

OBSTETRICS ABSTRACTION FORM

This form applies to ALL enrolled BPOS Participants
Complete after delivery

Date of Data Abstraction:	____ / ____ / ____ DD MMM YYYY	Initials of Data Abstractor:	
Participant Full Name:			Participant Date of Birth:
Participant National ID		Provincial Folder Number: specify 3 letter facility prefix; GUP or other	
Source Document	☐ Maternity Case Record ☐ Delivery Register ☐ PMTCT Register (incl DISA/Trakcare) ☐ Other, Please Specify: _____		

MOTHERS DETAILS

Name of clinic		GA at 1st visit		Booking Date	____ / ____ / ____ DD MMM YYYY
Hb		Rhesus	Pos	Neg	Syphilis
HIV results	Pos	Neg	HIV retest	Pos	Neg
Regimen	☐ NR			ART Start Date	____ / ____ / ____ DD MMM YYYY
Estimated Gestational Age	Weeks: _____ If weeks not recorded: ☐ Term ☐ Preterm		Gestational Age estimated by	☐ Dates ☐ Palpitation ☐ SFH ☐ Ultrasound Scan ☐ Not Reported	

LABOUR DETAILS

Delivery Date	____ / ____ / ____ DD MMM YYYY	Delivery time	____ : ____
Fetal Heart	Present	Absent	uncertain
Fetal Distress	Y	N	NR
Place of Delivery	☐ GMOU ☐ MMH ☐ GSH ☐ Other, Specify: _____	Delivery Method <i>Please tick all methods used during this delivery</i>	☐ NVD ☐ C/S ☐ Induction of labour ☐ Vacuum ☐ Forceps ☐ BBA

If C/S, Primary indication	☐ Fetal distress ☐ Obstructed labour ☐ Twins/Triplets ☐ Pre-eclampsia / eclampsia ☐ APH ☐ Previous C/S ☐ Other, specify: _____	If by C/S, was it performed after membrane rupture?	☐ Yes, Duration: ____ Mins ☐ No ☐ NR
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Please tick all major medical and/or obstetric conditions the mother experienced during pregnancy and/or during delivery.	☐ Chorio amnionitis	☐ Sepsis	☐ UTI / Pyelonephritis
	☐ IUGR	☐ Hypertension	☐ Pre-eclampsia/ eclampsia
	☐ Diabetes mellitus	☐ Preterm labour	☐ APH
	☐ PPH	☐ Prolonged ROM	☐ Prolonged labour
	☐ Cervical tear	☐ Perineal tear	☐ Episiotomy
	☐ Other, Specify: _____		

INFANT DETAILS

Infant DOB	____ / ____ / ____ DD MMM YYYY	Infant DOB for Twin B	____ / ____ / ____ DD MMM YYYY
Gender	☐ Male ☐ Female	Gender Twin B	☐ Male ☐ Female
Outcome	☐ Alive ☐ Stillborn ☐ NND	Outcome Twin B	☐ Alive ☐ Stillborn ☐ NND
Resuscitation	☐ Yes ☐ No	Resuscitation Twin B	☐ Yes ☐ No
Birthweight	_____ g	Birthweight Twin B	_____ g
Head circumference	_____ cm	Head circumference Twin B	_____ cm
Length	_____ cm	Length Twin B	_____ cm
APGAR Score	1 min: _____ 5 min: _____	APGAR Score Twin B	1 min: _____ 5 min: _____
Congenital Abnormalities?	☐ Yes ☐ No ☐ NR Specify: _____	Congenital Abnormalities Twin B	☐ Yes ☐ No ☐ NR Specify: _____
Polio Vaccine?	☐ Yes ☐ No ☐ NR	Polio Vaccine Twin B	☐ Yes ☐ No ☐ NR
BCG Vaccine?	☐ Yes ☐ No ☐ NR	BCG Vaccine Twin B	☐ Yes ☐ No ☐ NR
NVP at birth?	☐ Yes ☐ No ☐ NR	Twin B NVP at birth?	☐ Yes ☐ No ☐ NR
Feeding Option	☐ Breast ☐ Formula		

DISCHARGE SUMMARY

Family planning choice	☐ Oral contraceptive ☐ Injectable ☐ IUD ☐ Implant ☐ Tubal ligation ☐ Other: _____
Date of discharge	____ / ____ / ____ DD MMM YYYY