SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

South Carolina Very Low Birthweight Self-Monitoring Tool

1. Hospital: _____ City: _____
   Medical Record Number of mother: _____ Medical Record Number of infant: _____
2. ☐ Live Birth (<1500g) OR ☐ Fetal Death (>350 grams or 20 weeks by OB estimate of gestation)
3. ☐ Singleton; ☐ Multiple Gestation: Infant is____of____ (e.g.: Infant is 1 of 3)

SECTION I – PRENATAL CARE

Total number of prenatal care_____ Week of pregnancy at first prenatal visit _____

SECTION II – MATERNAL REPRODUCTIVE AND MEDICAL HISTORY

5. Maternal Age____; Gravida___ Para: Term___ Preterm____ Ab___ Living___; IUFD (≥ 20 weeks) ____

SECTION III – HOSPITAL ADMISSION, MEDICAL RISK FACTORS AND OB HISTORY

6. Admission Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
7. Obstetric estimate of gestation at admission (in weeks, by ultrasound if available) _____
8. Status of cervix and membranes on admission:
   Dilatation _____ Effacement _____ Station_____ Intact_____ Ruptured _____
   Comment_____
   Date and Time Membranes Ruptured: Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM

9. **Medical Risk Factors:**
   - ☐ Cardiac Disease
   - ☐ Renal Disease
   - ☐ Hematological Disease
   - ☐ Immunologic Disease
   - ☐ Neurologic Disease
   - ☐ Respiratory Disease
   - ☐ Other: specify_____

10. **Obstetrical History** (please check all current and past conditions)

Condition	Current pregnancy	Past	Condition	Current pregnancy	Past
Abnormal presentation			Macrosomic infant		
Abruptio placenta			Maternal anemia		
Cervical cerclage			Oligohydramnios		
Chorioamnionitis			Premature Rupture of Membranes (PROM)		
Congenital anomalies			Preterm labor		
Cord prolapse			Progesterone/17P rec'd		
Diabetes: ☐ Pre-pregnancy diabetes ☐ Gestational diabetes			Rh sensitization/Blood group incompatibility		
Growth restricted fetus (IUGR)			Substance abuse		
			Infections during pregnancy (STDs, group B strep, HIV) (Please list all conditions)	---------- ---------- ---------- ---------- ---------- ---------- ----------	---------- ---------- ---------- ---------- ---------- ---------- ----------
Hyperemesis Gravidarum					
Hypertensive disorders: ☐ Pre-pregnancy (chronic hypertension) ☐ Pregnancy-induced hypertension, preeclampsia ☐ HELLP Syndrome					

11. Was a Perinatal Regional Center contacted for a referral of the mother prior to delivery?
    - ☐ Yes, Date/time of contact: Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
    - ☐ No, Please comment: _____
12. Duration of labor in hours: Labored at home____hours; Labored in hospital____hours; Total hours _____
13. What type of providers participated in the delivery? (Check all that apply)
    - ☐ Maternal / Fetal Medicine Specialist
    - ☐ Obstetrician
    - ☐ Family Practitioner
    - ☐ Certified Nurse Midwife
    - ☐ Other physician_____
14. Intended source of payment for the delivery admission: (Check primary)
    - ☐ Medicaid
    - ☐ Commercial Insurance/Blue Cross/HMO
    - ☐ Other: Specify_____
    - ☐ Self pay
    - ☐ Military/Tricare

SECTION IV – DELIVERY

15. Place of delivery: ☐ Hospital ☐ Other _____
16. Method of delivery: (Check all that apply)
    - ☐ Vaginal birth
    - ☐ Forceps assisted
    - ☐ Vacuum assisted
    - ☐ Repeat C-section
    - ☐ Primary C-section
    - ☐ VBAC
    - ☐ Failed VBAC
17. Date and time the infant was born: Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
18. Birthweight: _____ Grams; _____lbs. _____oz.
19. Gestational age by infant examination in weeks: _____
20. Which of the following respiratory/oxygenation support were provided for the infant after birth? (Check all that apply)
    - ☐ Supplemental Oxygen > 2 hrs
    - ☐ Nasal CPAP > 2 hrs
    - ☐ Endotracheal intubation
    - ☐ Respirator support _____hrs.
    - ☐ Bag mask ventilation
    - ☐ Surfactant therapy
    - ☐ Neonatal resuscitation with chest compressions
    - ☐ None

SECTION V – REGIONAL PERINATAL CENTER CONSULTATION FOR NEWBORN

21. Was the Regional Perinatal Center contacted for consultation or transfer of the infant? ☐ Yes or ☐ No
22. If yes, what were the date and time of the initial phone call made to perinatal center regarding transfer of the infant? Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
23. If not transferred, check reasons not transferred? (Check all appropriate)
    - ☐ Died prior to transport
    - ☐ Medical condition did not require Level III care
    - ☐ Transport team/vehicle not available. Specify RPC contacted _____
    - ☐ Comments: _____
    - ☐ Non-viable infant
    - ☐ Family denied transfer

SECTION VI – DISPOSITION OF THE NEWBORN

24. What was the disposition of the infant from the delivering hospital?
    - ☐ Discharged to home/guardian: Date: (mm/dd/yy) _____/ Time:_____☐ AM ☐ PM
    - ☐ Transferred to another hospital- Receiving hospital name: _____
      Transfer Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
    - ☐ No Level III beds available. Specify RPC contacted_____
    - ☐ Died: Date: (mm/dd/yy)_____ Time:_____☐ AM ☐ PM
      Cause of Death: _____

At the time of infant discharge, please submit this form to SC DPH Bureau of Maternal and Child Health via e-mail at VLBWForm@DPH.SC.GOV or by fax to (803) 898-2065, Attn: VLBW form. **Please do not include patient names.**

Instructions for Completing 1839-ENG-DPH
Very Low Birthweight Self-Monitoring Tool

As required by Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Level I and II South Carolina hospitals are required to review all live births or fetal/neonatal deaths in which the neonate weighed at least 350 grams and less than 1500 grams at birth, utilizing the Department's Very Low Birthweight Self-Monitoring Tool."

A state and national goal is that 90% of VLBW births occur in Level III or above hospitals, as this is shown to reduce neonatal mortality. There are times when the decision is made, in consultation with the Regional Perinatal Center, to deliver a VLBW infant in a Level I or II facility. Review of these high-risk deliveries allows for surveillance of the statewide system of communication and care for our state's mothers and infants.

Explanation and Definition: Entries on the Very Low Birthweight Self-Monitoring Tool reflect information obtained through review of perinatal records, hospital records, and electronic birth certificate data and are specific to a mother and her neonate. The form should be completed by a licensed Registered Nurse to assure quality and completeness of data. Sections I, II, III, and IV should be completed within a week of delivery and sections V and VI should be completed at time of infant's discharge.

At the time of infant discharge, please submit this form to SC DPH Bureau of Maternal and Child Health via e-mail at VLBWForm@DPH.SC.GOV or by fax to (803) 898-2065, Attn: VLBW form. ***Please do not include patient names.***

Item by Item Instructions:

1. **Hospital:** Enter your hospital name and city.

   Medical Record Numbers: Enter the hospital medical record number of the mother and the infant.
2. **Live Birth or Fetal Death:** Identify whether infant was live birth or fetal death.
3. **Singleton Birth or Multiple Gestation:** Please mark appropriate box. If multiple gestation, enter the number in the space (e.g. 1 of 3).

SECTION I – PRENATAL CARE

4. Enter the **total number of prenatal care visits** mother received and the **week of pregnancy at the first prenatal visit.**

SECTION II – MATERNAL REPRODUCTIVE AND MEDICAL HISTORY

5. **Maternal Age** Enter the age of mother at time of delivery.
   Gravida Enter the number of times the mother has been pregnant.
   Term Enter the number of term babies the mother has delivered.
   Preterm Enter the number of premature babies (<37 weeks) the mother has delivered.

Ab Enter the number of pregnancies ending in abortion – spontaneous and induced.

Living Enter the number of children currently alive.

Fetal Deaths (IUFD) Enter the number of fetal deaths (≥ 20 weeks)

SECTION III – HOSPITAL ADMISSION, MEDICAL RISK FACTORS AND OB HISTORY

6. **Admission:** Enter the date and time mother was admitted to hospital.
7. **Obstetric estimate of gestation at the time of admission**: Enter the estimated gestational age in weeks, by ultrasound if available**.**
8. **Status of cervix and membranes on admission:** Enter the cm of dilation and effacement, if know; enter station and status of membranes upon admission; enter date and time membranes ruptured.
9. **Medical risk factors:** Check all medical risk factors for mother noted upon admission.
10. **Obstetrical history:** Check all that apply to current pregnancy and past pregnancies.
11. **Perinatal Regional Center (RPC) contact:** Check yes or no to indicate if a RPC was contacted for consultation or referral of mother prior to delivery. If yes, enter the date and time of contact. If no, please comment.
12. **Duration of labor:** Enter to the nearest fraction of an hour the time mother labored at home, in the hospital, and total hours of labor.
13. **Type of providers at delivery:** Check all that apply.
14. **Source of payment:** Check primary payment for delivery.

SECTION IV – DELIVERY

15. **Place of delivery:** Indicate where the baby was born.
16. **Method of delivery:** Check all that apply.
17. **Date and time of delivery:** Enter the date and time of infant's delivery.
18. **Birthweight:** Enter the infant's birthweight in grams and in pounds and ounces.
19. **Estimated gestational age:** Enter the estimated gestational age of infant by examination in weeks.
20. **Respiratory support provided for infant:** Check all that apply.

SECTION V – REGIONAL PERINATAL CENTER CONSULTATION FOR NEWBORN

21. **RPC contacted:** Check yes or no to indicate if RPC contacted for transfer of infant.
22. **Date and time of contact:** If RPC contacted, enter the date and time of contact.
23. **Reasons not transferred:** If the infant was not transferred, check all the reasons.

SECTION VI – DISPOSITION OF THE NEWBORN

24. **Disposition of the newborn:** Check the appropriate disposition of infant from delivering hospital. If infant transferred, write the name of the receiving hospital on line provided.

    Cause of death: If infant died in delivering hospital, enter the date, time and cause of death.

Recordkeeping: Per Regulation 61-16, the hospital shall retain the original form and a copy shall be sent to the Department of Public Health, Bureau of Maternal and Child Health.

At the time of infant discharge, please submit this form to SC DPH Bureau of Maternal and Child Health via e-mail at VLBWForm@DPH.SC.GOV or by fax to (803) 898-2065, Attn: VLBW form. ***Please do not include patient names.***