# Maternal Newborn Health Registry

## PERINATAL FORM

This form should be completed by the Registry Administrator for all deliveries and all maternal deaths.

### A. STATUS of MOTHER and HEALTH CARE SERVICES

1. Did mother have any antenatal care?  
   - 1| Yes  
   - 2| No  
   - 3| Don’t Know (DK)
   
   a. If yes, how many antenatal visits did she have?  
   - 1|  
   - 2|  
   - 3|  

   b. If yes, estimated date of mother’s first antenatal care visit?  
   - d|m|m|yyyy (enter 999 if unknown)

2. Did mother receive any of the following during this pregnancy?  
   - 1| Yes  
   - 2| No  
   - 3| Don’t Know (DK)
   
   a. Tetanus toxoid vaccine  
   - 1|  
   - 2|  
   - 3|  

   b. Iron  
   - 1|  
   - 2|  
   - 3|  

   c. HIV test  
   - 1|  
   - 2|  
   - 3|  

   d. Blood pressure measurement  
   - 1|  
   - 2|  
   - 3|  

   e. Ultrasound for gestational age/other  
   - 1|  
   - 2|  
   - 3|  

3. Maternal status at visit:  
   - 1| Alive  
   - 2| Died

   If died, complete MN06 Maternal Mortality Form

4. Date of delivery:  
   - d|m|m|yyyy

5. Who conducted delivery? (Check one, highest level of provider)  
   - 1| Obstetrician  
   - 2| Non-OB Physician  
   - 3| Nurse/nurse midwife  
   - 4| Traditional Birth Attendant  
   - 5| Family (no health provider)  
   - 6| Self delivery  
   - 7| Other a.  
   - 8| Don’t Know

6. Where did delivery occur?  
   - 1| Hospital  
   - 2| Clinic/health center  
   - 3| Home in Village

   a. Facility Name  
   b. Facility ID  
   c. Village Name  
   d. Village ID

   4| Other

### B. MATERNAL TREATMENT (Complete for all women)

Maternal treatment provided  
- 1| Yes  
- 2| No  
- 3| Don’t Know (DK)

1. Antibiotics  
   - 1|  
   - 2|  
   - 3|  

2. Corticosteroids  
   - 1|  
   - 2|  
   - 3|  

3. Oxytocin or misoprostol  
   - 1|  
   - 2|  
   - 3|  

4. Blood transfusion  
   - 1|  
   - 2|  
   - 3|  

5. D&C or suction  
   - 1|  
   - 2|  
   - 3|  

6. Magnesium sulfate  
   - 1|  
   - 2|  
   - 3|  

7. Hysterectomy  
   - 1|  
   - 2|  
   - 3|  

8. Episiotomy  
   - 1|  
   - 2|  
   - 3|  

7. Mode of delivery  
   - 1| Vaginal (with forceps/vacuum)  
   - 2| Vaginal (without forceps/vacuum)  
   - 3| C-section  
   - 4| Miscarriage  
   - 5| Medical termination of pregnancy (MTP)

8. Did the mother have any of the following conditions? (during this pregnancy)  
   - 1| Yes  
   - 2| No  
   - 3| Don’t Know (DK)
   
   a. Obstructed/prolonged labor/failure to progress  
   - 1|  
   - 2|  
   - 3|  

   b. Major antepartum hemorrhage  
   - 1|  
   - 2|  
   - 3|  

   c. Major postpartum hemorrhage  
   - 1|  
   - 2|  
   - 3|  

   d. Evidence of hypertensive disease/severe pre-eclampsia/eclampsia  
   - 1|  
   - 2|  
   - 3|  

   e. Breech/transverse or oblique lie  
   - 1|  
   - 2|  
   - 3|  

9. Did the mother experience any symptoms or signs of life threatening illness at any time during the pregnancy, or at delivery?  
   - 1| Yes – COMPLETE MN07  
   - 2| No  
   - 3| Don’t Know
C. NEONATAL CONDITIONS AND OUTCOME

1. Fetal/Neonatal outcome
   1|__|Miscarriage(<20wks) → Skip to E1
   2|__|Medically terminated pregnancy (MTP) → Skip to E1
   3|__|Stillbirth → **no movement, heartbeat or gasping**
   4|__|Born alive, died before visit
   5|__|Born alive, alive at visit

*If stillborn or newborn died, complete MN05 cause of death form*

2. Sex of the baby: 1|__| Male 2|__| Female 3|__| DK
3. Birth weight: |__| |__| |__| |__| grams (if unknown enter ‘9999’)
4. Date baby weighed: |__| |__| |__| |__| |__| |__| |__| dd mm yyyy

5. If birth weight unknown, baby appeared to be:
   1|__| Very small (<1000g) 2|__| Small (1000–1499g) 3|__| Small to normal (1500–2499g) 4|__| Normal >2500g 5|__| Don’t Know

6. Was this a multiple birth? 1|__| Yes 2|__| No

*If Yes, complete MN02, MN03 data forms for twin using ID ending in 2, for triplets 3*

7. Was baby resuscitated?
   1|__| Yes 2|__| No → Skip to C9 3|__| DK → Skip to C9
8. If baby was resuscitated, was resuscitation with bag and mask?
   1|__| Yes 2|__| No 3|__| DK
9. Was baby placed on mother’s chest after delivery?
   1|__| Yes 2|__| No 3|__| DK 4|__| NA
10. Was baby bathed within 6 hours after delivery?
    1|__| Yes 2|__| No 3|__| DK 4|__| NA
11. Did baby breastfeed within 1 hour after delivery?

D. NEONATAL TREATMENT (Complete for all infants)

Neonatal treatment provided. Yes No DK
1. Antibiotics ........................................ 1|__| .... 2|__| .... 3|__|
2. CPAP .................................................... 1|__| .... 2|__| .... 3|__|
3. Oxygen .................................................. 1|__| .... 2|__| .... 3|__|
4. Ventilation ............................................. 1|__| .... 2|__| .... 3|__|
5. Medicinal eye care ........................................ 1|__| .... 2|__| .... 3|__|
6. Cord care .................................................. 1|__| .... 2|__| .... 3|__|

E. FORM COMPLETION

1. Date visit completed: |__| |__| |__| |__| |__| |__| |__| |__| dd mm yyyy
2. Name of person completing form: ________________________
   a. ID: |__| |__| |__| |__|
   b. If applicable, Code of BA reporting birth: |__| |__| |__| |__|
3. Location of data collection
   1|__| Home 2|__| Health Center 3|__| Hospital