

AMOSS ID CASE NUMBER \_\_\_\_\_



## GENERAL INFORMATION

This paper-based form is included in your folder for your information, and in case you do not have access to the internet and need to submit a Case – (*normally you would use the web-based survey to enter data*). If you need to use this form, please copy it first, along with the relevant condition/s.

### Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Please record the ID number on the front of this form against the woman's name in your log book (ID number obtained from on-line data system, or contact AMOSS).
3. Fill in the form using the information available in the woman's case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided at the end of this General Information or Condition form.
5. Please complete all dates in the format DD/MM/YY, unless otherwise indicated.
6. Please complete all times using the 24hr clock e.g. 14:34.
7. Definition of each variable is contained in the data dictionary.
8. If you encounter any problems with completing this form, please contact the AMOSS Project Coordinator or use the space at end of each section to describe the problem.

AMOSS ID CASE NUMBER \_\_\_\_\_

### Details about the person filling in this form

Name of person completing the form \_\_\_\_\_

Professional group	Midwife	<input type="checkbox"/>
	Anaesthetist	<input type="checkbox"/>
	Obstetrician	<input type="checkbox"/>
	Nurse	<input type="checkbox"/>
	Other – please specify	<input type="checkbox"/> _____

Date data form was completed    //

In the case of queries, you may find it useful to keep a copy of this form

Thank you.

**Section 1: Woman's details**

1.1	Age in years			<input type="checkbox"/>	<input type="checkbox"/>
1.2	Country of birth	_____			
1.3	<i>(Answer this only if you are entering the data from an Australian hospital)</i>				
	Indigenous status Aboriginal but not Torres Strait Islander origin			<input type="checkbox"/>	
	Torres Strait Islander but not Aboriginal origin			<input type="checkbox"/>	
	Both Aboriginal and Torres Strait Islander origin			<input type="checkbox"/>	
	Neither Aboriginal nor Torres Strait Islander origin			<input type="checkbox"/>	
	Not stated/inadequately described			<input type="checkbox"/>	
	<i>(Answer this only if you are entering the data from a New Zealand hospital)</i>				
	New Zealand European			<input type="checkbox"/>	
	Maori			<input type="checkbox"/>	
	Samoan			<input type="checkbox"/>	
	Cook Island Maori			<input type="checkbox"/>	
	Tongan			<input type="checkbox"/>	
	Niuean			<input type="checkbox"/>	
	Chinese			<input type="checkbox"/>	
	Other (please specify)			<input type="checkbox"/>	
	Chinese			<input type="checkbox"/>	
_____					
1.4	Is English the primary language spoken at home?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not known <input type="checkbox"/>	
1.5	Marital status	Never married <input type="checkbox"/>			
		Widowed <input type="checkbox"/>			
		Divorced <input type="checkbox"/>			
		Separated <input type="checkbox"/>			
		Married <input type="checkbox"/>			
		De facto <input type="checkbox"/>			
		Not stated <input type="checkbox"/>			
1.6	Residential postcode			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.7	Private health insurance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not stated <input type="checkbox"/>	
1.8	Height at booking (cm)			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> cm
1.9	Weight at booking (kg)			<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> kg
1.10	Smoking status	Never smoked <input type="checkbox"/>			
		Quit smoking before becoming pregnant <input type="checkbox"/>			
		Quit smoking during pregnancy (<20 weeks) <input type="checkbox"/>			
		Quit smoking during pregnancy (≥ 20 weeks) <input type="checkbox"/>			
		Continued to smoke during pregnancy <input type="checkbox"/>			
		Unknown <input type="checkbox"/>			
1.11	Was the woman on a methadone / buprenorphine program, or a known user of illicit drugs during pregnancy?				



- 4.6 Please select the model of care that **BEST** describes the model chosen by the woman at the onset of pregnancy.
- Private obstetrician
- Hospital-based medical
- General practitioner - Shared care  or General practitioner - hospital
- Hospital-based midwife/midwives  or Independent midwife
- Birth Centre (not located within a hospital) or publically funded homebirth
- No antenatal care
- Other  Specify \_\_\_\_\_
- 4.7 Did this model of care change during pregnancy or labour/birth?
- Yes  No  Unknown
- 4.8 What is the current status of this pregnancy?
- Given birth  Still pregnant

**Section 5: Labour and birth details**

- 5.1 Did the woman labour? YES  NO  UNKNOWN
- If yes, please state date and time of onset of labour      □□/□□/□□ □□:□□
- If no, go to 5.2
- 5.1a Was labour induced? YES  NO  UNKNOWN
- 5.1b Was labour augmented? YES  NO  UNKNOWN
- 5.1c Did the membranes rupture spontaneously?
- YES  NO  UNKNOWN
- 5.1d Was syntocinon used during labour?
- YES  NO  UNKNOWN
- 5.1e Was a prostaglandin used for labour?
- YES  NO  UNKNOWN
- 5.1f Length of labour 1<sup>st</sup> stage □□:□□ 2<sup>nd</sup> stage □□:□□ 3<sup>rd</sup> stage □□:□□
- 5.2 Was the baby born by caesarean section? YES  NO
- 5.2a If yes, please state the type of caesarean section
- Planned – no labour
- Planned - during labour
- Unplanned – no labour
- Unplanned – during labour
- 5.2b Please give the indication for caesarean section
- Abnormal CTG
- Delayed first stage
- Delayed second stage
- Maternal exhaustion

	Maternal illness – acute/new onset e.g. preeclampsia	<input type="checkbox"/>
	Maternal medical condition (chronic) e.g. cardiac history	<input type="checkbox"/>
	Other - please specify	<input type="checkbox"/>
<hr/>		
5.3	Please indicate any analgesia or anaesthesia used during labour and birth	
	Nil	<input type="checkbox"/>
	Nitrous oxide	<input type="checkbox"/>
	Systemic opioids	<input type="checkbox"/>
	Pudendal or caudal block	<input type="checkbox"/>
	Epidural	<input type="checkbox"/>
	Spinal	<input type="checkbox"/>
	Combined spinal – epidural	<input type="checkbox"/>
	General anaesthesia	<input type="checkbox"/>
	Other	<input type="checkbox"/>
5.4	Did any major maternal morbidity occur? ( <i>relevant for Control women only</i> )	YES <input type="checkbox"/> NO <input type="checkbox"/>
	If yes, please specify	
	_____	

<b>Section 6: Maternal Outcomes</b>		
6.1	Was the woman admitted to ICU?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.2	Was the woman admitted to HDU?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.3	Was the woman managed in BS(Birthing suite) postpartum?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.4	Was the woman transferred to/from another hospital?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.4a	When was the transfer made in relation to the event?	
	After diagnosis of major concern	<input type="checkbox"/>
	After critical event had occurred	<input type="checkbox"/>
6.4b	When was the transfer made in relation to labour?	
	Antenatal	<input type="checkbox"/>
	During labour	<input type="checkbox"/>
	Postpartum	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	If other, please specify _____	
6.5	Did the woman die?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.5a	If yes, please specify date and time of death	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6.5b	What was the primary cause of death, as stated on the death certificate?	
	_____	
6.5c	Was a postmortem examination undertaken?	YES <input type="checkbox"/> NO <input type="checkbox"/>



