Alabama Perinatal Regionalization System Guidelines
Analysis Tool for Identifying Babies Born
at or < 1,500 grams at Birth

This form is for your facility use only. There may be some questions that you will not have answers.
Directions: Please complete one form on each birth of a very low birth weight infant (<1,500 gm birth weight) occurring at your facility during the most recent reporting period (January 1, 2018 through June 30, 2018). Please copy this form and use a separate form for each birth. Number each case for your identification purposes. Refer to the Alabama Perinatal Regionalization System Guidelines and the American Academy of Pediatrics: Levels of Neonatal Care for guidance. Both can be found at: www.alabamapublichealth.gov/perinatal

- Patient ID#: ______________ Mother’s presentation to the hospital: Date: ___________ Time: ___________
- Mother presented to the hospital:☐ In the ER ☐ To L&D Triage/Admit ☐ Direct Admit from Provider
☐ Other: ________________________ ☐ Unknown
- Did the Mother of the baby receive prenatal care during the pregnancy?
☐ Yes ☐ No ☐ Unknown
- Admission diagnosis: __________________________________________________________
- Due date (EDC): ______________ Estimated gestational age on admission: __________________________
- Condition on arrival: _______________________________________________________________________
- Labor status: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
- Cervical exam performed: ☐ Yes ☐ No If cervical exam was performed, how many cm dilated was the mother? ___________
- Are there any documented health risks or conditions that would have indicated an immediate delivery?
☐ Yes ☐ No ☐ No documentation noted
☐ Hypertension ☐ Diabetes ☐ Obesity
☐ History of prior pre-term birth ☐ History of prior LBW delivery ☐ Trauma
☐ Maternal Infection ☐ Pre-eclampsia/Eclampsia ☐ PROM ☐ Placenta Previa
☐ Placental Abruption ☐ Other: ________________________________
- Mother’s insurance status: ☐ Medicaid ☐ Private Insurance ☐ Self-pay
- Maternal transport request: ☐ No ☐ Yes If yes, provide the: Date_______ Time _______
- Hospital(s) for maternal transfer contacted: ________________________________________________
- Barriers to transporting the mother: _______________________________________________________
- Reason maternal transport did not occur prior to delivery: ______________________________________
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- Delivery: Date ___________ Time ___________ Mode of delivery: □ Vaginal □ C-Section
- Infant birth weight: _________________ Gestational age (by clinical exam): _________________
  Apgar scores: ____________________________
- Resuscitation and support required: □ Yes □ No
  If resuscitation and support were required, what type? □ Oxygen □ Mechanical Ventilation
  □ Continuous Positive Airway Pressure □ Conventional and/or High-frequency Ventilation □ Nitric Oxide
- Neonatal transfer request: □ Yes □ No Date: ___________ Time of transfer: ___________
- Hospital(s) for infant to be transferred to: ____________________________________________
- If the infant was not transported to a level III or IV facility within 24 hours of birth, please explain why not:
  ___________________________________________________________________________________
- If the infant was not transported to a level III or IV facility within 24 hours, but received a transfer to a level III or IV facility later, provide the date of transfer: ___________ Time of transfer: ___________
  Reason for transfer: __________________________________________________________________
- Hospital(s) contacted: __________________________________________________________________
- Barriers to transfer: ____________________________________________________________________
  ___________________________________________________________________________________

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