Alabama Perinatal Regionalization System Guidelines Analysis Tool For Identifying Babies Born At Or <1,500 Grams At Birth

This form is for your facility use only. There may be some questions that you will not have answers.

Directions: Please complete one form on each birth of a **very low birth weight infant (<1,500 gm birth weight)** occurring at your facility. Please copy this form and use a separate form for each birth. Number each case for your identification purposes. Refer to the Alabama Perinatal Regionalization System Guidelines and the American Academy of Pediatrics: Levels of Neonatal Care for guidance. Both can be found at alabamapublichealth.gov/perinatal.

Patient ID#: ________________ Mother's presentation to the hospital: Date: ____________ Time: ___________

Mother presented to the hospital: ❍ In the ER ❍ To L&D Triage/Admit ❍ Direct Admit from Provider ❍ Other: ________________________ ❍ Unknown

Did the Mother of the baby receive prenatal care during the pregnancy? ❍ Yes ❍ No ❍ Unknown

Admission diagnosis: ____

Due date (EDC): ______________________ Estimated gestational age on admission: ______________________

Condition on arrival: ____

Labor status: ❍ Stage I ❍ Stage II ❍ Stage III ❍ Stage IV

Cervical exam performed: ❍ Yes ❍ No

If cervical exam was performed, how many cm dilated was the mother? ________________________________

Are there any documented health risks or conditions that would have indicated an immediate delivery?

❍ Yes ❍ No ❍ No documentation noted

If yes, check the condition(s) that are applicable:

❍ Hypertension ❍ Diabetes ❍ Obesity ❍ History of prior pre-term birth
❍ History of prior LBW delivery ❍ Trauma ❍ Maternal Infection ❍ Pre-eclampsia/Eclampsia
❍ PROM ❍ Placenta Previa ❍ Placental Abruption ❍ Other: ______________________________

Mother's insurance status: ❍ Medicaid ❍ Private Insurance ❍ Self-pay

Maternal transport request: ❍ No ❍ Yes If yes, provide the: Date: ______________ Time: ______________

Hospital(s) for maternal transfer contacted: ____

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Barriers to transporting the mother:____

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Reason maternal transport did not occur prior to delivery:____

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Delivery: Date ______________ Time ______________ Mode of delivery: ❍ Vaginal ❍ C-Section

Infant birth weight: ______________________ Gestational age (by clinical exam): ______________________

Apgar scores: ____

Resuscitation and support required: ❍ Yes ❍ No

If resuscitation and support were required, what type?

❍ Oxygen ❍ Mechanical Ventilation ❍ Continuous Positive Airway Pressure

❍ Conventional and/or High-frequency Ventilation ❍ Nitric Oxide

Neonatal transfer request: ❍ Yes ❍ No Date: ______________ Time: ______________

Hospital(s) for infant to be transferred to: ____

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If the infant was not transported to a level III or IV facility within 24 hours of birth, please explain why not:

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If the infant was not transported to a level III or IV facility within 24 hours, but received a transfer to a level III or IV facility later, provide the date of transfer: ______________ Time of transfer: ______________

Reason for transfer: ____

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Hospital(s) contacted: ____

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Barriers to transfer: ____

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If you have any questions, please contact by phone or email.

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