**Maternal Newborn Health Registry**

**ENROLLMENT FORM**

This form should be completed by the Registry Administrator at the time the pregnant/delivered woman is screened and consented in the cluster (this may be any time during her pregnancy or after delivery). The goal is to enroll as early as possible; however, a woman may be enrolled at any point in pregnancy or after delivery.

### A. MATERNAL INFORMATION

1. Did mother enroll prior to delivery? 1|__|Yes 2|__|No- Skip to A3

2. Planned delivery location:
   1|__| Home → village ID|__|__|__|__|__|__|
   2|__| Facility → facility ID |__|__|__|__|__|__|
   3|__| Other, specify ___________________________________
   4|__| Don't know

3. Estimated delivery date: |__|__|-|__|__|-|__|__|__|__| (enter 999 if unknown) dd mm yyyy

4. Method to obtain estimated delivery date (EDD) *(Check all that apply)*
   1|__| Date of last menstrual period: a.|__|__|-|__|__|-|__|__|__|__| (enter 999 if unknown) dd mm yyyy
   2|__| Clinical exam
   3|__| USG  (enter 999 if unknown) dd mm yyyy
   4|__| Date unknown
   5|__| Other → c.

5. Maternal age at enrollment: |__|__| years (enter 99 if unknown)

6. Level of maternal schooling
   1|__|No formal schooling, illiterate 2|__| No formal schooling, literate
   3|__|Schooling → a. Years of schooling 1|__|__|
   4|__|Don’t know

7. Parity, excluding this pregnancy: |__|__| (enter 99 if unknown)

8. If you were pregnant (>20 wks) before this pregnancy,
   a. Did last pregnancy result in a live birth? 1|__|Yes 2|__|No
   b. Date of last delivery: |__|__|-|__|__|-|__|__|__|__| (enter 999 for parts or all of the date that are unknown)
   c. Maternal height: |__|__| (enter 999 if unknown)

9. Maternal height: |__|__| (enter 999 if unknown)

10. Maternal weight: |__|__| (enter 999 if unknown)
    a. Unit of measurement: 1|__| Kg 2|__| Lb
    b. Indicate timing of weight
       1|__| Pre-pregnancy or < 12 wks gestation 2|__| At visit
       3|__| Other → c.
    c. Method to determine weight
       1|__| Measured 2|__| Self Report 3|__| Not Available

11. Hemoglobin: |__|__|.|__|gm/dl  □ a. unavailable

### B. FORM COMPLETION

1. Date form completed: |__|__|-|__|__|-|__|__|__|__| dd mm yyyy

2. Name of person completing form: ____________________________________________
   a. ID: |__|__|__|__|
   b. If applicable, Code of BA reporting birth: |__|__|__|__|