

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 _____
 HOSPITAL NO. 3 CASE NO. 6 ADDRESS OF _____
 Y Y Y Y HOSPITAL _____

INFANT'S DETAILS

DATE OF BIRTH (DD/MM/YYYY) 14

TIME OF BIRTH _____

IF MULTIPLE BIRTH ORDER OF BIRTH No. 22 of 23

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

BIRTHWEIGHT 25 GRAMMES

PERIOD OF GESTATION 29 WEEKS

FATHER'S/PARTNER'S DETAILS

COUNTY _____ 52

COUNTRY _____ 55

NATIONALITY _____ 59

OCCUPATION _____ 63

DATE OF BIRTH (DDMMYYYY) 65

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

MISCARRIAGES 96

MOTHER'S DETAILS

COUNTY _____ 52

COUNTRY _____ 55

NATIONALITY _____ 59

OCCUPATION _____ 63

DATE OF BIRTH (DDMMYYYY) 65

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

MISCARRIAGES 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

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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
