FOUNDATION FOR Health Care Quality

OB COAP Data Collection Form
Version: 4.0: Implemented July 1, 2018

1900 NAME OF DATA ABSTRACTOR: _____

PATIENT DEMOGRAPHICS (1000)

Patient Name **1000** Last: _____ **1010** First: _____ **1020** MI:_____

1030 Date of Birth: _____/_____/_____ 1040 Medical Record Number: _____ 1045 Site Patient ID: _____

1050 Race:
- American Indian/Alaskan Native
- Native Hawaiian/Pacific Islander
- Asian-Far East
- Asian-Southeast
- Asian-Indian
- Asian-Unspecified
- White/Caucasian
- Black/African American
- Multiple Race/Ethnicity
- Other
- Not in record

1060 Hispanic/Latina Ethnicity: ☐yes

EPISODE OF CARE (2000)

2000 Admit Place _____

2010 Date/Time of Admission to L&D Service: ____/____/____ , ____:____

2020 Facility:
- Hospital
- Birth Center
- Home

2030 Patient Zip Code: _____ 2040 ☐ Zip Code N/A

Payor

2050 None/No Insurance: ☐yes

2060 Commercial Health Insurance: ☐yes

2061 Type of Commercial/Private (select primary):
- Regence
- Premera
- First Choice
- Aetna
- Cigna
- United Healthcare
- Group Health
- Kaiser
- Uniform Medical
- Other Commercial

2070 Government Health Insurance: ☐yes

- 2080 Medicare ☐yes
- 2090 Medicaid ☐yes
- 2100 Military Health Care ☐yes
- 2110 State-Specific Plan ☐yes
- 2120 Indian Health Svc ☐yes

2130 Non-US Insurance: ☐yes

2131 Accountable Care Network Patient:
- UW Medicine ACN
- PSHVN ACN
- Not Applicable

2133 Health Plan Type:
- PEBB
- Boeing
- Premera

2132 Accountable Care Network Patient ID #_____

2140 Current Pregnancy:
- Singleton
- Twins
- Multiple

2141 IVF Pregnancy: ☐yes

2151 Chorionicity/Amnionicity:
- Dichorionic Diamniotic
- Monochorionic Diamniotic
- Monoamniotic
- Not Determined Prenatally

2160 Intrapartum Transfer: To Higher Level of Care
Received From
No Transfer

2170 Intrapartum Transfer to Higher Level of Care: maternal reasons
fetal reasons

2171 Intrapartum Transfer to Location: _____
(Name of hospital)

2180 Date/Time of Transfer: ____/____/_____ ____:____

2190 Intrapartum Transfer Received From: Another hospital
Birth Center
Home Birth Attempt
This Hospital's Antepartum Service

2191 Name of Transferring Hospital: _____
2192 Name of Transferring Birth Center/Home Birth Provider: _____

3160 First Prenatal Visit Date: ___/___/___

Weight and Height

2200 Initial Wt. Collected in: Pounds
Kilograms
Not Available

2210 Initial Wt. # Pounds: _____
2220 Initial Wt. # Kilograms: _____

2240 Final Weight Collected in: Pounds
Kilograms
Not Available

2250 Final Wt. # Pounds: _____
2260 Final Wt. # Kilograms: _____

2229 Initial Wt. done at 1st Prenatal Visit: ☐yes

2230 Initial Wt. Date/Time **(Add If 2229=NO)**: ___/___/___

2270 Final Wt. Date/Time: ___/___/___

2280 Height Collected in: Inches
Centimeters

2290 Height # Inches: _____
2300 Height # Centimeters: _____

OB GYN HISTORY (3000)

3000 Gravidity #:_____

3010 #Liveborn:_____ 3016 #Liveborn Preterm _____ 3017 Liveborn Preterm Gestational Age: _____
(#2 GA____, #3 GA____, #4 GA____, #5 GA____)

3020 #Stillborn >20 wks: _____ 3021 Stillborn Gestational Age: _____ 3022 17 OHP: ☐yes ☐no
(#2 GA____, #3 GA____, #4 GA____, #5 GA____)

3030 Uterine Surgical History: ☐yes 3039 History of CS: ☐yes 3040 # Prior CS: _____

3050 History Classical Incision: ☐yes
3060 History Low Vertical Incision: ☐yes
3070 Other Uterine Surgical History:☐yes
3080 History of Uterine Rupture: ☐yes

Pre Pregnancy Diagnosis

3090 Hypertension:	☐yes ☐no ☐NiR	3103 Nicotine:	☐yes ☐no ☐NiR
3100 Diabetes:	☐yes ☐no ☐NiR	3104 Marijuana:	☐yes ☐no ☐NiR
3101 Substance Use:	☐yes ☐no ☐NiR	3105 Alcohol:	☐yes ☐no ☐NiR
3102 Mental Illness:	☐yes ☐no ☐NiR	3110 Other:	☐yes 3111 Other Description(s): _____

3120 LMP: ___/___/_____ 3130 EDC: ___/___/_____
3140 EDC Source: LMP
Ultrasound 3150 Ultrasound at: ___weeks
Other
Not in Record

Complications of Pregnancy

3170 Preeclampsia/HTN: ☐yes
3180 Eclampsia: ☐yes
3190 Gestational Diabetes: ☐yes
3191 Gall Bladder Disease: ☐yes
3192 Placental Abruption: ☐yes
3194 Nicotine: ☐yes
3195 Marijuana: ☐yes
3196 Alcohol: ☐yes
3197 Substance Use: ☐yes
3200 Other: ☐yes 3201 Other Description(s): _____
3193 Absent/Minimal Prenatal Care:☐yes

3210 Antenatal Steroids: ☐yes ☐no ☐not eligible
3211 Antenatal Steroids Course #1 Date: ___/___/___ 3212 Antenatal Steroids Course #1 Gest. Age: ____ weeks
3213 Antenatal Steroids Course #2 Date: ___/___/___ 3214 Antenatal Steroids Course #2 Gest. Age: ____ weeks

3215 Was ASA recommended during this pregnancy: ☐yes
3216 ASA recommended for prevention of preeclampsia: ☐yes

Patient Practitioners & Nurses

Practitioner Type:
OB = Obstetrician **MFM = Maternal Fetal Medicine** **OTH = Other**
FPC = Family Practice w/CS Privileges **MW = Midwife**
FP = Family Practice w/o CS Privileges **H = Hospitalist**

3220 Practitioner at Prenatal Visits:
First Name:_____ Last Name:_____ NPI:_____ Type:____

3230 Practitioner at Admission (for delivery):
First Name:_____ Last Name:_____ NPI:_____ Type:____
3240 Nurse at Admission (for delivery): _____

3250 Practitioner During Labor Management:
First Name:_____ Last Name:_____ NPI:_____ Type:____
3260 Nurse During Labor: _____

3270 Practitioner at Delivery:
First Name:_____ Last Name:_____ NPI:_____ Type:____
3280 Nurse at Delivery: _____

LABOR INTERVENTIONS – MOTHER (4000)

3900 Breech Presentation at 36 weeks: ☐yes
3901 ECV discussed: ☐yes
3902 ECV attempted: ☐yes
3903 ECV Successful: ☐yes

4000 Attempting vaginal delivery: ☐yes ☐no

4001 If No, vaginal delivery is not being attempted, has surgical delivery previously been scheduled for this patient: ☐yes

4010 If yes, vaginal delivery *IS* being attempted, Labor Type: Spontaneous
Induced

4020 Indication for Induction:

Preeclampsia/Gestational HTN	Chorioamnionitis	Advanced Maternal Age
Post Dates	Isoimmunization	Suspected Macrosomia
Oligohydramnios	Abnormal Antepartum Testing	Elective
Gestational Diabetes Mellitus	Fetal Demise	Non-Medically Indicated
Diabetes Mellitus	Twins/Multiples	Other 4021 Other Description: _____
IUGR	Polyhydramnios	Date Not in Record
Fetal Anomalies	History of Stillborn	
PROM	Cholestasis of Pregnancy	

4030 If Elective or Non-Medically Indicated Ind, Bishop Score: 0 1 2 3 4 5 6 7 8 9 10 >10 Not in Record

4040 If surgical delivery previously scheduled, was cesarean performed at date/time originally scheduled: ☐yes ☐no

4050 If no, indicate the reason for unscheduled or rescheduled time:

Spontaneous Onset of Labor	Chorioamnionitis
Premature Rupture of Membranes	Isoimmunization
Preeclampsia/Gestational HTN	Abnormal Antepartum Testing
Oligohydramnios	Fetal Demise
Gestational Diabetes Mellitus	Cord Prolapse
Diabetes Mellitus	Fetal Distress
IUGR	Other 4051 Other Description: _____
Fetal Anomalies	Data Not in Record

4060 If yes, and the indication for *delivery* is different than the ind for *cesarean*, select indication for delivery:

Preeclampsia/Gestational HTN	Chorioamnionitis
Post Dates	Isoimmunization
Oligohydramnios	Abnormal Antepartum Testing
Gestational Diabetes Mellitus	Fetal Demise
Diabetes Mellitus	Elective
IUGR	Other 4061 Other Description: _____
Fetal Anomalies	Data Not in Record
PROM	Not Applicable
Fetal Distress	

4070 Cervical Ripening: ☐yes

4080 Cervical Ripening Took Place During This Admission: ☐yes

4090 Cervix Dilation @ 1st Exam: _____
(Closed, FT; 1; 2; 3; 4; 5; 6; 7; 8; 9; RIM; Complete; Not in record)

4100 Effacement @ 1st Exam: _____
(Uneffaced; 10%; 15%; 20%; 25%; 30%; …95%; 100%; Not in Record)

Reason for admission in spontaneous labor at <=3 cm:
- 4091 Clinical concern for maternal status ☐yes
- 4092 Clinical concern for fetal status ☐yes
- 4093 Labor Pain Management ☐yes

4110 Membrane Status: ☐ Intact ☐ Ruptured

4120 AROM: ☐yes

4130 Date/Time of Membrane Rupture: ___/___/_____ _____:_____

4140 Meconium: ☐yes

4150 Cervix Dilation at ROM: _____ (Closed, FT; 1; 2; 3; 4; 5; 6; 7; 8; 9; RIM; Complete; Not in Record)

Intrapartum Pain Management

- **4155** Nitrous Oxide: ☐yes
- **4156** IV/IM Medication: ☐yes
- **4157** Doula: ☐yes
- **4160** Regional Anesthesia: ☐yes

4170 Date/Time: ___/___/_____ _____:_____

4180 Oxytocin: ☐yes

4190 Date/Time: ___/___/_____ _____:_____

4192 Acute Severe Intrapartum HTN: ☐yes

4193 DX Date/Time: ___/___/_____ _____:_____

4194 Treatment Date/Time: ___/___/_____ ____:____
Not Treated: ☐yes

4199 Chorioamnionitis: ☐yes 4200 Antibiotics for Chorioamnionitis: ☐yes

4213 GBS Prophylaxis Eligibility: ☐yes 4214 GBS Prophylaxis Antibiotic: ☐yes

4220 Magnesium Sulfate: ☐yes

4230 IUPC: ☐yes

4231 Amnioinfusion: ☐yes

4240 Date/Time of Complete Dilation: ___/___/____ ___:___
4245 Date/ Time Pushing Begins: ___/___/____ ___:___

4250 3rd or 4th Degree Laceration: ☐yes 4251 Antibiotics for 3rd or 4th Degree Laceration: ☐yes

4260 Episiotomy: ☐yes

CESAREAN

4270 Indication:

Repeat
Breech
Maternal Request Primary
Placenta Previa
Maternal Disease
Placenta Accreta/Percreta
Placental Abruption;
Fetal Distress/Non-Reassuring Fetal Heart Rate Tracing Irrespective of Contractions
History of Uterine Surgery (other than CS)
Fetal Anomalies
Twins/Multiples
Active HSV
Suspected Macrosomia
Failure to Progress (1st stage arrest)
Failure to Descend (2nd stage arrest)
Failed Induction
Fetal Intolerance of Labor/Non-Reassuring FHR Tracing in Presence of Contractions
Abnormal Presentation
Cord Prolapse
Failed Operative Delivery Attempt
Unsuccessful Induction Earlier This Pregnancy
Other 4271 Other Description ___
Not in Record

4272 If Indication = Failure to Progress or Failure to Descend, was there also Fetal Intolerance of Labor: ☐yes

4280 Dilation at Cesarean: _____ (Closed, FT; 1; 2; 3; 4; 5; 6; 7; 8; 9; RIM; Complete; Not in Record)

4281 Uterine Activity >200 Montevideo units or at least every 3 minutes palpably strong contractions: ☐yes

4290 Date/Time First Reached Dilation at Cesarean: __/__/____ ___:___

4300 Prophylactic Antibiotics: ☐yes ☐no ☐not eligible

4310 DVT Prophylaxis: ☐yes ☐no ☐not eligible
4311 DVT Prophylaxis Type: ☐Mechanical ☐Chemoprophylaxis ☐Both

4320 Anesthesia: (circle) Regional; General; Both; Not in Record

4330 Uterine Incision: ☐ Transverse ☐ Classical ☐ Low Vertical

POSTPARTUM (5000)

5000 Normal Postpartum Course: ☐yes ☐no

DIAGNOSIS: *If normal postpartum course = No, select diagnoses made:*

5010 Atony	☐ yes	5090 Endometritis	☐ yes
5020 Hemorrhage	☐ yes	5100 Wound Infection	☐ yes
5030 Retained Placenta	☐ yes	5110 Amniotic Fluid Embolus	☐ yes
5040 Ruptured Uterus	☐ yes	5120 DVT/PE	☐ yes
5050 Uterine Inversion	☐ yes	5130 Septic Pelvic Thrombophlebitis	☐ yes
5060 Preeclampsia/HTN	☐ yes	5140 Placenta Accreta/Percreta	☐ yes
5065 Acute Severe HTN post del	☐ yes	5150 Other	☐ yes
5066 Diagnosis Date/Time	__/__/_____ ____:____	5151 Other Description(s): _____	
5067 Treatment Date/Time	__/__/_____ ____:____		
Not Treated ☐ yes			
5070 Eclampsia	☐ yes		
5080 DIC	☐ yes	5160 Death ☐ yes	

INTERVENTIONS: *If normal postpartum course = No, select interventions done:*

5170 Manual Removal of Placenta	☐ yes	5250 Wound Debridement	☐ yes
5180 Curettage	☐ yes	5260 Arterial Embolization	☐ yes
5190 Repair of Cx/Vag/Uterine Lac	☐ yes	5270 ICU Level of Care	☐ yes
5200 Compression Suture (e.g. B-Lynch Suture)	☐ yes	5280 Blood Transfusion	☐ yes
5210 Tamponade (e.g. Bakri Balloon)	☐ yes	5281 # Units RBC _____	
5220 Uterine Artery Ligation	☐ yes	5282 # Units FFP _____	
5230 Hypogastric Artery Ligation	☐ yes	5283 # Units Platelets_____	
5240 Hysterectomy	☐ yes	5284 # Units Cryo _____	
		5290 Medications	☐ yes
		5300 Other	☐ yes
		5301 Other Description(s): _____	
5310 Expected Interventions for Known Complications In Pregnancy	☐ yes		

5320 Post-partum transfer to higher level of care for maternal reasons: ☐yes

NEWBORN (6000)

6000 Birth Order: A, B, C, D, E, F, G, H

NEWBORN A – LABOR INTERVENTIONS

6020 Operative Vaginal Delivery Attempt: ☐yes

6010 Spontaneous Vaginal Delivery: ☐yes

6030 Indication for operative delivery: Deliverable
Maternal Exhaustion
Fetal Concerns
Prolonged 2nd Stage
Pushing Effort Contraindicated
Not in Record

6040 Forceps: ☐yes ☐no ☐failed
6050 Vacuum: ☐yes ☐no ☐failed

6060 Operative Vaginal Delivery: ☐yes

6070 Breech Extraction: ☐yes

6080 Cesarean Delivery: ☐yes
6081 Instrument Assist: ☐yes
6082 Instrument Type: ☐Vacuum ☐Forceps

6101: Presentation at Delivery:
Vertex
Breech
Face
Brow
Transverse Lie
Oblique Lie
Unstable Lie

6110 Shoulder Dystocia: ☐yes

6120 Date/Time of Delivery of Placenta: __/__/____ ___:___

NEWBORN A - DATA (7000)

7000 Date/Time of Delivery: ___/___/_____ ____:____

APGAR Score: 7010 1 min: ____
7020 5 min: _____
7021 10 min: _____

7040 Gender: ☐ Male ☐ Female ☐ Unassigned

7049 Fetal Anomalies: ☐yes 7050 Fetal Anomalies Affecting Delivery Plans: ☐yes

7051 Timing of Fetal Anomaly Diagnosis: ☐ Antepartum ☐ Postpartum

7055 3rd Trimester Estimated Fetal Weight Noted: ☐yes
7056 EFW Method: ☐Ultrasound ☐Leopold's Maneuvers
7057 EFW Date: ___/___/_____
7058 EFW: _____grams

7060 Baby Wt Collected: ☐ Pounds ☐ Grams ☐ Not in Record

7070 Baby Wt. Pounds: _____ 7080 Baby Wt. Ounces: _____ *OR* 7090 Baby Wt. Grams: _____

7100 Resuscitation Efforts at Delivery: ☐yes

If resuscitation efforts = Yes, indicate what was done:

7110 Supplemental Oxygen	☐ yes	
7112 CPAP	☐ yes	
7120 Positive Pressure Ventilation	☐ yes	
7130 Chest Compression	☐ yes	
7140 Epinephrine	☐ yes	
7150 Intubation	☐ yes	
7160 Narcan Administration	☐ yes	
7170 Umbilical Lines	☐ yes	
7180 Other	☐ yes	7181 Other Description(s): _____

7191 Cord Blood Collected: ☐yes
7192 Arterial Blood Collected: ☐yes 7193 Arterial Blood pH_____ 7194 Arterial pH Not in Record: ☐yes
7195 Venous Blood Collected: ☐yes 7196 Venous Blood pH_____ 7197 Venous pH Not in Record: ☐yes

7200 Normal Newborn Course: ☐yes

7210 Birth Trauma: ☐yes If birth trauma = Yes, indicate which:

7220 Cephalohematoma	☐ yes	7270 Fracture of Clavicle	☐ yes	
7230 Subgaleal Hemorrhage	☐ yes	7280 Brachial Plexus Injury	☐ yes	
7240 Intracranial Hemorrhage	☐ yes	7290 Fetal Laceration	☐ yes	
7250 Skull Fracture	☐ yes	7300 Other	☐ yes	7301 Other Description(s): _____
7260 Fracture of Humerus	☐ yes			

7310 Newborn Complications: ☐yes If complications = Yes, indicate which:

7320 Respiratory	☐yes	7370 Septicemia/Bacteremia	☐yes
7330 Glucose Instability	☐yes	7380 Other Infection	☐yes
7340 Temperature Instability	☐yes	7390 Bilirubin	☐yes
7350 Anemia	☐yes	7391 Neonatal Abstinence Syndrome	☐yes

7360 Seizures/Neurologic Dysfunction ☐yes 7400 Other ☐yes 7401 Other Description(s): _____

7410 Death ☐yes

7420 NICU Level of Care: ☐yes

7421 Newborn Administration IV Antibiotics: ☐yes

7430 Post Delivery Transfer of Newborn to Higher Level of Care: ☐yes

7440 Hepatitis B Vaccine Given to Newborn: ☐yes ☐no ☐refused

7451 Eligible for Exclusive Breast Feeding: ☐yes ☐no ☐refused

7452 Exclusive Breast Feeding Compliance: ☐yes

7460 Timing of Death: ☐ Antepartum ☐ Intrapartum ☐ Newborn

DISCHARGE/POST DISCHARGE (8000) – NEWBORN A

8000 Date and Time of Baby A's Discharge: ___/___/_____ ____:____

8010 Re-Admission within 30 Days of Delivery - Newborn Baby A: ☐yes

DISCHARGE/POST DISCHARGE (9000) – MOTHER

9000 Date and Time of Mother's Discharge: ___/___/_____ ____:____

9010 Re-Admission within 30 Days of Delivery – Mother: ☐yes

9011 Date/Time Re-Admission of Mother: ___/___/_____ ____:____

9015 Re-Admission Admit Diagnosis: _____

9080 Re-Admission Discharge Diagnosis:_____

9090 Re-Admission Discharge Disposition: ☐Home ☐Another Facility ☐Deceased

NOTES:

NEWBORN (6000)

6000 Birth Order: B, C, D, E, F, G, H

NEWBORN B-H – LABOR INTERVENTIONS

6020 Operative Vaginal Delivery Attempt: ☐yes

6010 Spontaneous Vaginal Delivery: ☐yes

6030 Indication for operative delivery:
Deliverable
Maternal Exhaustion
Fetal Concerns
Prolonged 2nd Stage
Pushing Effort Contraindicated
Not in Record

6040 Forceps: ☐yes ☐no ☐failed
6050 Vacuum: ☐yes ☐no ☐failed

6060 Operative Vaginal Delivery: ☐yes

6070 Breech Extraction: ☐yes

6080 Cesarean Delivery: ☐yes
6081 Instrument Assist: ☐yes
6082 Instrument Type: ☐Vacuum ☐Forceps

6101: Presentation at Delivery:
Vertex
Breech
Face
Brow
Transverse Lie
Oblique Lie
Unstable Lie

6110 Shoulder Dystocia: ☐yes

6120 Date/Time of Delivery of Placenta: __/__/____ ___:___

NEWBORN B-H DATA (7000)

7000 Date/Time of Delivery: ___/___/_____ ____:____

APGAR Score: 7010 1 min: ____
7020 5 min: _____
7021 10 min: _____

7040 Gender: ☐ Male ☐ Female ☐ Unassigned

7049 Fetal Anomalies: ☐yes 7050 Fetal Anomalies Affecting Delivery Plans: ☐yes

7051 Timing of Fetal Anomaly Diagnosis: ☐ Antepartum ☐ Postpartum

7055 3rd Trimester Estimated Fetal Weight Noted: ☐yes
7056 EFW Method: ☐Ultrasound ☐Leopold's Maneuvers
7057 EFW Date: ___/___/_____
7058 EFW: _____grams

7060 Baby Wt Collected: ☐ Pounds ☐ Grams ☐ Not in Record

7070 Baby Wt. Pounds: _____ 7080 Baby Wt. Ounces: _____ *OR* 7090 Baby Wt. Grams: _____

7100 Resuscitation Efforts at Delivery: ☐yes

If resuscitation efforts = Yes, indicate what was done:

7110 Supplemental Oxygen	☐ yes	
7112 CPAP	☐ yes	
7120 Positive Pressure Ventilation	☐ yes	
7130 Chest Compression	☐ yes	
7140 Epinephrine	☐ yes	
7150 Intubation	☐ yes	
7160 Narcan Administration	☐ yes	
7170 Umbilical Lines	☐ yes	
7180 Other	☐ yes	7181 Other Description(s): _____

7191 Cord Blood Collected: ☐yes
7192 Arterial Blood Collected: ☐yes 7193 Arterial Blood pH_____ 7194 Arterial pH Not in Record: ☐yes
7195 Venous Blood Collected: ☐yes 7196 Venous Blood pH_____ 7197 Venous pH Not in Record: ☐yes

7200 Normal Newborn Course: ☐yes

7210 Birth Trauma: ☐yes If birth trauma = Yes, indicate which:

7220 Cephalohematoma	☐ yes	7270 Fracture of Clavicle	☐ yes	
7230 Subgaleal Hemorrhage	☐ yes	7280 Brachial Plexus Injury	☐ yes	
7240 Intracranial Hemorrhage	☐ yes	7290 Fetal Laceration	☐ yes	
7250 Skull Fracture	☐ yes	7300 Other	☐ yes	7301 Other Description(s): _____
7260 Fracture of Humerus	☐ yes			

7310 Newborn Complications: ☐yes If complications = Yes, indicate which:

7320 Respiratory	☐yes	7370 Septicemia/Bacteremia	☐yes
7330 Glucose Instability	☐yes	7380 Other Infection	☐yes
7340 Temperature Instability	☐yes	7390 Bilirubin	☐yes
7350 Anemia	☐yes	7391 Neonatal Abstinence Syndrome	☐yes

7360 Seizures/Neurologic Dysfunction ☐yes 7400 Other ☐yes 7401 Other Description(s): _____

7410 Death ☐yes

7420 NICU Level of Care: ☐yes

7421 Newborn Administration IV Antibiotics: ☐yes

7430 Post Delivery Transfer of Newborn to Higher Level of Care: ☐yes

7440 Hepatitis B Vaccine Given to Newborn: ☐yes ☐no ☐refused

7451 Eligible for Exclusive Breast Feeding: ☐yes ☐no ☐refused

7452 Exclusive Breast Feeding Compliance: ☐yes

7460 Timing of Death: ☐ Antepartum ☐ Intrapartum ☐ Newborn

DISCHARGE/POST DISCHARGE (8000) – NEWBORN B-H

8000 Date and Time of Baby B-H's Discharge: ___/___/_____ ____:____

8010 Re-Admission within 30 Days of Delivery - Newborn Baby B-H: ☐yes

NOTES: