DOLPHIN2 STUDY (054) Delivery CRF Infant (011)

Visit code: ☐☐.☐

Visit Date: ☐☐ ☐☐ ☐☐☐☐
dd *mm* *yyyy*

Study ID
☐ – ☐☐☐☐
Site # Subject #

Delivery CRF (INFANT)

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Date of delivery:..... ☐☐ ☐☐ ☐☐☐☐
dd *mm* *yyyy*

INFANT DETAILS

		FOR TWIN B *(Fill only, if twin pregnancy)*
	Infant ID: ☐☐	Infant ID: ☐☐
1 Was any resuscitation done to infant: *(if yes, describe in notes)*	☐ Yes ☐ No ☐ NR	☐ Yes ☐ No ☐ NR
2 Did infant have any iatrogenic birth injuries? *(if yes, describe in notes)*	☐ Yes ☐ No ☐ NR	☐ Yes ☐ No ☐ NR
3 Gender of infant:.....	☐ Male ☐ Female	☐ Male ☐ Male
4 Outcome of infant.....	☐ Alive ☐ Stillborn/ Fresh ☐ Stillborn/ Macerated ☐ Demised after delivery ☐ NR	☐ Alive ☐ Stillborn/ Fresh ☐ Stillborn/ Macerated ☐ Demised after delivery ☐ NR
5 Birth weight.....	☐☐☐☐ g	☐☐☐☐ g
6 Placental weight *(if done)*.....	☐☐☐☐ g	☐☐☐☐ g
7 Head circumference.....	☐☐ cm	☐☐ cm
8 Length.....	☐☐ cm	☐☐ cm
9 Apgar scores.....	☐ *1 min* ☐ *5 min* ☐ *10 min* ***(if done)*** ☐ NR	☐ *1 min* ☐ *5 min* ☐ *10 min (if done)* ☐ NR
	Notes: *10 min (if done)*	Notes:

Patient initials ☐ - ☐ - ☐
First Middle Last

Staff initials/Signature / Date (dd/mm/yy)

DOLPHIN 2 STUDYPROTOCOL

Please Initial and date the appropriate section below:

1st Review: _____ Initials _____/_____/20___ Date	*Faxed by:* _____ Initials _____/_____/20___ Date
2nd Review: _____ Initials _____/_____/20___ Date	*Faxed by:* _____ Initials _____/_____/20___ Date
3rd Review: _____ Initials _____/_____/20___ Date	*Faxed by:* _____ Initials _____/_____/20___ Date
4th Review: _____ Initials _____/_____/20___ Date	*Faxed by:* _____ Initials _____/_____/20___ Date