ No

   If yes, specify

   _____

   _____

   _____

   _____

   _____

6. **Were any morbidities noted during nursery stay?**
   - ❒ Yes
   - ❒ No

   If yes, check all that apply
   - ❒ Anemia due to fetal hemorrhage
   - ❒ Hypothermia
   - ❒ Delayed feeding adequacy
   - ❒ Hypotonia
   - ❒ Delayed transition
   - ❒ Metabolic acidosis
   - ❒ Drug withdrawal
   - ❒ Perinatal asphyxia
   - ❒ Convulsion
   - ❒ Respiratory distress
   - ❒ Hemolysis due to
     ____ Rh ____ ABO ____ other
   - ❒ Temperature instability
   - ❒ Hyaline membrane disease
   - ❒ Transient Tachypnea Newborn (TTN)
   - ❒ Hypoglycemia (<40) (*specify*)

   _____
   - ❒ Jaundice (*specify highest bilirubin level*)

   _____
   - ❒ Neonatal sepsis (*specify*)

   _____
   - ❒ Perinatal STD exposure (*specify*)

   _____
   - ❒ Perinatal STD infection (*specify*)

   _____
   - ❒ Other *(specify)*

   _____

   If yes, please describe treatment

   _____

   _____

   _____

   _____

   _____

   _____

   _____

7. Were any birth injuries noted?

❒ Yes
❒ No

If yes, check all that apply

❒ Bruising
❒ Peripheral nerve damage
❒ Cephalohematoma
❒ Fractures
❒ Other *(specify)*

_____

8. Was a urine toxicology done?

❒ Yes
❒ No

If yes, were the results positive?

❒ Yes
❒ No
❒ Results not in record

If results are positive, please specify which substances? (Check all that apply)

❒ Alcohol
❒ Cocaine
❒ Amphetamines
❒ Heroine
❒ Barbiturates
❒ Methadone
❒ Cannabis
❒ Other *(specify)*

_____

9. Did the mother receive health education about any of the following? (*Check all that apply)*

❒ Bath safety
❒ SIDS risk reduction
❒ Bottle feeding
❒ Small object avoidance
❒ Breast feeding
❒ Use of infant car seat
❒ Protection from falls
❒ Use of home smoke detector
❒ Shaken Baby Syndrome
❒ Other *(specify)*

_____

❒ Other *(specify)*

_____

10. Was the family referred to any health or human services program?

❒ Yes
❒ No

If yes, check all that apply

❒ Case management
❒ Infant/child health program
❒ Child Protection Services
❒ Legal aid
❒ County PHN home visits
❒ Medicaid
❒ Family planning
❒ Mental health service
❒ Financial planning
❒ Methadone maintenance program
❒ GED programs
❒ Physically handicapped child program
❒ Genetic evaluation/counseling
❒ Smoking cessation program
❒ Group shelters
❒ Unemployment office
❒ Homemaker/home health aide
❒ WIC
❒ Housing authority
❒ Home technology (i.e. photo therapy, etc) *specify* _____
❒ Alcohol cessation program
❒ Other *(specify)*

_____

11. Did pediatric medical, nursing or social work personnel identify any of the psychosocial or lifestyle problems listed below?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the mother or infant requiring continuing medical care *specify* _____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other *(specify)* _____		

12. Were any medications prescribed for the baby to take after discharge from the hospital?

❒ Yes
❒ No

If yes, list below

_____

_____

_____

_____

a. Were parents instructed in medication administration?

❒ Yes
❒ No
❒ Unknown

If yes, specify

_____

_____

_____

13. Discharge Diagnoses *(Check all that apply)*

❒ Convulsions
❒ Normal Newborn
❒ Drug withdrawal
❒ Postdates
❒ Exposed to Hepatitis B
❒ Prematurity
❒ Jaundice
❒ Sepsis
❒ LGA
❒ SGA/IUGR
❒ Meconium aspiration
❒ RDS
❒ Birth defect (*specify*)

_____

❒ Birth injuries (*specify*)

_____

❒ Other respiratory distress (*specify*)

_____

❒ Other (*specify*)

_____

14. Nutrition at Discharge

❒ Breastfeeding
❒ Formula
❒ Both
❒ Unknown

15. Age at Discharge (in hours from delivery)

_____

16. Final Disposition

❒ Deceased before discharge after leaving delivery room *(Go to question #19)*
❒ Transferred to NICU:
  ❒ Same hospital
  ❒ Another hospital
❒ Transferred to regular nursery at another hospital
❒ Home with parents
❒ Discharged to public/private foster care
❒ Discharged to prospective adoptive parents
❒ Continued as boarder
❒ Other (*specify*)

_____

17. If the infant was alive at discharge, was a discharge plan documented in the infant's records?

❒ Yes
❒ No

18. Was a follow-up pediatric visit scheduled for the newborn?

❒ Yes
❒ No

If yes, check all that apply

❒ Clinic/hospital outpatient department
❒ Private physician
❒ Community health center
❒ Managed care organization
❒ Other (*specify*)

_____

If yes, how many weeks after delivery was the visit scheduled? _____ wks.

19. If the infant died prior to discharge, was an autopsy done?

❒ Yes
❒ No
❒ Unknown

If yes, please complete the separate autopsy form.

20. If the infant died, was it documented that the family received counseling or bereavement support?

❒ Yes
❒ No

ABSTRACTOR'S NOTES: (Add any information that will help you summarize this case.)

Data Entry Staff:

Is this record completely entered?

❒ Yes
❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Newborn Intensive Care Unit Record

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

1. Was the infant transferred from the Level 1 birth hospital to a NICU?

❒ Yes
❒ No

If yes, indicate type of Transfer

❒ In-house
❒ Level 1 – Level II
❒ Level I – Level III
❒ Level II – Level III
❒ Level III – Level III
❒ Free Standing Birth Center to Level
❒ Home Birth to Level
❒ Other (*specify*)

_____

2. Was there any documentation that the mother saw the infant before the transport?

❒ Yes
❒ No

3. Admitting Diagnosis(es)

Primary

_____
_____
_____
_____

Secondary

_____
_____
_____
_____

4. What was the payor source for this hospitalization? *(Check all that apply)*

❒ Private Insurance
❒ Medicaid
❒ Managed Care Organization (MCO)
❒ Military (*specify*)

_____

❒ Self pay
❒ Other (*specify*) _____

_____

5. Condition Upon Admission

Estimated Gestational Age at Birth _____
Please specify system used

_____

Heart Rate _____
Respiratory Rate _____
Blood Pressure _____ / _____
Temperature _____ C°
Weight _____ grams
Head Circumference _____ cm
Crown-heel length _____ cm
Intubated?

❒ Yes
❒ No
❒ Unknown

6. Were Disorders of Size Noted?

❒ Yes
❒ No

If yes, specify

❒ SGA
  ❒ BirthWt _____ gm.
  ❒ G.A. _____ wks.
❒ LGA
  ❒ BirthWt _____ gm.
  ❒ G.A. _____ wks.
  ❒ Other (*specify*)

_____

7. Was the infant premature?

❒ Yes
❒ No

If yes, specify

❒ Extreme prematurity (less than 28 weeks)
❒ Moderate Preterm (33-36 weeks)
❒ Very Preterm (26-32 weeks)
❒ Other (*specify*)

_____

8. Did the infant require supplemental oxygen?

❒ Yes
❒ No

If yes, check all that apply

❒ Supplemental
❒ Oxyhood
❒ CPAP
❒ Conventional
❒ Oscillator
❒ Jet
❒ Nitric oxide
❒ ECMO
❒ NCPAP
❒ Highest level of O2 _____
❒ Other (*specify*)

_____

9. Did the infant require ventilatory assistance?

❒ Yes
❒ No

If yes, specify

❒ 1–12 hours
❒ 13–24 hours
❒ 25–48 hours
❒ >49 hours
❒ Unknown

10. Was the infant exposed to any infection?

❒ Yes
❒ No

If yes, check all that apply

❒ Syphilis
❒ Hepatitis B
❒ HIV Positive
❒ Chlamydia
❒ Herpes
❒ Gonorrhea
❒ Group B-Strep
❒ Other (*specify*)

_____

If yes, did the infant incur any infection?

❒ Yes
❒ No

If yes, check all that apply

❒ Syphilis
❒ Hepatitis B
❒ HIV Positive
❒ Chlamydia
❒ Herpes
❒ Gonorrhea
❒ Group B-Strep
❒ Other (*specify*)

_____

11. Were chromosomal abnormalities noted?

❒ Yes
❒ No

If yes, specify

❒ **Single**
❒ Trisomy 13 (13 Patau)
❒ Trisomy 18 (Edwards)
❒ Trisomy 21 (Downs)
❒ Other (*specify*)

_____

❒ **Multiple/Complex**
❒ Pierre Robin
❒ Heterotopia
❒ VACHTERL
❒ Other (*specify*)

_____

12. Were any other birth defects noted before or during intensive care stay?

❒ Yes
❒ No

If yes, check all that apply

❒ **Cardiac**
❒ PDA (Patent Ductus Arteriosus)
❒ Tetrology of Fallot
❒ ASD (Atrial Septal Defect)
❒ Coarctation of Aorta
❒ VSD (Ventricular Septal Defect)
❒ Hypoplastic Left Heart
❒ TGV (Transposition of Great Vessels)
❒ Other (*specify*)

_____

❒ **Craniofacial Abnormality**
❒ Cleft lip or palate
❒ Hydrocephaly
❒ Anencephaly
❒ Microcephaly
❒ Other (*specify*)

_____

❒ **Pulmonary**
❒ Congenital diaphragmatic hernia
❒ Cystadenomatoid malformation of lung
❒ Other (*specify*)

_____

❒ **Gastrointestinal malformation**
❒ T.E. fistula/esophageal atresia
❒ Rectal atresia/stenosis
❒ Omphalocele/gastroschisis
❒ Other (*specify*)

_____

❒ **Genital or urinary malformations**
❒ Hypospadias
❒ Indeterminate sex
❒ Other (*specify*)

_____

❒ **Musculoskeletal abnormalities**
❒ Spina bifida/meningocele
❒ Fetal Alcohol Spectrum Disorder (FASD)
❒ Polydactyly/Syndactyly
❒ Club foot
❒ Congenital hip
❒ Other birth defects *(specify)*

_____

❒ Other (*specify*)

_____

❒ **Suspected Fetal Alcohol Syndrome Effects**

13. Were any morbidities noted before or during intensive care unit stay?
❒ Yes
❒ No

If yes, check all that apply
❒ **Fractures (*specify*)**

_____

❒ **Pulmonary**
❒ **Acute**
❒ Apnea of prematurity
❒ Transient Tachypnea
❒ Pulmonary hemorrhage
❒ Meconium aspiration
❒ Pneumothorax
❒ Pneumonia
❒ Pulmonary Interstitial
❒ Other (*specify*)

_____

❒ **Chronic**
❒ Bronchopulmonary dysplasia
❒ Other (*specify*)

_____

❒ **Central Nervous System**
❒ Hypotonia
❒ Seizures
❒ Intracranial Hemorrhage *(specify)*

_____

❒ Other (*specify*)

_____

❒ **Hemolysis**
Immune Hemolysis due to
❒ ABO
❒ Polycythemia (central Hct > 65%)
❒ Rh
❒ Other (*specify*)

_____

❒ **Jaundice due to**
❒ Isoimmune hemolysis due to Rh, ABO, other
❒ Idiopathis Hyperbilirubinemia
❒ Other (*specify*)

_____

❒ **Gastrointestinal**
❒ Hemorrhage
❒ Necrotizing Enterocolitis
❒ Meconium Plug Syndrome
❒ Diarrhea
❒ Other (*specify*)

_____

❒ **Other Infection**
❒ Hepatitis
❒ Urinary Tract Infection
❒ Bacterial – sepsis
❒ Meningitis
❒ TORCH (*specify*)

_____

❒ Viral (*specify*)

_____

❒ Nosocomial, Site (*specify*)

_____

❒ Other (*specify*)

_____

❒ **Metabolic & Endocrine**
❒ Infant of a diabetic mother
❒ Hypocalcemia – Ca < 6 mg%
❒ Preterm Hypoglycemia – Glucose < 30 mg%
❒ Term Hypoglycemia – Glucose < 40%
❒ Hypothyroidism
❒ Other (*specify*)

_____

❒ **Eyes**
❒ Retinopathy of prematurity
❒ Other (*specify*)

_____

❒ **Drug Abuse *(Check all that apply)***
❒ Maternal Screen Positive for

_____

❒ Infant Screen Positive for

_____

❒ Other (*specify*)

_____

14. Did the infant have any surgery performed?
❒ Yes
❒ No

If yes, specify procedure(s)

_____

_____

_____

_____

_____

15. Was the infant made DNR (do not resuscitate) during hospitalization?
❒ Yes
❒ No

If yes, did the infant receive any of the following
❒ Pain medication
❒ Case management
❒ Hospice
❒ Other (*specify*)

_____

16. Did the mother receive health education about any of the following? *(Check all that apply)*
❒ Bath Safety
❒ SIDS Risk Reduction
❒ Breast Feeding
❒ Small Object Avoidance
❒ Formula Feeding
❒ Use of Infant Car Seat
❒ Protection from Falls
❒ Use of Home Smoke Detector
❒ Shaken Baby Syndrome
❒ Other (*specify*)

_____

❒ Other (*specify*)

_____

17. Did pediatric medical, nursing or social work personnel identify any of psychosocial or lifestyle problems listed below during this hospitalization?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the mother or infant requiring continuing medical care *please specify* _____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other (*specify*) _____		
❒ Other (*specify*) _____		

18. Was the family referred for any support services?

❒ Yes
❒ No

If yes, check all that apply

❒ Mental Health Service
❒ Child Protection Services
❒ Genetic Evaluation/Counseling
❒ PHN Home Assessment/Follow-up
❒ Family Planning
❒ Early Intervention
❒ WIC
❒ Smoking Cessation Program
❒ Housing Services
❒ Homemaker/Home Health Aide
❒ Medicaid
❒ Methadone Maintenance Program
❒ Alcohol Cessation Program
❒ Unemployment Office
❒ Home Technology (e.g. photo therapy, etc)
❒ Case Management *(specify)*

_____

❒ Other (*specify*)

_____

19. Was the infant transferred from the NICU to another hospital?

❒ Yes
❒ No

If yes, indicate type of transfer

❒ In-house
❒ Level III – Level III
❒ Level III – Level II
❒ Level III – Level I
❒ Other (*specify*)

_____

20. Was there any documentation that the mother saw the infant before the transport?

❒ Yes
❒ No

21. Final Disposition

❒ Deceased before discharge (Skip to question 29)
❒ Public/Private Foster care
❒ Home with parents
❒ Continued boarder in hospital
❒ Discharged to prospective adoptive parents
❒ Other (*specify*)

_____

22. Discharge Diagnosis(es)

Primary

_____

_____

_____

_____

Secondary

_____

_____

_____

_____

23. Was a discharge plan documented in the infant's records?

❒ Yes
❒ No

24. All NICU infants should have case management. Was a case coordinator identified for the infant?

❒ Yes
❒ No

If yes, specify

❒ Private Physician
❒ Managed Care Organization
❒ Clinic/Hospital Outpatient Department
❒ Community Health Center
❒ Other (*specify*)

_____

25. Were any medications prescribed for the baby at discharge?

❒ Yes
❒ No

If yes, specify

_____

_____

_____

26. Was there documentation that the parents were instructed in medication administration?

❒ Yes
❒ No
❒ Unknown

27. Was the infant technologically dependent at discharge?

❒ Yes
❒ No

If yes, check all that apply

❒ Oxygen
❒ Tracheotomy
❒ Suctioning
❒ Tube Feeding
❒ Parenteral Nutrition
❒ Colostomy
❒ Kidney Dialysis
❒ Respirator
❒ Tracheostomy
❒ Cardio/Respiratory Monitors (apnea)
❒ Other (*specify*)

_____

28. If yes, did the parents receive special training on any of the following?

❒ Yes
❒ No

If yes, check all that apply

❒ Resuscitation
❒ 24 hour number for medical back-up
❒ 24 hour number for equipment malfunction
❒ Care of the equipment
  a. Use of the equipment
  b. Infant symptoms requiring immediate medical help
  c. Other (specify)

_____

29. If the infant died prior to discharge, was an autopsy done?

❒ Yes
❒ No
❒ Unknown

If yes, please complete the autopsy form.

30. If the infant died, was it documented that the family received counseling or bereavement support

❒ Yes
❒ No

ABSTRACTOR'S NOTES: (Add any information that will help you summarize this case.)

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Ambulatory Infant Care Record

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

OUTPATIENT CARE FORM

This form includes pages on which to collect information about the LAST visit closest to the date of death. If you choose to collect information on additional pediatric visits, please duplicate this form.

1. Age in months _____

2. Who brought the baby to the visit?
(Check all that apply)
- ❒ Father
- ❒ Grandmother
- ❒ Foster mother
- ❒ Mother
- ❒ Other *(specify)*

_____

3. What were the payor sources for this visit?
(Check all that apply)
- ❒ Managed care organization (MCO)
- ❒ Private insurance
- ❒ Medicaid
- ❒ Self pay
- ❒ Military *(specify)*

_____
- ❒ Other *(specify)*

_____

4. Provider type
- ❒ Community health center
- ❒ Managed care organization
- ❒ County public health center
- ❒ Private office
- ❒ General pediatric clinic/hospital outpatient department
- ❒ Specialty center *(specify)*

_____
- ❒ Other *(specify)*

_____

5. Reason for visit
- ❒ Regular checkup
- ❒ Sick baby follow-up visit
- ❒ Sick Baby Exam
- ❒ Other *(specify)*

_____

6. Weight _____grams

7. Length _____cms

8. Head Circumference _____cms

9. Immunization received at this visit?
- ❒ Yes
- ❒ No

If yes, specify
- ❒ DPT
- ❒ HepB
- ❒ Oral Polio Vaccine
- ❒ MMR
- ❒ HIB
- ❒ Other *(specify)*

_____

10. Presenting Problem/Chief Complaint
(name problem)

_____

_____

11. Diagnostic Test(s) Done *(list tests)*

_____

_____

12. a. Diagnosis(es)

_____

b. Developmental assessment done?

_____
- ❒ Yes
- ❒ No

If yes, results
- ❒ Normal
- ❒ Abnormal

Comments

_____

_____

_____

Treatment given

❒ Advice *(specify)*

_____

❒ Medication *(specify)*

_____

❒ Other *(specify)*

_____

13. Follow-up appointment given?

❒ Yes
❒ No

14. Disposition

❒ Home
❒ Emergency department
❒ Hospital
❒ Other *(specify)*

_____

HEALTH EDUCATION

15. Did the person who brought the infant for care receive health education about any of the following at this visit:

❒ Bath safety
❒ SIDS risk reduction
❒ Breast feeding
❒ Small object avoidance
❒ Formula feeding
❒ Use of infant car seat
❒ Protection from falls
❒ Use of home smoke detector
❒ Shaken Baby Syndrome
❒ Other *(specify)*

_____

❒ Other *(specify)*

_____

REFERRALS

16. Was the family referred to any health or human services program at this visit?

❒ Yes
❒ No

If yes, check all that apply

❒ Alcohol cessation program
❒ Housing authority
❒ Case management
❒ Infant child health program
❒ Child protection services
❒ Legal aid
❒ County PHN home follow-up
❒ Medicaid
❒ Family planning
❒ Mental health service
❒ Financial planning
❒ Methadone maintenance program
❒ GED programs
❒ Physically handicapped child program
❒ Genetic evaluation/counseling
❒ Smoking cessation program
❒ Group shelters
❒ Unemployment office
❒ Homemaker/home health aide
❒ WIC
❒ Other *(specify)*

_____

PSYCHOSOCIAL ASSESSMENT

17. Did medical, nursing or social work personnel identify any of the problems listed below at any of the visits?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the infant requiring continuing medical care *specify* _____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner/child)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other *(specify)* _____		
❒ Other *(specify)* _____		

MEDICATIONS

18. a. Were any medications prescribed for the baby at this visit?

❒ Yes
❒ No

If yes, list all that were prescribed

_____
_____
_____
_____
_____
_____
_____

b. Were parents instructed in medication administration?

❒ Yes
❒ No
❒ Unknown

DISCHARGE

19. Was a follow-up medical visit schedule for infant?

❒ Yes
❒ No

If yes, specify

❒ With private physician
❒ At clinic/hospital outpatient department
❒ Other *(specify)*

_____

a. How many hours or days between this visit and the follow-up visit?
_____hours or _____days

20. Was a discharge plan documented in the infant's records?

❒ Yes
❒ No

ABSTRACTOR'S NOTES: (Add any information that will help you summarize this case.)

_____
_____
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Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Pediatric Emergency Department and/or Hospitalization Record

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

Use one form for the <u>last</u> emergency department visit and/or the <u>last</u> hopitalization the infant experienced before the death

1. ❒ **Emergency Department Only**
❒ **Hospital Admission**

2. Admission Time *(military)* _____
Day of the week _____

3. Age in months _____

4. Admitting Diagnoses

1 _____
_____
_____
_____

2 _____
_____
_____
_____

3 _____
_____
_____
_____

4 _____
_____
_____
_____

5. Admission Vital Signs
Weight _____ grams
Length _____ cm
Head Circumference _____ cm
Heart Rate _____
Respiratory Rate _____
Blood Pressure _____ /_____

a. Was the infant deceased upon arrival?
❒ Yes (If yes, skip to question 18)
❒ No

6. Did medical, nursing or social work personnel identify any of psychosocial or lifestyle problems listed below during this hospitalization or ED visit?

❒ Yes
❒ No

If yes, check all that apply

	Was a referral made?	
	Yes	**No**
❒ Battered (mother)		
❒ Chronic medical conditions of the mother or infant requiring continuing medical care *please specify*_____		
❒ Communication difficulties (no phone)		
❒ Crime/legal problems (mother/partner)		
❒ Depression (mother/partner)		
❒ Disturbed mother/infant relationship		
❒ Drug use (mother/partner)		
❒ Employment/education needs (mother/partner)		
❒ ETOH abuse (mother)		
❒ ETOH abuse (partner)		
❒ History of abuse (other children)		
❒ Housing inadequate/homeless		
❒ Inadequate support systems		
❒ Language barriers (non-English speaking)		
❒ Mother abused as child		
❒ Need for Public Assistance, Medicaid, Food Stamps, WIC, other financial support		
❒ Physical/developmental handicap (mother/partner)		
❒ Single mother		
❒ Teen mother		
❒ Transportation Limitation		
❒ Other *(specify)* _____		
❒ Other *(specify)* _____		

7. Was the family referred for any other support services before discharge?

❒ Yes
❒ No

If yes, check all that apply

❒ Case management (*specify*)

_____

❒ Child protection services
❒ Mental health service
❒ Early intervention
❒ Methadone maintenance program
❒ Family planning
❒ PHN home assessment/home visit
❒ Genetic evaluation/counseling
❒ Smoking cessation program
❒ Homemaker/home health aide
❒ Unemployment office
❒ Housing services
❒ WIC
❒ Medicaid
❒ Alcohol cessation program
❒ Other (*specify*)

_____

8. Did a case worker contact this family during the infant's hospitalization?

❒ Yes
❒ No

Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____

9. Final Disposition

❒ Continued as boarder
❒ Discharged to prospective adoptive parents
❒ Deceased before discharge (Skip to question 18)
❒ Discharged to public/private foster care
❒ Transferred to another hospital
❒ Home
❒ Unknown
❒ Other (*specify*)

_____

10. Discharge Diagnoses

1 _____
_____
_____
_____

2 _____
_____
_____
_____

3 _____
_____
_____
_____

4 _____
_____
_____
_____

11. Time of Discharge *(military)* _____

Day of the week _____

12. If the infant was alive at discharge, was a discharge plan documented in the infant's records?
❒ Yes
❒ No

13. Were any of the following topics discussed at discharge? *(Check all that apply)*
❒ Infant signs and symptoms that warrant immediate medical attention
❒ Where to call in case of infant emergency
❒ SIDS risk reduction activities
❒ Small object avoidance
❒ Use of an infant car seat
❒ Protection from falls
❒ Shaken body syndrome
❒ Use of home smoke detector
❒ Other (*specify*)

_____

❒ Other (*specify*)

_____

14. Were any medications prescribed for the baby at discharge?
❒ Yes
❒ No

If yes, list all prescribed

_____

_____

_____

If yes, were parents instructed in medication administration?
❒ Yes
❒ No
❒ Unknown

15. Was a follow-up pediatric visit scheduled for infant?
❒ Yes
❒ No

If yes, specify
❒ With private physician
❒ At clinic/hospital outpatient department
❒ Other (*specify*)

_____

16. Was the infant scheduled to any other follow-up visit?
❒ Yes
❒ No

If yes, specify

_____

_____

_____

17. Was the infant technologically dependent at discharge?
❒ Yes
❒ No

If yes, check all that apply
❒ Cardio/respiratory monitors (apnea)
❒ Respirator
❒ Colostomy
❒ Suctioning
❒ Kidney dialysis
❒ Tracheostomy
❒ Oxygen
❒ Tracheotomy
❒ Parenteral nutrition
❒ Tube feeding
❒ Other (*specify*)

_____

If yes, did the parents receive special training on any of the following?
❒ Yes
❒ No

If yes, check all that apply
❒ Care of equipment
❒ Use of equipment
❒ Infant symptoms requiring immediate medical help
❒ 24-hour number for medical back-up
❒ Resuscitation
❒ 24-hour number for equipment repair
❒ Other (*specify*)

_____

18. If the infant died, was an autopsy done?

❒ Yes
❒ No

If yes, please complete the separate autopsy form.

19. If the infant died, was it documented that the family received counseling or bereavement support?

❒ Yes
❒ No

ABSTRACTOR'S NOTES: (Add any information that will help you summarize this case.)

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Fetal/Infant Death Certificate and Autopsy Report

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

DEATH CERTIFICATE

1. **Time of death** *(military)* _____

   Type of death
   ❒ Fetal
   ❒ Infant

2. **Fetal age** _____ weeks ❒ Unknown

   Neonatal infant age at death _____ days

   Postneonatal age at death
   _____ months

3. **Sex**
   ❒ Male
   ❒ Female
   ❒ Unknown

4. **Did the delivery involve multiple births?**
   ❒ Yes
   ❒ No

   If yes, specify number of births
   ❒ 2
   ❒ 3
   ❒ 4
   ❒ 5
   ❒ 6

   If yes, specify birth order of deceased infant
   ❒ 1st
   ❒ 2nd
   ❒ 3rd
   ❒ Other *(specify)*

   _____
   ❒ Unknown

5. **Place of delivery**
   ❒ Home
   ❒ Hospital
   ❒ On way to hospital
   ❒ Other *(specify)*

   _____

6. **Did the death occur in hospital?**
   ❒ Yes
   ❒ No

7. **County in which death occurred**
   _____ _____ _____ (code number)
   ❒ Leave country code blank

8. **Death caused by**
   Immediate Cause

   _____

   As a consequence of

   _____

   As a consequence of

   _____

9. **Autopsy Performed**
   ❒ Yes
   ❒ No
   ❒ Unknown

   If autopsy done, please complete autopsy questions on page 2.

ABSTRACTOR'S NOTES: (Abstractor: Add all information which would help you summarize this certificate.)

AUTOPSY REPORT

10. Number of days from death to completion of autopsy _____

11. Was Evidence of Injury noted? ***(Check all that apply)***

❒ Yes
❒ No

If yes, specify

❒ Cigarette burns
❒ Abrasions/scratches
❒ Fractures
❒ Hemorrhage
❒ Resuscitative marks
❒ Contusion/bruises
❒ Other (*specify*)

_____

12. Cause of Death

a. Primary

_____
_____
_____
_____

b. Other contributory/associated findings/ causes

_____
_____
_____
_____

ABSTRACTOR'S NOTES: (Abstractor: Add all information which would help you summarize this report.)

_____
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Data Entry Staff:

Is this record completely entered?

❒ Yes
❒ No

NATIONAL

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Home Interview

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

INDEX

BEGINNING THE INTERVIEW

The first 10 to 15 minutes of the home visit will usually be used to develop rapport with the mother, to thank her for allowing the visit, and to explain the program. Once a comfortable atmosphere has been achieved, the best way to begin the interview is to ask the mother to describe in her own words the events leading up to the loss of her infant. The interviewer should call the baby by his/her name, if given by the family. The mother may have already started telling the interviewer about the loss before the interviewer had to ask.

It is important to remain sensitive to the mother's need to expound on or digress from any particular event that generates strong feelings and to give her time to recall details and relate her experiences in her own words. The standardized questionnaire can follow when the mother is able.

1. Can you tell me about what happened? (Refer to baby by name, if known)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. How was the baby's death explained? (Refer to baby by name, if known)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Note: The interviewer should *listen* while the mother expands on these two questions, and then record the information after the home visit.

PART A – PRECONCEPTION HEALTH INFORMATION

The first few questions are about the time just before the start of your most recent pregnancy.

1. **Were you ever told you had any of the following health problems *before* you became pregnant? *(Check all that apply)***
   - ❒ Diabetes
   - ❒ Heart Disease/Conditions *(specify)*

     _____
   - ❒ High Blood Pressure
   - ❒ Seizures/Epilepsy
   - ❒ Anemia
   - ❒ Viruses/Infections *(specify)*

     _____
   - ❒ HIV
   - ❒ Tooth Decay/Gum Disease
   - ❒ Other *(specify)*

     _____
   - ❒ Don't remember
   - ❒ I did not have any of these health problems

   If yes, what treatment was provided

   _____

   _____

   _____

2. **Before this pregnancy, did you talk with a health care provider about pregnancy planning?**
   - ❒ Yes
   - ❒ No
   - ❒ Don't remember

3. ***Before this pregnancy,* did you or the baby's father use medical treatments to help you become pregnant?**
   - ❒ Yes
   - ❒ No

   If yes, complete question 3 and go to question 6

   If yes, which of the following medical treatments did you or the baby's father use to help you become pregnant? *(Check all that apply)*
   - ❒ Advice on how to time intercourse for most fertile times
   - ❒ Infertility test for father (sperm count, etc.)
   - ❒ Infertility tests for mother
   - ❒ Medicine to stimulate ovulation (Clomid, Pergonal, etc.)
   - ❒ Hormone shots
   - ❒ Treatment/surgery for blocked fallopian tube
   - ❒ Treatment/surgery of the father's reproductive system
   - ❒ In vitro test tube fertilization
   - ❒ Artificial insemination
   - ❒ Other *(specify)*

     _____

4. **What kind of birth control were you using during the three months before you got pregnant? *(Check all that apply)***
   - ❒ Pill
   - ❒ Diaphragm
   - ❒ Condom (Rubbers)
   - ❒ Foam, Jelly or Cream
   - ❒ Rhythm
   - ❒ Depo-Provera
   - ❒ IUD
   - ❒ Withdrawal (Pulling Out)
   - ❒ Other *(specify)*

     _____
   - ❒ None

     _____

5. ***(If applicable)*** **Why were you not using birth control during the three months before you got pregnant?** ***(Check all that apply)***
   - ❒ I wanted to get pregnant
   - ❒ I didn't think I was going to have sex
   - ❒ I didn't think I could get pregnant
   - ❒ I didn't like using birth control
   - ❒ I had trouble getting birth control
   - ❒ I was having side effects from the birth control I was using
   - ❒ My partner does not believe in birth control
   - ❒ Other *(specify)*

   _____

6. **Did you take the B Vitamin called Folic Acid, prior to becoming pregnant?**
   - ❒ Yes
   - ❒ No
   - ❒ Don't Know

   a. **If yes, how did you hear about taking Folic Acid?**

   _____

7. **How would you describe the time just before your pregnancy?**
   - ❒ One of the happiest times of my life
   - ❒ A happy time with a few problems
   - ❒ A moderately hard time
   - ❒ A very hard time
   - ❒ One of the worst times of my life

PART B – PRENATAL CARE

These are a few questions about the prenatal care you received.

1. **How many weeks pregnant were you when you first thought you *might* be pregnant?**
   _____ weeks
   - ❒ Don't remember

2. **How many weeks pregnant were you when you were *sure* you were pregnant?**
   (For example, you had a pregnancy test or a doctor/nurse said you were pregnant.)
   _____ weeks
   - ❒ Don't remember

3. **How do you remember feeling about becoming pregnant?**
   - ❒ I wanted to be pregnant sooner
   - ❒ I wanted to be pregnant later
   - ❒ I wanted to be pregnant then
   - ❒ I didn't want to be pregnant then
   - ❒ I didn't want to be pregnant then or at any time in the future
   - ❒ I don't know

4. **Did you receive any prenatal care from a doctor, nurse-midwife, or nurse practitioner during this pregnancy?**
   - ❒ Yes (Go to next question)
   - ❒ No (Skip to question 27)

5. **Did you get prenatal care as early as you wanted?**
   - ❒ Yes
   - ❒ No

   If no, check all that apply
   - ❒ I had no one to take care of my children
   - ❒ I did not think I was pregnant
   - ❒ I had no way to get to the clinic or office
   - ❒ I did not have enough money or insurance to pay for my visits
   - ❒ I could not get a doctor or nurse to take me as a patient
   - ❒ I did not know where to go
   - ❒ I could not get an appointment earlier in my pregnancy
   - ❒ None
   - ❒ Other *(specify)*

   _____

6. **If NO to question 5, did you go to the hospital emergency room when you needed care during your pregnancy?**
   - ❒ Yes
   - ❒ No

   If yes, please explain

   _____

   _____

   _____

   _____

7. **During your most recent pregnancy, did any of the following make it difficult for you to receive as many prenatal care visits as you would have liked? *(Check all that apply)***
   - ❒ I had no one to take care of my children
   - ❒ I had no way to get to the clinic or office
   - ❒ I did not have enough money or insurance to pay
   - ❒ I could not get a doctor or nurse to take me for my visits as a patient
   - ❒ I did not know where to go
   - ❒ I could not get an appointment earlier in my pregnancy
   - ❒ None
   - ❒ Other *(specify)*

   _____

8. **How old were you when you went for your first prenatal visit?** _____

9. **How many weeks or months pregnant were you on your first visit for prenatal care?**
   (Don't count a visit that was only for a pregnancy test, sonogram, or WIC appointment.)

   _____
   - ❒ I can't remember

   Interviewer: Convert months to weeks

   _____ weeks

10. **Where did you go for your first prenatal visit? *(Check one answer)***
    - ❒ Private Provider's Office
    - ❒ Clinic at work or at school
    - ❒ County Health Department
    - ❒ Clinic in a hospital
    - ❒ Managed Care Organization (MCO)
    - ❒ Hospital emergency room or as needed care provider
    - ❒ Community Health Center
    - ❒ I did not get any more prenatal care
    - ❒ Other *(specify)*

    _____

11. **What was the payor source for your prenatal visits? *(Check all that apply)***
    - ❒ Private Insurance
    - ❒ Medicaid
    - ❒ Managed Care Organization (MCO)
    - ❒ Military (*specify*)

    _____
    - ❒ Self pay
    - ❒ Other (*specify*)

    _____

12. **How did you usually get to this place?**
    - ❒ Car
    - ❒ Walked
    - ❒ Taxi
    - ❒ Clinic provided transportation
    - ❒ Bus or other public transit
    - ❒ Other *(specify)*

    _____

13. How long did it usually take you to travel one way to this place?

_____ hours _____ minutes

14. Did you usually see the same doctor, nurse-midwife, or other provider on each visit to this site?

❒ Yes
❒ No

15. Did you have to change your prenatal care provider during this pregnancy?

❒ Yes
❒ No

If no, skip to question 19

If yes, why? (Check all that apply)

❒ The provider would not accept Medicaid
❒ The provider would not accept my insurance
❒ Could not pay
❒ Moved
❒ Other *(specify)*

_____

16. If you had to change prenatal care providers, where did you receive the rest of your prenatal care? *(Check <u>one</u> answer)*

❒ Private Provider's Office
❒ Clinic at work or at school
❒ County Health Department
❒ Clinic in a hospital
❒ Managed Care Organization (MCO)
❒ Hospital emergency room or as needed care provider
❒ Community Health Center
❒ I did not get any more prenatal care
❒ Other *(specify)*

_____

17. What was the payor source for these visits? *(Check <u>one</u> answer)*

❒ Private Insurance
❒ Medicaid
❒ Managed Care Organization (MCO)
❒ Military (*specify*)

_____

❒ Self pay
❒ Other (*specify*) _____

_____

18. How did you usually get to this place?

❒ Car
❒ Walked
❒ Taxi
❒ Clinic provided transportation
❒ Bus or other public transit
❒ Other *(specify)*

_____

19. How long did it usually take you to travel one way to this place?

_____ hours _____ minutes

20. On a scale of 1 to 5, where 5 is very satisfied and 1 is very dissatisfied, how satisfied were you with the prenatal care you received? If you went to more then one place for prenatal care, answer for the place where you received *most* of your care?

	Rating
The amount of time you had to wait after you arrived for your visits	
The amount of time the doctor or nurse spent with you during your visits	
The advice you received on how to take care of yourself	
The hours the office or clinic was open	
The understanding and respect the staff showed toward you as a person	

21. This question is about things that a doctor, nurse or any other health workers might have talked with you about when you received prenatal care during your most recent pregnancy. *(Check all that apply)*

	Yes	No/Don't remember
Breastfeeding your baby		
Signs and symptoms of premature labor		
Signs and symptoms that mean you should call the doctor/hospital immediately		
How to get help after office hours for these signs and symptoms of preterm labor or other health problems		
Avoiding smoking during pregnancy		
Avoiding alcohol during pregnancy		
Avoiding illegal drugs during pregnancy		
Taking vitamins or iron during pregnancy		
Benefits of your own dental care and hygiene		
Getting tested for HIV (the virus that causes AIDS)		
How to avoid getting sexually transmitted diseases		
Finding a doctor or nurse practitioner to care for your baby		
Safe Sleep/SIDS Risk Reduction Activities		

22. Did a doctor or nurse or other health worker discuss any of the following? ***(Check all that apply)***

- ❒ What you should eat during your pregnancy
- ❒ Whether you had enough to eat
- ❒ Whether you had family problems
- ❒ About your working conditions
- ❒ Whether you felt anxious or concerned about this pregnancy
- ❒ Whether you were experiencing any stress
- ❒ Whether you were depressed

23. During your most recent pregnancy, did you attend any of the following? ***(Check all that apply)***

- ❒ Childbirth education classes
- ❒ Parenting classes
- ❒ Counseling sessions about stress, family problems or mental health problems

24. Did you develop any of the following health problems *while* you were pregnant?

- ❒ Diabetes
- ❒ Heart Disease
- ❒ High Blood Pressure
- ❒ Anemia
- ❒ Viruses/Infections *(specify)*

_____

- ❒ Seizures
- ❒ STDs *(specify)*

_____

- ❒ HIV
- ❒ Vaginal bleeding
- ❒ Other *(specify)*

_____

- ❒ I did not have any of these problems

If yes, what treatment was provided during pregnancy?

_____

25. Sometimes during pregnancy, women are expected to take special precautions to prevent preterm or early labor. During this pregnancy, did you do anything to prevent premature labor or early labor?

- ❒ Yes
- ❒ No

If yes, which of the following did you do to prevent premature or early delivery? ***(Check all that apply)***

- ❒ Took medicine to prevent labor or miscarriage
- ❒ Got hormone shots
- ❒ Stopped or limited sex during pregnancy
- ❒ Used condoms to prevent infection
- ❒ Doctor sewed the cervix closed (cerclage of incompetent cervix)
- ❒ Had bed rest for one or more weeks at home
- ❒ Was hospitalized for one or more nights
- ❒ Reduced work hours or stopped working earlier than expected
- ❒ Reduced housework or other physical activities
- ❒ Other *(specify)*

_____

26. If your doctor advised you to rest in bed, were you able to stay in bed as long as recommended?

- ❒ Yes
- ❒ No

If no, check all that apply

- ❒ No help at home
- ❒ Had to go to work
- ❒ Had to go to appointments
- ❒ Other *(specify)*

_____

27. How would you describe your health during pregnancy?

- ❒ Excellent
- ❒ Good
- ❒ Fair
- ❒ Poor

28. How would you describe the time during your pregnancy?

❒ One of the happiest times of my life
❒ A happy time with a few problems
❒ A moderately hard time
❒ A very hard time
❒ One of the worst times of my life

Is there anything else you would like to tell me about your pregnancy?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

PART C – NUTRITION, WEIGHT GAIN, AND HEALTH HABITS

1. How much weight did you gain during your pregnancy?

_____ pounds
❒ Don't know

2. How tall are you without shoes?

_____ pounds _____ inches
❒ Don't know

3. Did a doctor, nurse or nutrition counselor tell you how much weight you should gain during this pregnancy?

❒ Yes
❒ No
❒ Don't remember

If yes, what did they tell you?

_____ lbs.

4. During your pregnancy, did you see a special diet counselor (dietician)?

❒ Yes
❒ No

If yes, please tell me why

_____

_____

_____

_____

5. Some mothers tell us they craved and ate non-foods during their pregnancies. Did you eat ice, clay, starch or any other non-food during your recent pregnancy?

❒ Yes
❒ No

If yes, specify

_____

Interviewer: Use your discretion in deciding if it is appropriate to ask questions 6 through 10.

6. Did you think that you had enough money to buy food for you and your family?
- ❒ Yes
- ❒ No
- ❒ Don't remember

7. During your recent pregnancy, did you cut back on the amount of food you bought?
- ❒ Yes
- ❒ No
- ❒ Don't remember

If yes, why?

_____

_____

8. During your recent pregnancy, was there a time when you and your family needed food but couldn't afford to buy it?
- ❒ Yes
- ❒ No (Go to question 12)
- ❒ Don't Remember (Go to question 12)

a. If yes, when that happened, did some person or organization help get food?
- ❒ Yes
- ❒ No

b. If yes, who helped you?

_____

9. During your pregnancy, were you on WIC?
- ❒ Yes
- ❒ No (Go to question 15)

10. Was it convenient or easy for you to get your WIC vouchers?
- ❒ Yes
- ❒ No

If no, why?

_____

11. Have you smoked at least 100 cigarettes in your entire life?
- ❒ Yes
- ❒ No
- ❒ I have never smoked (skip to question 17)

12. In the three months *before you got pregnant*, how many cigarettes or packs of cigarettes did you smoke *on an average day*? (A pack of cigarettes has 20 cigarettes)
- ❒ _____ number of cigarettes or _____ packs
- ❒ I didn't smoke

13. In the *last three* months of your pregnancy, how many cigarettes or packs of cigarettes did you smoke on *an average day*? (A pack of cigarettes has 20 cigarettes)
- ❒ _____ number of cigarettes or _____ packs
- ❒ I didn't smoke (Go to question 16)

14. Did you quit smoking cigarettes for at least one month during your pregnancy?
- ❒ Yes
- ❒ No
- ❒ Don't remember

15. What influenced you to reduce your smoking? *(Check all that apply)*
- ❒ I was urged by my doctor or nurse
- ❒ Smoking tasted or smelled bad to me
- ❒ I was urged by my friends or family
- ❒ Smoking made me feel sick
- ❒ I lost the desire to smoke
- ❒ Other *(specify)*

_____

16. How many cigarettes or packs of cigarettes do you currently smoke on an average day?
- ❒ _____ number of cigarettes or _____ packs
- ❒ I didn't smoke

17. During the *three months before* you got pregnant, how many alcoholic drinks did you have in an average week? (A drink is one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor or one mixed drink.)

❒ I didn't drink then (Go to question 18)
❒ 7 to 13 drinks per week
❒ 1 to 3 drinks per week
❒ 14 or more drinks per week
❒ 4 to 6 drinks per week
❒ I don't know

a. During the *three months before* you got pregnant, how many times did you drink four or more alcoholic drinks at one sitting?

_____ Times
❒ I didn't drink then
❒ I don't know

18. During the *last three months* of your pregnancy, how many alcoholic drinks did you have in an average week?

❒ I didn't drink then (Go to question 20)
❒ 7 to 13 drinks per week
❒ Less than one drink per week
❒ 14 or more drinks per week
❒ 1 to 3 drinks per week
❒ I don't know
❒ 4 to 6 drinks per week

a. During the *last three months* of your pregnancy, how many times did you drink four or more alcoholic drinks at one sitting?

_____ times
❒ I didn't drink then
❒ I don't know

b. What factors influenced you to continue to drink alcoholic beverages during your pregnancy?

_____
_____
_____
_____
_____
_____

19. Did you ever reduce or stop drinking alcoholic beverages at any time during your pregnancy?

❒ Yes
❒ No

Check all factors that apply

❒ I was urged by my doctor or nurse
❒ Alcohol tasted or smelled bad to me
❒ I was urged by my friends or family
❒ Alcohol made me feel sick
❒ I lost the desire to drink
❒ Other *(specify)*

_____

20. Which of the following prescription or over the counter medications did you take during this pregnancy? *(Check all that apply)*

❒ Vitamins
❒ Allergy medications
❒ Diet pills or amphetamines
❒ Methadone
❒ Sleeping pills or tranquilizers
❒ None
❒ Antidepressants or mood regulators *(specify)* _____
❒ Demerol, Morphine *(specify)*

_____
❒ Pain killers *(specify)*

_____
❒ Steroids *(specify)*

_____
❒ Antibiotics *(specify)*

_____
❒ Antiseizure *(specify)*

_____
❒ Hormones *(specify)*

_____
❒ Any other medications *(specify)*

_____

21. Some mothers tell us that the stress of their pregnancy is so high they use street drugs while they are pregnant. Which of these recreational or street drugs did you take during your pregnancy? *(Check all that apply*)

❒ Marijuana or hashish
❒ Crack
❒ Speed/uppers
❒ Cocaine/coke in other forms
❒ Heroin
❒ PCP, angel dust, LSD
❒ Methadone
❒ Ecstasy
❒ Oxycontin
❒ Huffing glue or aerosols in can
❒ Other *(specify)*

_____

❒ Other nonprescribed drugs *(specify)*

_____

❒ None

Is there anything else you would like to tell me about your nutrition or health habits?

PART D – DELIVERY OF BABY

1. Please tell me about your delivery

2. Did a support person come with you during your labor and delivery?

❒ Yes
❒ No

If yes, who was with you?

_____

3. How many nights did you stay in the hospital/ other facility after delivering the baby?

❒ _____ of nights
❒ I did not stay overnight
❒ Don't remember

4. Were you transferred from one hospital to another during labor?

❒ Yes
❒ No

If yes, do you know the reason for the transfer?

5. **At any time of your labor, even if it was false labor or very early labor, were you denied admission to a hospital?**
   - ❒ Yes
   - ❒ No

   If yes, explain why

   _____

6. **How was your hospital stay paid for?** ***(Check all that apply)***
   - ❒ Private Insurance
   - ❒ Medicaid
   - ❒ Managed Care Organization (MCO)
   - ❒ Military *(specify)*

     _____
   - ❒ Self pay
   - ❒ Other *(specify)*

     _____

7. ***Interviewer: If a fetal death or still birth, check this box and skip to Part E*** ❒

8. **When your baby was born, how many nights did he/she stay in the hospital?**
   - ❒ _____ number of nights
   - ❒ My baby did not stay in the hospital
   - ❒ I don't know

9. **When your baby was born, was he/she put in an intensive care unit or premature nursery?**
   - ❒ Yes
   - ❒ No

10. **Was your baby transferred to another hospital immediately after the delivery?**
    - ❒ Yes (Go to next question)
    - ❒ No (Go to final question)

Is there anything else you would like to tell me about the delivery of your baby?

PART E – OTHER BABIES

1. **Have you ever been pregnant before your most recent pregnancy?**
   ❒ Yes
   ❒ No

   If yes, please complete pregnancy history
   If no, then go to question 3

Pregnancy	Delivery Date	Gestational Age	Birth Weight	Pregnancy Outcome (See key below)	Comments/ Complications
1	/ /				
2	/ /				
3	/ /				
4	/ /				
5	/ /				
6	/ /				
7	/ /				
8	/ /				

Pregnancy Outcome

A Live birth, still living
B Live birth, deceased
C Preterm
D Elective Abortion
E Spontaneous Abortion
F Ectopic
G IUFD

2. Have any of your children been placed in foster care or adopted?

❒ Yes
❒ No

If yes, please tell me about it

3. Do you expect to have more children?

❒ Definitely yes (Go to next question)
❒ Probably no (Go to question 7)
❒ Probably yes (Go to next question)
❒ Definitely no (Go to question 7)
❒ Doesn't know

4. How many more children do you expect to have?

_____ no. of children
❒ Don't know

5. When would you want to have another child?

_____ months
❒ Don't know

6. Are you currently pregnant?

❒ Yes
If yes, how many weeks pregnant are you now? _____
❒ Unknown
❒ No
❒ Don't know

7. Are you currently using birth control?

❒ Yes
❒ No

If no, why are you not using birth control?

❒ I want to get pregnant
❒ I don't believe in birth control
❒ I am not having sex
❒ My partner does not want me to use birth control
❒ I can't afford birth control
❒ I don't know where to find out about birth control
❒ I had my tubes tied
❒ Other *(specify)*

_____

Is there anything else you would like to share regarding your other pregnancies?

PART F – INFORMATION ON MOTHER

1. **What was your marital status during the pregnancy?**
   - ❒ Single
   - ❒ Divorced
   - ❒ Married
   - ❒ Separated
   - ❒ Widowed

2. **Has your marital status changed just before pregnancy, during pregnancy or after delivery?**
   - ❒ Yes
   - ❒ No

   If yes, specify

   _____

3. **Where were you born?**

   _____

4. **Which one of these groups best describes your racial background?**
   - ❒ White
   - ❒ Black
   - ❒ Other *(specify)*

   _____

   (Refer to NFIMR Software)

5. **Are you Spanish or Hispanic?**
   - ❒ Yes
   - ❒ No

   If yes, which one of these groups best descries your origin?
   - ❒ Mexican, Mexican-American, Chicano
   - ❒ Cuban
   - ❒ Puerto Rican
   - ❒ Central or South American
   - ❒ Other Spanish/Hispanic *(specify)*

   _____

6. **What is the highest grade/year of school or college you completed?**
   - ❒ 0–8
   - ❒ 9–11
   - ❒ 12
   - ❒ 13–14
   - ❒ 15–16
   - ❒ 17+

7. **Did you attend a vocational or trade school?**
   - ❒ Yes
   - ❒ No

   If yes, describe

   _____

8. **What language do you speak at home?**
   - ❒ English
   - ❒ Spanish
   - ❒ Other *(specify)*

   _____

   a. **How comfortable are you speaking and listening to English?**
      - ❒ Very comfortable/fluent (Go to section G)
      - ❒ Somewhat comfortable (Go to section G)
      - ❒ Fairly uncomfortable (Go to question 8B)
      - ❒ Not comfortable at all/do not speak English (Go to question 8B)

b. Were you offered interpretation or translation services in the following settings during pregnancy?

	Yes	No
During prenatal care		
At an emergency room		
At the hospital when you delivered		
At the hospital after you delivered		
At the pediatrician's visit		
At the family planning visit		

PART G – INFORMATION ON MOTHER'S EMPLOYMENT

1. Were you employed at any time *during your recent pregnancy*?

❒ Yes
❒ No

If no, skip to Part H

a. If yes, did you work during? *(Check all that apply)*

❒ First three months of pregnancy
❒ Second three months of pregnancy
❒ Third three months of pregnancy

b. Please describe what you did at your job *(Note: If using NFIMR Software, please refer to the appropriate Employment Code)*

Code _____

c. How did you usually get to work?

❒ Car
❒ Bus
❒ Taxi
❒ Walked
❒ Other *(specify)*

_____

2. How long did it take to get to work?

_____ hours _____ minutes

3. While working at your most recent job during pregnancy *(Check all that apply)*

❒ Were you able to take a rest break at work when you felt tired?
❒ Did you work on an assembly line?
❒ Did you work with heavy machinery that produces vibrations?
❒ Were you required to perform repetitive tasks?
❒ Did you consider your work outside the home boring?
❒ Was there a lot of noise?
❒ Did you work in an uncomfortably hot area?
❒ Did you work in an uncomfortably cold area?
❒ Were you on your feet most of the time?

4. Did you consider your job to be physically hard?

❒ Yes
❒ No
❒ Unsure

If yes, please explain

_____

_____

_____

_____

a. Did your job include heavy lifting (>40 lbs.)?

❒ Yes
❒ No

If yes, please explain

_____

5. Would you say your job was stressful?
- ❒ Yes
- ❒ No
- ❒ Unsure

6. Were you required to use protective clothing/equipment on your job?
- ❒ Yes
- ❒ No

If yes, check all that apply
- ❒ Gloves
- ❒ Coveralls
- ❒ Goggles
- ❒ Safety shoes
- ❒ Respirator
- ❒ Other *(specify)*

_____

7. Did you stop work before your delivery?
- ❒ Yes
- ❒ No

8. What were the reasons you stopped work? ***(Check all that apply)***
- ❒ Employer made me quit
- ❒ The baby's father wanted me to stop working
- ❒ I felt sick and wanted to stop working
- ❒ I was fired
- ❒ My doctor or nurse advised me to stop working
- ❒ I was fired because I was pregnant
- ❒ I wanted to stop working
- ❒ Other *(specify)*

_____

9. Did you get maternity leave?
- ❒ Yes
- ❒ No

a. If yes, was the leave?
- ❒ Paid
- ❒ Unpaid

Is there anything else you would like to tell me about your work activities or other questions in this part?

PART H – INFORMATION ON FATHER

1. **What is the highest grade of school or college the baby's *father* completed?**
   - ❒ 0–8
   - ❒ 9–11
   - ❒ 12
   - ❒ 13–14
   - ❒ 15–16
   - ❒ 17+

2. **Did the baby's father complete vocational or trade school?**
   - ❒ Yes
   - ❒ No

   If yes, describe

   _____

3. **How old is the baby's father?**
   _____ years

4. **Which one of these groups best describes the racial background of the baby's father?**
   - ❒ White
   - ❒ Black
   - ❒ Other *(specify)*

   _____

   Is the baby's father Spanish or Hispanic?
   - ❒ Yes
   - ❒ No

   If yes, which one of these groups best describes his origin?
   - ❒ Mexican, Mexican-American, Chicano
   - ❒ Cuban
   - ❒ Puerto Rican
   - ❒ Central or South American
   - ❒ Other Spanish/Hispanic *(specify)*

   _____

5. **Did the father of your baby have a job during your pregnancy?**
   - ❒ Yes
   - ❒ No

   If yes, describe

   _____

   Code : _____
   (Note: If using NFIMR Software, please refer to the appropriate Employment Code)

6. **Was the father required to use protective clothing/equipment on his job?**
   - ❒ Yes
   - ❒ No

   If yes, check all that apply
   - ❒ Gloves
   - ❒ Coveralls
   - ❒ Goggles
   - ❒ Safety shoes
   - ❒ Respirator
   - ❒ Other *(specify)*

   _____

We would like you to think now about your relationship with the baby's father (FOB).

7. **How would you describe your relationship with this partner during your pregnancy?**
   - ❒ Excellent
   - ❒ Good
   - ❒ Fair
   - ❒ Poor
   - ❒ FOB was not around
   - ❒ Unsure

   If the father was not around, skip to Part I

8. **How satisfied were you with his contribution(s) toward your financial support?**
   - ❒ Very satisfied
   - ❒ Somewhat satisfied
   - ❒ Not satisfied
   - ❒ Unsure

9. Now I am going to talk about some problems fathers may have. During your pregnancy, did the baby's father have any of the following? *(Check all that apply)*

❒ Work or employment problems
❒ Problems with drugs or alcohol
❒ Money problems
❒ Housing problems
❒ Emotional problems
❒ A death in the family
❒ Problems with children or other relatives
❒ Problems with the law
❒ Health problems
❒ Other *(specify)*

_____

❒ None
❒ Don't know

10. Overall, how would you describe your relationship with the father of the baby now?

❒ Excellent
❒ Good
❒ Fair
❒ Poor
❒ FOB is not around
❒ Unsure

Is there anything else you would like to tell me about the baby's father?

PART I – LIVING SITUATION

In this section, we would like to find out about your living situation during your recent pregnancy. Think about where you lived and the things you could afford to do and buy.

1. **How did you feel about your overall living situation?**
   - ❒ Very satisfied
   - ❒ Somewhat dissatisfied
   - ❒ Somewhat satisfied
   - ❒ Very dissatisfied
   - ❒ Neither satisfied or dissatisfied
   - ❒ Don't know

2. **Would you be willing to share with me an estimate of your annual household income?**
   - ❒ Yes
   - ❒ No

   (If no, skip to question 5)

   Estimated Income: $ _____

3. **Which rooms are in the house, trailer, or apartment where you live for most of the time during your recent pregnancy?** ***(Check all that apply)***
   - ❒ Bedrooms (number _____)
   - ❒ Bathrooms (number _____)
   - ❒ Living room
   - ❒ Recreation room, den, or family room
   - ❒ Separate dining room
   - ❒ Finished basement
   - ❒ Kitchen
   - ❒ One-room residence

4. **How many adults and children lived with you in this house during your pregnancy?**
   Adults _____
   Children _____

5. **How much rent or mortgage did you pay each month?**
   $ _____
   - ❒ Don't remember

6. **How many times did you move in the past year?**

   _____

7. **Did you consider your home where you lived for most of the time during your pregnancy safe?**
   - ❒ Yes
   - ❒ No

   If no, please explain

   _____

Interviewer: Use your discretion in deciding if it is appropriate to ask questions 8 through 13

8. **Did you live in public housing?**
   - ❒ Yes
   - ❒ No

9. **Did you live in any of the following places during this pregnancy?** ***(Check all that apply)***
   - ❒ None of these
   - ❒ Prison/correction Facilities
   - ❒ Mental Health Facilities
   - ❒ Drug treatment center
   - ❒ Battered women's shelter
   - ❒ Homeless shelter
   - ❒ Home for pregnant teens
   - ❒ Other *(specify)*

   _____

   If yes, did they provide or help you get prenatal care?
   - ❒ Yes
   - ❒ No

10. **During your recent pregnancy or before your baby died, was there a time when you couldn't afford a place to stay or when you couldn't pay the rent or mortgage?**
    - ❒ Yes
    - ❒ No

11. **Were you evicted from your home?**
    - ❒ Yes
    - ❒ No

12. Did your gas, electricity or telephone get turned off because you couldn't afford to pay the bill?

❒ Yes
❒ No

13. Did you have phone service available in your home accessible to you during your pregnancy?

❒ Always
❒ Rarely
❒ Most of the time
❒ Never
❒ Sometimes

14. Was your home sprayed with a "pesticide" during your pregnancy (or after your baby was born)?

❒ Yes
❒ No

a. Do you know what the pesticide was used for?

_____

b. Do you know what the name of the pesticide was?

_____

15. During your recent pregnancy, did you worry about not having enough money from one month to the next?

❒ Not worried at all
❒ Very worried
❒ A little worried
❒ Extremely worried
❒ A little worried
❒ Not sure

Is there anything else you would like to tell me about your living situation?

_____
_____
_____
_____
_____
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_____

SECTION J – LIFE CHANGES/SOCIAL SUPPORTS

Pregnancy can be a difficult time for some women. The next questions are about some things that may have happened to you during your most recent pregnancy.

1. This question is about things that may have happened during your most recent pregnancy.

	Yes	No
A close family member was very sick and had to go into the hospital		
You got separated or divorced from your husband or partner		
You moved to a new address		
You were homeless		
Your husband or partner lost his job		
You lost your job even though you wanted to continue working		
You and your husband or partner argued more than usual		
Your husband or partner said he did not want you to be pregnant		
You had a lot of bills you couldn't pay		
You were involved in a physical fight		
You or your husband or partner went to jail		
Someone very close to you had a bad problem with drinking or drugs		
Someone very close to you died		
You were afraid of violence in your neighborhood		

2. During your pregnancy, you probably had to get different kinds of health-related services. Do you feel that you were ever treated differently or unfairly in getting these services?

❒ Yes
❒ No

If yes, please describe which factors were related to the unfair treatment

❒ Your race
❒ Your age
❒ Your culture
❒ Being female
❒ Your citizenship
❒ Your height or weight
❒ The type of insurance you had
❒ Your partner
❒ Other *(specify)*

_____

Interviewer: The next question is about physical abuse. Physical abuse means pushing, hitting, slapping, kicking or any other way of physically hurting someone.

3. During your most recent pregnancy, did any of these people physically abuse you? *(Check all that apply)*

❒ Your husband or partner
❒ A family or household member other than my husband or partner
❒ A friend
❒ Someone else *(please tell us whom)*

_____

❒ No one physically abused me during my pregnancy

4. **In the *last month*, how often have you felt difficulties were piling up so high that you could not overcome them?**
   - ❒ Never
   - ❒ Fairly often
   - ❒ Almost never
   - ❒ Very often
   - ❒ Sometimes
   - ❒ Don't know

5. **During your recent pregnancy, who would have helped you if a problem had come up? (For example, if you needed a ride to the clinic or needed to borrow $20.)** ***(Check all that apply)***
   - ❒ My husband or partner
   - ❒ A friend
   - ❒ My mother, father or in-laws
   - ❒ No one would have helped me
   - ❒ Other family member or relative
   - ❒ Don't know
   - ❒ Other *(specify)*

   _____

6. **In the last month, how often have you felt depressed/down/blue?**
   - ❒ Fairly often
   - ❒ Almost never
   - ❒ Never
   - ❒ Very often
   - ❒ Sometimes
   - ❒ Don't know

7. **Since the loss of your infant, did you receive counseling or join a support group for parents who have lost a baby?**
   - ❒ Yes
   - ❒ No

   If yes, please describe your experience

   _____

   _____

   _____

   _____

   _____

   _____

   _____

8. **Thinking back on this entire experience, what do you think would have made things better for you?**

   _____

   _____

   _____

   _____

   _____

   _____

9. **Thinking back, what experiences were really helpful or supportive for you?**

   _____

   _____

   _____

   _____

   _____

   _____

10. **What do you think needs to be done to help women and families who experience the death of an infant?**

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

Is there anything about the loss of your infant that you would like to share with me?

INTERVIEWER NOTES: (Interviewer: please describe home environment, and note any other information that may help you summarize this case.)

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Home Interview Supplement: Baby's Health At Home

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

These questions are about the care of your baby at home. We know that some questions may be difficult to answer and some may be a painful reminder. Please give us whatever information you can. We are asking these questions so that we can try to help other women with their pregnancies.

1. a. How old was your baby when he/she *first* came home from the hospital?

_____ hours _____ days or _____ months
❒ Unsure

b. Before you took your new baby home from the hospital, did you know where to take the baby if he/she got sick?
❒ Yes
❒ No
❒ Don't remember

2. Did you feel ready to begin taking care of a new infant when the baby came home?
❒ Yes
❒ No
❒ Not sure

Please explain

_____
_____
_____
_____
_____
_____
_____

3. Did you feel you had family or friends who could help you with the baby at home?
❒ Yes
❒ No

If yes, please specify who
❒ Father of the baby
❒ Other partner
❒ Relative
❒ Friend
❒ Other *(specify)*

_____
_____
_____

4. What was the most difficult part of being a new mother?

_____
_____
_____
_____
_____
_____

5. In the months prior to your baby's death, how often did you feel that daily activities were overwhelming?
❒ Never
❒ Almost never
❒ Sometimes
❒ Fairly often
❒ Very often

6. In the months prior to your baby's death, how often did you feel very sad?
❒ Never
❒ Almost never
❒ Sometimes
❒ Fairly often
❒ Very often

7. Did you ever feel that you did not have enough time or energy to care for yourself or your baby?
❒ Yes
❒ No

Please explain

_____
_____
_____
_____
_____
_____
_____

8. After your baby was born, did you go to work or attend school?

❒ Yes
❒ No

If yes, please describe

_____
_____
_____
_____
_____
_____
_____

a. If yes, when did you return to work or school after the baby was born?

_____ weeks

b. If yes, who provided baby care?

❒ A relative or friend
❒ Licensed home-based provider
❒ Private day care facility
❒ Private day care facility
❒ Other *(specify)*

_____
_____
_____

9. Approximately how many hours per day, on average, was your new baby in the same room with someone who was smoking?

_____ hours
❒ My baby was never in the same room with someone who was smoking

10. How did you put your new baby down to sleep most of the time? *(Check one answer)*

❒ On his/her side
❒ On his/her back
❒ On his/her stomach
❒ Sitting, as in a car seat
❒ Varies *(specify)*

_____
_____
_____

❒ Back and stomach
❒ Back and side
❒ Stomach and side

11. Did you have a crib or bassinet for the baby?

❒ Yes
❒ No

a. How often did the baby sleep in it?

❒ Always *(Skip to question 12)*
❒ Usually
❒ Half the time
❒ Occassionally
❒ Never

b. Where else did the baby sleep?

❒ Crib
❒ Play pen
❒ Couch/sofa
❒ Adult bed
❒ Car seat
❒ Swing
❒ Other *(specify)*

_____

12. After the baby came home, did you receive financial help or support from any program or organization?

❒ Yes
❒ No

(If yes, check all that apply)

❒ Mental health service
❒ Medicaid
❒ Financial planning
❒ Methadone maintenance program
❒ Genetic evaluation/counseling
❒ Employment office
❒ Family planning
❒ Child protective services
❒ WIC
❒ Ongoing social work case management
❒ Housing authority
❒ PHN home assessment/follow-up
❒ Group shelters
❒ Smoking cessation program
❒ Homemaker/home health aide
❒ Other *(specify)*

_____
_____
_____

13. About how many times had your baby been to a doctor or nurse for baby shots or routine well baby care?

_____ times
❒ None
❒ Don't remember

14. Did any of these things keep your baby from having routine well baby care? ***(Check all that apply)***

❒ I didn't have enough money or insurance to pay for it
❒ I couldn't get an appointment
❒ I did not know where to go
❒ I had no way to get the baby to the clinic or office
❒ I didn't have anyone to take care of my other children
❒ Other *(specify)*

_____
_____
_____

15. When your baby went for routine well baby care, where did you take him/her most of the time? ***(Check all that apply)***

❒ Private doctor's office
❒ Managed care center
❒ County or city health department
❒ Hospital clinic
❒ Community health center
❒ Hospital emergency room
❒ Don't remember
❒ Other *(specify)*

_____
_____
_____

16. Did your baby have any chronic health problem? (Interviewer: ask only if question seems relevant.)

❒ Yes
❒ No *(If no, skip to question 18)*
❒ Don't remember

If yes, please describe

_____
_____
_____
_____
_____
_____
_____

17. When your baby was at home with you, did he/she develop any of the following problems or illnesses? Do not include problems or illnesses that occurred when the baby was in the hospital.

❒ Yes
❒ No

(If yes, check all that apply)

❒ Cold	_____ times
❒ Fever	_____ times
❒ Eye infection	_____ times
❒ Ear infection	_____ times
❒ Vomiting	_____ times
❒ Diarrhea	_____ times
❒ Injury from a bad fall or accident	_____ times
❒ Other illness *(specify)*	_____ times

18. After the baby came home, approximately how many times did you take the baby to the doctor *because he or she was sick*?

_____ times
❒ None *(If none, skip to question 21)*
❒ Don't remember

19. Have you ever had a problem paying for medical care when your baby was sick?

❒ Yes
❒ No
❒ Don't remember

20. Did any of these things keep your baby from receiving care when sick? *(Check all that apply)*

❒ I didn't have enough money or insurance to pay for it
❒ I couldn't get an appointment
❒ I did not know where to go
❒ I had no way to get the baby to the clinic or office
❒ I didn't have anyone to take care of my other children
❒ Other *(specify)*

_____
_____
_____

21. How did you pay for the baby's medical expenses? (Include both sick and well baby care) *(Check all that apply)*

❒ Private insurance
❒ Medicaid
❒ Managed care organization (MCO)
❒ Self pay
❒ Military (specify)

_____
_____
_____

❒ Other *(specify)*

_____
_____
_____

22. Did your child receive any other health program assistance?

❒ Yes
❒ No

If yes, check all that apply

❒ Public health nursing home visits or care
❒ Respite/day care
❒ County/state funded medical care, treatments or equipment
❒ Infant child health program
❒ Social Security
❒ WIC
❒ Physically handicapped child program
❒ Other *(specify)*

_____
_____
_____

23. Where was the last place your baby received medical care before he/she died? (Do not include the hospital where your baby died or was taken after death.)

❒ Private doctor's office
❒ Managed care center
❒ County or city health department
❒ Hospital clinic
❒ Community health center
❒ Hospital emergency room
❒ Don't remember
❒ Other *(specify)*

_____
_____
_____

24. Please tell me about the baby's health after the last visit

_____
_____
_____
_____
_____
_____
_____

Interviewer: There are just a few more questions about the baby. These questions are about the times the baby was in the hospital.

25. After your baby came home from the hospital after delivery, did he/she have to go back into the hospital overnight for any reason?

❒ Yes
❒ No *(If no, go to question 27)*

a. Why was your baby hospitalized?

_____
_____
_____
_____
_____
_____
_____

❒ Don't know

b. Approximately how many nights was your baby in this hospital?

_____ nights
❒ Don't know

Why was your baby hospitalized the last time? ***Please tell me about this experience***

_____

_____

_____

_____

_____

_____

_____

26. How old was your baby when admitted to this hospital for the last time?

_____ weeks or _____ months

27. Babies sometimes receive many health and social services. At any time, do you feel that your baby was ever treated differently or unfairly in getting any of these services?

❒ Yes
❒ No

If yes, please specify all reasons that apply

❒ Race
❒ Culture/ethnic background
❒ Citizenship status
❒ Marital Status
❒ Type of insurance
❒ Ability to pay for services
❒ Other *(specify)*

_____

_____

_____

Is there anything else you would like to tell me about your baby's health?

_____

_____

_____

_____

_____

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_____

ABSTRACTOR'S NOTES (**Abstractor: Add any information that will help you summarize the case.)**

Data Entry Staff:

Is this record completely entered?

❒ Yes

❒ No

N A T I O N A L

NFIMR

FETAL– INFANT MORTALITY REVIEW PROGRAM

Home Interview Supplement: Special SIDS Questions

Client I.D. #:

DATA ABSTRACTION FORM

National Fetal and Infant Mortality Review Program

Interviewer: The mother may have answered some or all of these questions at the beginning of the interview. If so, do not repeat them.

1. Where was the baby last placed for sleep or a nap?

❒ Crib*
❒ Play pen*
❒ Couch/sofa*
❒ Adult bed*
❒ Car seat
❒ Swing
❒ Other

***When the baby died, was s/he sharing a crib, bed, sofa or play pen with others?**

❒ Yes
❒ No

If yes, please tell me with whom and what are their ages and weights.

_____

_____

_____

_____

2. What types and numbers of layers of bedding were both over and under the baby (not including wrapping blanket)?

Bedding UNDER Infant	None	Number	Bedding OVER Infant	None	Number
Receiving blankets			Receiving blankets		
Infant/child blankets			Infant/child blankets		
Infant/child comforters (thick)			Infant/child comforters (thick)		
Adult comforters/duvets			Adult comforters/duvets		
Adult blankets			Adult blankets		
Sheets			Sheets		
Sheepskin			Sheepskin		
Pillows			Pillows		
Rubber of plastic sheets			Rubber of plastic sheets		
Other *(specify)*_____					

3. Which of the following devices were in the baby's room?
- ❒ None
- ❒ Apnea Monitor
- ❒ Humidifier
- ❒ Vaporizer
- ❒ Air Purifier
- ❒ Other *(specify)*

_____

4. How would you describe the temperature of your baby's room that last day?
- ❒ Hot
- ❒ Cold
- ❒ Normal
- ❒ Other *(specify)*

_____

5. How would you describe your baby's temperature that last day?
- ❒ Hot
- ❒ Cold
- ❒ Normal
- ❒ Other *(specify)*

_____

6. Which of the following items were near your baby's face, nose, or mouth?
- ❒ Bumper pads
- ❒ Infant pillows
- ❒ Positional supports
- ❒ Stuffed animals
- ❒ Toys
- ❒ Other *(specify)*

_____

7. Which of the following items were within your baby's reach?
- ❒ Blankets
- ❒ Toys
- ❒ Pillows
- ❒ Pacifier
- ❒ Nothing
- ❒ Other *(specify)*

_____

ABSTRACTOR'S NOTES: (Add any information that will help you summarize the case.)

Data Entry Staff:

Is this record completely entered?

- ❒ Yes
- ❒ No

The History of the NFIMR Data Abstraction Forms and Software

From the inception of the FIMR process in the mid 1980s, it was apparent that each local FIMR program would need some type of standardized data abstraction protocols and a basic software application to store the standardized case data, analyze case review team deliberations and perhaps aggregate a few select priority cross tabulations from individual case data. Those few early local FIMR programs that actually developed their own data abstraction forms and software from scratch found that this process was extremely time consuming (at least 1½ to 2 years work), costly and left the FIMR program without any visible results to show their community for its first years of operation. A few projects even become over involved in this development phase and never moved past it.

To assist projects to start-up the FIMR process in a timely way, in 1992, the National Fetal and Infant Mortality Review Program (NFIMR) first developed standardized data abstraction forms and accompanying software using DOS as the platform. It was thought that, if projects would use these forms and software, they could move more quickly to implement FIMR and focus on improving local service systems and resources, rather than become mired in questionnaire and software development. In 1996, with additional support from the Robert Wood Johnson Foundation, NFIMR totally revamped this 1992 standardized data package with input from three state Health Departments that had already developed FIMR data abstraction forms and software including South Carolina, Massachusetts, and New York. Representatives from the three states decided to revise the existing forms developed by the Infant Mortality Review Program in New York State Department of Health. NFIMR also contracted with R&D Systems in Canandaigua, New York to develop accompanying software titled *NFIMR for Windows*. FoxPro was used as the platform for software development. The *NFIMR for Windows* software stored case data, and created case summaries for review team utilization, cross tabulations and graphs.

From 2004 through 2007, the Centers for Disease Control and Prevention, National Center for Birth Defects and Developmental Disabilities provided additional supports to update the data abstraction forms and to include more information in them about fetal alcohol spectrum disorder (FASD). The update was accomplished with input from a broad panel of national public health and provider experts (See Acknowledgements). Accompanying software has once again been developed by R&D Systems using ACCESS as the platform.

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