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Not Recorded

7. Was the patient referred to this hospital from another hospital or clinic? 1 0
8. Was the patient transferred from another hospital? 1 0
9. Was the patient alive at discharge? 1 0

10. EDC (by best OB estimate on admission note)

<input type="checkbox"/> <input type="checkbox"/>	/	<input type="checkbox"/> <input type="checkbox"/>	/	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Month		Day		Year

11. How was the pregnancy dated?

- Last Menstrual Period (LMP) only
- LMP consistent with first trimester ultrasound (<14 weeks)
- LMP consistent with second trimester ultrasound (14 0/7 - 27 6/7 weeks)
- LMP consistent with third trimester ultrasound (≥ 28 weeks)
- First trimester ultrasound only (<14 weeks)
- Second trimester ultrasound only (14 0/7 - 27 6/7 weeks)
- Third trimester ultrasound only (≥ 28 weeks)
- Assisted reproductive technology (ART)
- Not documented

B. SIGNS AND SYMPTOMS

Signs and Symptoms – (Increasing or New Onset)

12. Did the patient present with, or develop during this admission, any of the following signs or symptoms?

- | | <u>Yes</u> | <u>No/NR</u>
Not Recorded |
|---|----------------------------|------------------------------|
| a. Headache | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| b. Blurry vision | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| c. Right upper quadrant pain or epigastric pain | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| d. Nausea, vomiting | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| e. Vaginal Bleeding | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| f. Seizure | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

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C. MEDICAL AND SOCIAL HISTORY

13. Was there documentation of any of the following:

- | | <u>Yes</u> | <u>No/NR</u>
Not Recorded |
|--|----------------------------|------------------------------|
| a. Diabetes prior to pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| b. Gestational diabetes in prior pregnancies | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| c. Gestational diabetes in current pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| d. Hypertension prior to pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| e. Gestational hypertension in prior pregnancies | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| f. Gestational hypertension in current pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| g. Preeclampsia in prior pregnancies | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h. Preeclampsia in current pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| i. Thyroid disease | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| j. Smoking prior to current pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| k. Smoking during pregnancy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| l. Known seizure disorder | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

D. PHYSICAL EXAM

Vital Signs Intrapartum (excluding intra-operative). A qualifying blood pressure for gestational hypertension is systolic ≥ 140 or diastolic ≥ 90 . For severe, qualifying blood pressure is systolic ≥ 160 or diastolic ≥ 110 . If a systolic BP ≥ 160 or diastolic BP ≥ 110 was documented, record the first severe BP and subsequent highest BP 4-240 hours after the first severe BP. If a documented systolic BP ≥ 140 and <160 or diastolic BP ≥ 90 but <110 , record the first qualifying BP and subsequent highest BP 4-240 hours after the qualifying BP

14. Was a systolic BP ≥ 140 or diastolic BP ≥ 90 documented? 1 Yes 0 No/NR

	Date	Time	Systolic / Diastolic
a. Initial qualifying blood pressure (must be prior to 24 hrs postpartum)	a1 <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	a2 <input type="text"/> : <input type="text"/> <input type="text"/> Hour Min AM/PM	a3 <input type="text"/> / <input type="text"/> a4 <input type="text"/> <input type="text"/>
b. Confirming qualifying blood pressure (within 4-240 hours of initial BP)	b1 <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	b2 <input type="text"/> : <input type="text"/> <input type="text"/> Hour Min AM/PM	b3 <input type="text"/> / <input type="text"/> b4 <input type="text"/> <input type="text"/>

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15. Was the patient treated with new or increased dosage of anti-hypertensive medications during this admission? 0 No 1 Yes 9 NR

16. Was a sterile vaginal exam done at admission? (if No/NR, skip to question 17) 0 No 1 Yes 9 NR

a. Dilation cm

b. Effacement %

E. BIOCHEMICAL TESTS

17. Are there any available prenatal records/data? 1 Yes 0 No/NR (if No/NR, skip to question 18)

a. Was a baseline 24-hour urine completed? 1 Yes 0 No/NR (if NR, skip to 17b.)

a1. Date

//

a2. Total urine volume

, ml

a3. Total protein

,

units? 1=mg/24 hours or 2= mg/dl

b. Was a 50 g Glucose loading test completed? (Report most recent) 1 Yes 0 No/NR (if No/NR, skip to question 17c)

b1. glucose mg/dL

b2. Date: //

c. What type of oral glucose tolerance test (OGTT) was done? (report most recent or best documented)

100 g load

75g load

Test performed, but type of glucose load not documented

Not performed/Not recorded (skip to item d.)

If OGTT performed:

c.1. Date of OGTT: //

c.1a. Were discrete values reported? 1 Yes 0 No
(if Yes, disable c2 and c3. If No, skip to c2)

Results of OGTT?

c.1b. Fasting glucose mg/dL

c.1c. 1 hour glucose mg/dL

c.1d. 2 hour glucose mg/dL

c.1e. 3 hour glucose mg/dL

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c.2. If discrete values were not reported, was the number of abnormal values noted? 1 Yes (disable c3) 0 No (skip to c3)

c.2a Number of abnormal values:

- 0/4
- 1/4
- 2/4
- 3/4
- 4/4 (4 or more tests)

c.3. If OGTT documented as performed, but neither values nor number of abnormal values was recorded, what was documented?

- normal OGTT
- abnormal OGTT
- no result documented

d. Was a prenatal outpatient Hgb A1c recorded? 1 Yes 0 No/NR (skip to item 17e)

	a. Value	b. Date
d.1. First Hgb A1c (\leq 20 weeks gestation)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
d.2. First Hgb A1c ($>$ 20 weeks gestation)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

e. Was prenatal outpatient blood pressure recorded for $<$ 20 weeks or \geq 20 weeks? 1 Yes 0 No/NR (skip to item 18)

	a. Value	b. Date
e1. Highest systolic BP (\leq 20 wks gestation)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
e2. Highest systolic BP ($>$ 20 wks gestation)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
e3. Highest diastolic BP (\leq 20 wks gestation)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
e4. Highest diastolic BP ($>$ 20 wks gestation)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

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f. Is data on gestational weight gain available?

1 Yes 0 No/NR
(If No/NR, skip to 18)

f1. Pre-Pregnancy weight: .

f1a. Units 1 kg 2 lb 9 NR

f2. First visit weight: .

f2a. Units 1 kg 2 lb 9 NR

f2b. Date: //

f3. Last visit weight: .

f3a. Units 1 kg 2 lb 9 NR

f3b. Date: //

g. Is there documentation of outpatient medication to treat gestational diabetes?

1 Yes 0 No/NR
(If No/NR, skip to 18)

g1. Insulin 1 Yes 0 No/NR

g2. Glyburide 1 Yes 0 No/NR

g3. Metformin 1 Yes 0 No/NR

g4. Other 1 Yes 0 No/NR

g4a Specify _____

18. Most recent assessment of proteinuria

a. Was a 12 or 24 hour urine test done?

1 Yes 0 No/NR

a1. Date

//

a2. Total volume

,mL

a3. Total protein, mg

,

a4. Total creatinine, g

,

a5. Duration

12h 24h

b. Was the last urine protein: creatinine ratio recorded?

1 Yes 0 No/NR

b1. Date

//

b2. Value

.

19. Tests during this admission

a. Was any platelet count recorded?

1 Yes 0 No/NR

a1. Lowest platelet count value

x1000

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b. Was any AST (SGOT), U/L value recorded?

1 Yes 0 No/NR

b1. Highest AST or SGOT Value

--	--	--	--

b.2. Was a lab upper limit for AST or SGOT recorded?

1 Yes 0 No/NR

b2a. Upper limit for AST or SGOT

--	--	--	--

c. Was an ALT, U/L value recorded?

1 Yes 0 No/NR

c1. Highest ALT value

--	--	--	--

c.2. Was a lab upper limit for ALT, U/L recorded?

1 Yes 0 No/NR

c2a. Upper limit for ALT

--	--	--	--

d. Was a serum creatinine, mg/dL value recorded?

1 Yes 0 No/NR

d1. Highest serum creatinine value

		.		
--	--	---	--	--

e. Was a uric acid value recorded?

1 Yes 0 No/NR

e1. Highest value

		.		
--	--	---	--	--

f. Was an LDH, U/L value recorded?

1 Yes 0 No/NR

f1. Highest value

--	--	--	--	--

g. Was the admission hematocrit (%) recorded?

1 Yes 0 No/NR

g1. Value

		.	
--	--	---	--

h. Was the post-delivery hematocrit (%) recorded?

1 Yes 0 No/NR

h1. Lowest value

		.	
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i. Pulmonary edema on x-ray or chest CT?

1 Yes 0 No/NR

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F. TREATMENTS

20. Were any of the following intrapartum treatments given during this visit?

a. Magnesium

- 1=None
- 2=Yes, for preeclampsia
- 3= Yes, for Preeclampsia and other indication
- 4=Yes, for tocolysis
- 5=Yes, for fetal neuroprotection (choose neuroprotection if given for tocolysis and neuroprotection)
- 6=Yes, other indication
- 7=Yes, indication not documented
- 9=Unsure/NR

- | | <u>Yes</u> | <u>No/NR</u> |
|---|----------------------------|----------------------------|
| b. Insulin (subcutaneous) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| c. Insulin (IV or drip) | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| d. Antihypertensives IV | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| e. Antihypertensives PO | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| f. Were steroids for fetal lung maturity including Betamethasone or Dexamethasone IM given to the mother ANYTIME DURING THIS PREGNANCY? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| f.1. If yes, was this for prematurity? | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| g. Tocolysis | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

G. BIRTH

21. Did the patient deliver during this hospitalization?

<u>Yes</u>	<u>No</u>	<u>NR</u>
1 <input type="checkbox"/>	0 <input type="checkbox"/>	9 <input type="checkbox"/>

If yes: a. Date of delivery: / /

b. Time of delivery: : (AM. or PM.)

22. Gestational age at delivery: a. weeks and b. days

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23. Type of labor? (If 2, 3, or 9, skip to 25)

- 1 No labor
- 2 Spontaneous
- 3 Spontaneous, augmented
- 4 Induced
- 9 Unsure/NR

24. If scheduled delivery (induced or had a C-Section w/o labor), what was the main indication? (Choose one)

<input type="checkbox"/> IUFD (intrauterine fetal demise)	<input type="checkbox"/> Hypertension / preeclampsia	<input type="checkbox"/> Elective
<input type="checkbox"/> Prior stillbirth	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Not documented
<input type="checkbox"/> Congenital malformation / fetal anomaly	<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Other
<input type="checkbox"/> IUGR (intrauterine growth restriction)	<input type="checkbox"/> PROM	<input type="checkbox"/> N/A
<input type="checkbox"/> Oligohydramnios	<input type="checkbox"/> Macrosomia	
<input type="checkbox"/> Non-reassuring fetal status	<input type="checkbox"/> Post-term	
<input type="checkbox"/> Abrupton	<input type="checkbox"/> Cholestasis	

24a. If other, specify reason: _____

25. If C-section, what was indication? (Choose one) (if N/A, skip to item 28)

<input type="checkbox"/> CPD	<input type="checkbox"/> Abrupton	<input type="checkbox"/> Macrosomia
<input type="checkbox"/> Failed induction / FTP	<input type="checkbox"/> Previa	<input type="checkbox"/> Elective
<input type="checkbox"/> Fetal distress	<input type="checkbox"/> Preeclampsia / hypertension	<input type="checkbox"/> Not documented
<input type="checkbox"/> Cord prolapsed	<input type="checkbox"/> Multiple gestation	<input type="checkbox"/> Other
<input type="checkbox"/> Malpresentation Twin A / Singleton	<input type="checkbox"/> Communicable disease	<input type="checkbox"/> N/A
<input type="checkbox"/> Malpresentation Twin B	<input type="checkbox"/> Previous C section	

25a. If other, specify reason: _____

26. If C-section, what type of skin incision? Vertical Pfannensteil NR
Not Recorded

27. If C-section, what type of uterine incision?

Low vertical Classical, other vertical Low Transverse T or J incision NR

28. Were any of the following complications or treatments experienced during this hospitalization?

	<u>Yes</u>	<u>No/NR</u>
a. Placental abrupton	1 <input type="checkbox"/>	0 <input type="checkbox"/>
b. Postpartum hemorrhage	1 <input type="checkbox"/>	0 <input type="checkbox"/>
c. Third degree laceration	1 <input type="checkbox"/>	0 <input type="checkbox"/>
d. Fourth degree laceration	1 <input type="checkbox"/>	0 <input type="checkbox"/>
e. Injury to viscera (bowel, bladder, other)	1 <input type="checkbox"/>	0 <input type="checkbox"/>

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- | | | |
|---|----------------------------|----------------------------|
| f. Intubation, other than for surgery | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| g. ICU admission | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h. Transfusion of: Packed red blood cells | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h.1. Platelets | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h.2. Cryoprecipitate | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| h.3. Fresh frozen plasma | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| i. Tubal ligation | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| j. Dilation & curettage | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| k. Hysterectomy | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| l. Intrapartum IV/IM narcotic | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| m. Intrapartum regional epidural | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| n. Intrapartum regional spinal | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| o. Intrapartum general anesthesia | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

H. INFANT(S)

29. How many infants were born? 1
 2
 3
 4
 NR

For each infant, document:

Infant	a. Birth weight	b. One minute apgar	c. Five minute apgar	d. Shoulder dystocia	e. Birth trauma	f. Stillbirth?	g. Type of delivery?	h. Sex
30.	1. Gms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2. Lbs. <input type="checkbox"/> <input type="checkbox"/> 3. Oz. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> SVD <input type="checkbox"/> FAVD <input type="checkbox"/> VAVD <input type="checkbox"/> Breech vaginal <input type="checkbox"/> C-section <input type="checkbox"/> NR/other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NR
31.	1. Gms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2. Lbs. <input type="checkbox"/> <input type="checkbox"/> 3. Oz. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> SVD <input type="checkbox"/> FAVD <input type="checkbox"/> VAVD <input type="checkbox"/> Breech vaginal <input type="checkbox"/> C-section <input type="checkbox"/> NR/other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NR
32.	1. Gms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2. Lbs. <input type="checkbox"/> <input type="checkbox"/> 3. Oz. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> SVD <input type="checkbox"/> FAVD <input type="checkbox"/> VAVD <input type="checkbox"/> Breech vaginal <input type="checkbox"/> C-section	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NR

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							<input type="checkbox"/> NR/other	
33.	1. Gms. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> NR	<input type="checkbox"/> SVD <input type="checkbox"/> FAVD <input type="checkbox"/> VAVD <input type="checkbox"/> Breech vaginal <input type="checkbox"/> C-section <input type="checkbox"/> NR/other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NR
	2. Lbs. <input type="checkbox"/> <input type="checkbox"/>							
	3. Oz. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							