New York State Perinatal Quality Collaborative – Scheduled Delivery Form

Scheduled is defined as all inductions and cesarean sections prior to onset of labor between 36 0/7 and 38 6/7 weeks gestational age

A. Patient Demographics

1.Permanent Facility Identifier(PFI):	2. Facility Name:	3. Sequence Number:	‡Medical Record Number:
4. Admit Date (Month and Year): mm/yyyy	_____ / ______(mm/yyyy)	5. Maternal Age: ______years	6. NOTES:

Delivery Type		
7. Vaginal:	Spontaneous ☐	Operative ☐
8. Cesarean:	Primary ☐	Repeat ☐
9. Induced Labor:	Yes ☐	No ☐

10. Patient ethnicity:	Hispanic ☐ Non-Hispanic ☐ Ethnicity Unknown ☐
11. Patient race:	White ☐ Black or African American ☐ American Indian/ Alaskan Native ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ Some Other Race ☐ Race Unknown ☐
12. Primary Insurer:	Medicaid ☐ Uninsured ☐ Private ☐ Other ☐

B. Clinical Data

13. Final Gestational Age at Delivery:	____weeks ____days
14. Was gestational age documented in the chart?	☐Yes ☐No
15. Was gestational age of less than 39 weeks confirmed by one of the following? • First or second trimester ultrasound < 20 weeks • Fetal heart tones documented for 30 weeks by Doppler ultrasonography • 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result	☐Yes ☐No
16. Was fetal lung maturity documented by amniocentesis?	☐Yes ☐No
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?	☐Score ≥8 primigravida, ≥6 multigravida ☐ Determined, did not meet criteria ☐ Not measured or cannot be calculated

Patient Counseling

18. Was there documentation in the medical record that the maternal and fetal/newborn risks and benefits of scheduled delivery at 36 0/7 – 38 6/7 weeks were discussed with the mother?	☐Yes ☐ No

Reason for Scheduled Delivery

19. Was there documentation in the medical or prenatal record of the primary reason for scheduled delivery?	☐Yes ☐No

Which of the following was the PRIMARY reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial)

SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED)

20. Maternal Reasons for Scheduled Delivery ***SELECT ONLY ONE ***

Premature rupture of membranes	☐	Prepregnancy hypertension	☐	Hematological condition(specify in #23 below)	☐
Prolonged rupture of membranes	☐	Gestational diabetes	☐	Active genital herpes infection	☐
Chorioamnionitis	☐	Diabetes(Type I/II)	☐	Prior myomectomy	☐
Placental abruption	☐	Heart disease (specify in #23 below)	☐	Prior vertical or "T" incision c-section	☐
Placenta previa/Vasa previa	☐	Liver disease(specify in #23 below)	☐	History of poor pregnancy outcomes(specify in #23 below)	☐
Gestational hypertension	☐	Renal disease(specify in #23 below)	☐	History of fast labor (<3 hrs) and distant from hospital	☐
Preeclampsia/Eclampsia	☐	Pulmonary disease(specify in #23 below)	☐	HIV	☐
Other (specify in #23 below)					

 ‡Medical Record # and initials for site use only-will not be sent to NYSDOH

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	3. Sequence Number (from front of form):

21. Fetal Reasons for Scheduled Delivery ***SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED***

Oligohydramnios	☐	Intrauterine growth restriction (< 5th percentile for gestational age)	☐	Fetal demise	☐
Macrosomia–Sono EFW>5,000 gms	☐	Abnormal fetal testing (by NST, BPP, or continuous wave Doppler)	☐	Other (specify in #23 below)	☐
Major fetal anomaly	☐	Alloimmunization/fetal hydrops	☐		

22. Psychosocial Reasons for Scheduled Delivery

SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED

Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)	☐	Patient request – "Elective"	☐	Convenience of patient/doctor (includes scheduling difficulties)	☐
				Other (specify in #23 below)	☐

23.Specify (narrative as directed above)

____

____

____

24a. When 'Other' is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel? ☐Yes ☐ No ☐ Review Pending	Results of scheduled delivery review from Q24a: 24b. Medically indicated based on review? ☐Yes ☐No

Infant Outcome

25. Plurality – please enter the number of infants delivered: |______|	
26. Was any infant(s) admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours?	☐Yes ☐ No
27. If 'Yes': Number of days in NICU (Baby #1)	|___|___|___|
28. If 'Yes': Number of days in NICU (Baby #2)	|___|___|___|
29. If 'Yes': Number of days in NICU (Baby #3)	|___|___|___|

C. Data collection, entry and verification

30. Initials of individual *completing* this form:		‡Initials of obstetrician:	

D. Optional Data Collection (for site use only)

31. Optional Field for Data Collection(#1)	
32. Optional Field for Data Collection(#2)	
33. Optional Field for Data Collection(#3)	
34. Optional Field for Data Collection(#4)	
35. Optional Field for Data Collection(#5)	

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