### INFANT DETAILS

1. **Was any resuscitation done to infant:**
   - [ ] Yes
   - [ ] No
   - [ ] NR

2. **Did infant have any iatrogenic birth injuries:**
   - [ ] Yes
   - [ ] No
   - [ ] NR

3. **Gender of infant:**
   - [ ] Male
   - [ ] Female

4. **Outcome of infant:**
   - [ ] Alive
   - [ ] Stillborn/ Fresh
   - [ ] Stillborn/ Macerated
   - [ ] Demised after delivery
   - [ ] NR

5. **Birth weight:**
   - [ ] g

6. **Placental weight (if done):**
   - [ ] g

7. **Head circumference:**
   - [ ] cm

8. **Length:**
   - [ ] cm

9. **Apgar scores:**
   - [ ] 1 min
   - [ ] 5 min
   - [ ] 10 min (if done)

### FOR TWIN B

*(Fill only, if twin pregnancy)*

- **Infant ID:** [ ]
- **Infant ID:** [ ]

- [ ] Yes
- [ ] No
- [ ] NR

- [ ] Yes
- [ ] No
- [ ] NR

- [ ] Male
- [ ] Male

- [ ] Alive
- [ ] Stillborn/ Fresh
- [ ] Stillborn/ Macerated
- [ ] Demised after delivery
- [ ] NR

- [ ] g
- [ ] g

- [ ] cm
- [ ] cm

- [ ] cm
- [ ] cm

- [ ] 1 min
- [ ] 5 min
- [ ] 10 min (if done)

**Notes:**

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**Visit code:** [ ] [ ]

**Visit Date:** [ ] [ ]

**Site #** [ ] [ ]

**Subject #** [ ] [ ]
DOLPHIN 2 STUDY PROTOCOL

Please Initial and date the appropriate section below:

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