Notification of Birth – To: National Perinatal Reporting System, Healthcare Pricing Office (HPO)

TYPE OF BIRTH (Live = 1, Still = 2) 1 ☐ PLACE OF BIRTH (Hospital = 1, BBA = 2, Domiciliary = 3) 2 ☐

NAME AND ADDRESS OF HOSPITAL _____

[redacted]

HOSPITAL NO. 3 ☐☐☐☐ CASE NO. 6 ☐☐☐☐☐☐☐☐ Y Y Y Y

INFANT'S DETAILS

DATE OF BIRTH (DD/MM/YYYY) 14 ☐☐☐☐☐☐☐☐

TIME OF BIRTH

IF MULTIPLE BIRTH ORDER OF BIRTH No. ☐ 22 of ☐ 23

[redacted]

SEX (Male = 1, Female = 2, Indeterminate = 3) 24 ☐

BIRTHWEIGHT 25 ☐☐☐☐ GRAMMES

PERIOD OF GESTATION 29 ☐☐ WEEKS

FATHER'S DETAILS

[redacted]

COUNTY _____ 31 ☐☐☐

COUNTRY _____ 34 ☐☐☐

NATIONALITY _____ 38 ☐☐☐

OCCUPATION _____ 42 ☐☐

DATE OF BIRTH (DDMMYYYY) 44 ☐☐☐☐☐☐☐☐

[redacted]

MOTHER'S DETAILS

[redacted]

COUNTY _____ 52 ☐☐☐

COUNTRY _____ 55 ☐☐☐

NATIONALITY _____ 59 ☐☐☐

OCCUPATION _____ 63 ☐☐

DATE OF BIRTH (DDMMYYYY) 65 ☐☐☐☐☐☐☐☐

[redacted]

CIVIL STATUS (Married = 1, Single = 2, Widowed = 3, Separated = 4, Divorced, = 5, Civil Partner = 6, Former Civil Partner = 7, Surviving Civil Partner = 8) 73 ☐

DATE OF PRESENT MARRIAGE/CIVIL PARTNERSHIP (DDMMYYYY) 74 ☐☐☐☐☐☐☐☐

DATE OF LAST BIRTH (live or still) (DDMMYYYY) 82 ☐☐☐☐☐☐☐☐

NO. OF PREVIOUS LIVE BIRTHS 90 ☐☐

CHILDREN STILL LIVING 92 ☐☐

STILLBIRTHS 94 ☐☐

SPONTANEOUS ABORTIONS 96 ☐☐

PERINATAL DEATH

TYPE OF DEATH (Early Neonatal = 1, Stillbirth = 2) 98 ☐

WAS AUTOPSY PERFORMED (Yes = 1, No = 2) 99 ☐

AGE AT DEATH 100 ☐ DAYS 101 ☐☐ HOURS

PLACE OF DEATH _____ 103 ☐☐☐

IF STILLBIRTH, DID DEATH OCCUR BEFORE LABOUR (1) DURING LABOUR (2) NOT KNOWN (3) 106 ☐

CAUSE OF DEATH

MAIN DISEASE OR CONDITION IN FOETUS OR INFANT _____

_____ 107 ☐☐☐☐☐☐☐

OTHER DISEASES OR CONDITIONS IN FOETUS OR INFANT _____

_____ 112 ☐☐☐☐☐☐☐

MOTHER'S HEALTH

ANTENATAL CARE THIS PREGNANCY (Hospital / Obstetrician = 1, G.P. Only = 2, Combined = 3, None = 4, Midwife Only=5) 117 ☐

DATE OF FIRST VISIT TO DOCTOR DURING PREGNANCY (DDMMYYYY) 118 ☐☐☐☐☐☐☐☐

DATE OF FIRST VISIT TO HOSPITAL DURING PREGNANCY (DDMMYYYY) 126 ☐☐☐☐☐☐☐☐

WAS MOTHER IMMUNE TO RUBELLA (Yes = 1, No = 2, Not Known = 3) 134 ☐

METHOD OF DELIVERY (Spontaneous = 1, Breech ± Forceps = 2, Forceps = 3, Vac. Extraction = 4, Caesarean Sec. = 5, Other = 6) 135 ☐

MAIN MATERNAL DISEASE OR CONDITION AFFECTING FOETUS OR INFANT

_____

_____ 136 ☐☐☐☐☐

OTHER MATERNAL DISEASES OR CONDITIONS AFFECTING FOETUS OR INFANT

_____

_____ 141 ☐☐☐☐☐

INFANT'S HEALTH

TYPE OF FEEDING (Artificial = 1, Breast = 2, Combined = 3) 146 ☐

WAS BCG ADMINISTERED (Yes = 1, No = 2) 147 ☐

MAIN DISEASE OR CONGENITAL MALFORMATION AFFECTING INFANT

_____

_____ 148 ☐☐☐☐☐

OTHER DISEASES OR CONGENITAL MALFORMATIONS AFFECTING INFANT

_____

_____ 153 ☐☐☐☐☐

HOSPITAL

WAS ADMISSION BOOKED (Yes = 1, No = 2) 158 ☐

DATE OF MOTHER'S ADMISSION (DDMMYYYY) 159 ☐☐☐☐☐☐☐☐

DATE OF MOTHER'S DISCHARGE (DDMMYYYY) 167 ☐☐☐☐☐☐☐☐

DATE OF INFANT'S DISCHARGE (DDMMYYYY) 175 ☐☐☐☐☐☐☐☐

WAS INFANT TRANSFERRED TO OTHER HOSPITAL FOR MEDICAL REASONS (Yes = 1, No = 2) 183 ☐

IF 'YES', NAME OF HOSPITAL _____

_____

_____ 184 ☐☐☐

GENERAL PRACTITIONER ATTENDED BY MOTHER

[redacted]

Signature Date **BNF01/2014**