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Perinatal Information System

SIMPLIFIED PERINATAL CLINICAL RECORD

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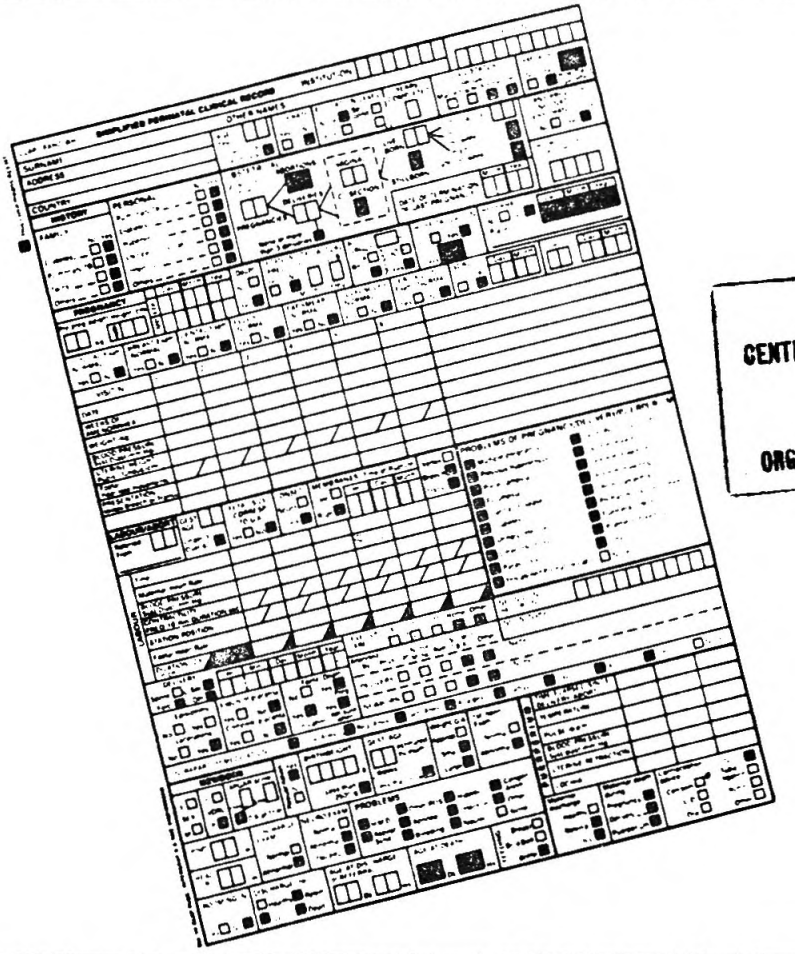

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This color means ALERT

CLAP - PAHO/WHO **SIMPLIFIED PERINATAL CLINICAL RECORD** INSTITUTION FILE Nº

SURNAME OTHER NAMES

ADDRESS

COUNTRY

AGE Years — Under 15 y s. — Over 35 y s.

LITERATE Yes No

EDUCATION LEVEL None Prim Second. Univ.

YEARS COMPLETED

CIVIL STATUS Com-law Married wife Single Oth

SMOKES No Yes How many cigarettes?

HISTORY

FAMILY — No Yes
Diabetes
Pulmonary TB
Twins
Others

PERSONAL — No Yes
Pulmonary TB
Diabetes
Hypertension
Uter-pelvic - surgery
Infertility
Others

OBSTETRICAL
Write total number of PREGNANCIES
DELIVERIES
ABORTIONS
None or more than 3 deliveries
VAGINAL
C - SECTION
LIVE BORN — STILL ALIVE — DIED in 1st week — DIED after 1st week
STILLBORN

ANY PREVIOUS NEONATE OF LESS THAN 2500 g No Yes

HIGHEST PREVIOUS BIRTHWEIGHT g

DATE OF TERMINATION OF LAST PREGNANCY Month Year

PREGNANCY

Pre-preg weight Height (cm) Kg 1

EDC Day Month Year

LMP Day Month Year

Doubt. No Yes

TETANUS TOX. PREVIOUS Yes No — ACTUAL 1º 2º/B — Month of Pregn.

BLOOD GROUP Rh + − Sensitiz. No Yes

HOSPITALIZATION No Yes Days

REFERRAL No Yes (Place) Day Month Year

CLINICAL Exam (NORMAL)	BREAST Exam. (NORMAL)	DENTAL Exam (NORMAL)	PELVIS (NORMAL)	PAPSMEAR (NORMAL)	COLPOSCOPY (NORMAL)	CERVIX CLIN. Exam. (NORMAL)
Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

VDRL − + Day Month

Hb g Day Month

VISIT Nº	1	2	3	4	5	6
DATE						
WEEKS OF AMENORRHEA						
WEIGHT (Kg.)						
BLOOD PRESSURE Syst/Diast (mm Hg)						
UTERINE HEIGHT Pubis - fundus (cm)						
Foetal hear rate/movements	/	/	/	/	/	/
PRESENTATION Vertex Breech or Transv.						

LABOUR/ABORT

Referred From

GEST AGE Under 37 Over 42

FETAL SIZE CORRESP TO G.A. Yes No

ONSET Spont. Ind.

MEMBRANES Time of Rupture Int. Rupt. — Hr. Day Month

Vertex Breech Transv

LABOUR							
Time							
Maternal Heart Rate							
BLOOD PRESSURE Syst/Diast (mm Hg)							
CONTRACTILITY FREQ. 10 min/DURATION sec.	/	/	/	/	/	/	/
STATION/POSITION	/	/	/	/	/	/	/
Foetal Heart Rate							
DILATION CX. (in cm.) / MECONIUM	/	/	/	/	/	/	/

PROBLEMS OF PREGNANCY/DELIVERY/PUERPERIUM

- Multiple pregnancy
- Previous hypertension
- Pre-eclampsia
- Eclampsia
- Cardiac Disease
- Diabetes
- Urinary infection
- Other infections.
- Parasitosis
- Threatened Premature Labor
- Ceph Pelv Disproportion
- 1sr trim bleeding
- 2nd trim bleeding
- 3rd trim bleeding
- Chronic anaemia
- Premature rupture of membr
- Puerperal infection
- Puerperal bleeding
- Other
- None

DELIVERY Spont. C-Sec. Forc. Oth. — Hr. Min Day Month Year

LEVEL OF CARE 3º 2º 1º Home Other

Attended by Physician Nurse/ Midw Auxil. Student/ T.B.A. Other

DELIVERY

NEWBORN

NEON.CLIN. RECORD Nº

NEON. Name

Name

Name

Episiotomy No Yes

Lacerations No Yes

Expuls of placenta Yes No

Complete placenta Yes No

Foetal Death No Yes Preg — Yes in Labor Yes not sure when

INTRAPARTUM MEDICATION Local Anest. Reg. Anest. Gen. Anest. Analges. Tranquil. Oxytocin. Antibiot. Other None

NEWBORN

SEX F M

VDRL − +

APGAR score 1m 5m 0-6 at 1º m

Resuscitation Yes No

BIRTHWEIGHT g Less than 2500 g

GEST. AGE estimated by exam. Weeks Less than 37 w

Weight/G.A. Approp. Small Large

1st neon. Exam. Normal Abnormal

Length Cm

HEAD CIRC Cm

DISCHARGE EXAM. Normal Abnormal

NEURO.EXAM Normal Abnormal Doubtful

PROBLEMS. H.M.D. Aspirat. Synd. Other RDS Apnoea Bleeding Hiperbili. Infection Neurol. Congen. Anom. Other None

ROOMING-IN Yes No

DISCHARGE (neon) Healthy Referr ILL Dead

AGE AT DISCHARGE or REFERRAL Ds. Hs

AGE AT DEATH Ds. Hs.

FEEDING Breast Br.+Bott. Bottle

PUERPERIUM

TIME ELAPSED SINCE DELIVERY/ABORT			
TEMPERATURE			
PULSE (b.p.m.)			
BLOOD PRESSURE Syst/diast (mm Hg.)			
UTERINE RETRACTION			
LOCHIA			

Maternal discharge: Healthy Referral ILL

Maternal death. during: Pregnancy Delivery Puerperium

Contraceptive advice: Condom I.U.D. Oral — None Tubal ligation Rythm Other

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1. INTRODUCTION

The Latin American Centre for Perinatology and Human Development (C.L.A.P.) has being developing a series of appropriate technologies to help extend coverage in perinatal care, with the intention of contributing to the goal of Health for All by the Year 2000 following the regional strategies drawn up by the governments of PAHO/WHO. The introduction of the Simplified Perinatal Clinical Record (SPCR) is an example of this work (1).

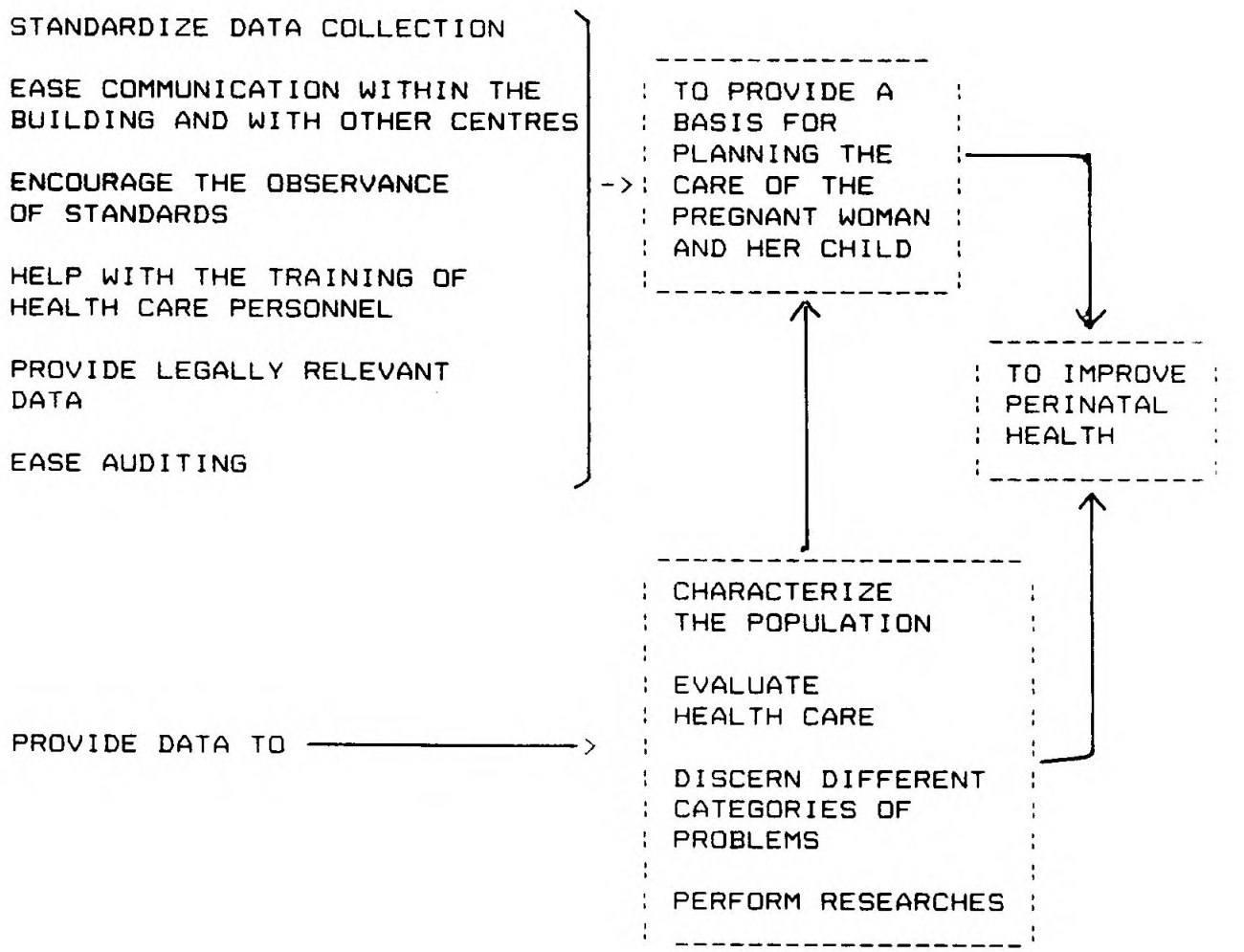


Table 1 - Aims of the SPCR

The simple-to-use low-cost SPCR form succeeds in bringing together on one page easily-obtainable data. This data is the

minimum information needed to provide adequate perinatal care. It was intended as an alternative to the more complex and detailed Perinatal Clinical Record (PCR) which is used widely in the Americas and was also designed at this Centre (2). The SPCR, which was designed to serve the objectives stated in Table 1, is based on a warning system that highlights those factors increasing perinatal risk. It also offers the possibility of using a personal computer and sofware package designed by C.L.A.P. to set up a Perinatal Information System.

2. FEATURES OF THE SIMPLIFIED PERINATAL CLINICAL RECORD

All the data to be collected about the perinatal event has been condensed onto one 8 1/2" x 11" form (27.5 x 21.5 cm). The form consists of a series of modules containing the necessary data about an obstetric event and the newborn in the early neonatal period. A list of questions is displayed which can be answered in a multiple-choice fashion. The SPCR is laid out so as to encourage systematic gathering of information at the appropriate time. The present instruction manual provides guidelines for a uniform recording of data.

2.1 Sections of the SPCR

The SPCR begins with identification, age, and sociocultural status. This is followed by data of the personal and family history which is known to be of great importance in the prognosis of the current pregnancy.

The **Pregnancy** section asks for information or lab exam results which must be recorded or recalled at each prenatal visit. Through filling out this section the attending health worker ensures that a minimum of perinatal services needed are provided.

The **Labour or Abortion** section includes the basic information necessary for controlling dilatation period. It also contains those facts relating to labour and delivery which are essential to provide the mother and the newborn with good pospartum care.

The **Newborn** section records key data obtained from initial examination of the baby; these data help to determine the type and level of care the newborn needs.

The **Puerperium** section summarizes the post-partum or post-abortion procedures.

Both maternal and neonatal sections end with the condition at discharge and any diagnosed pathology. The maternal component also contains a section on contraceptive advice.

2.2 The warning system, an approach to risk identification

Some of the boxes of the SPCR are coloured bright yellow. These boxes highlight important conditions that often indicate increased perinatal risk. When one or more of these conditions exist, the corresponding yellow box or boxes are checked. This is an attempt to alert the personnel responsible for maternal and child primary care. It also facilitates decision-making according to local standards.

2.3 Processing of SPCR data

The SPCR data may be processed by a computer. Different processing modalities have different influences on perinatal care. C.L.A.P. recommends that SPCR data be processed in the very place where health care is provided.

Whenever within-the-building processing is not possible data processing may be done outside the place where perinatal care is given.

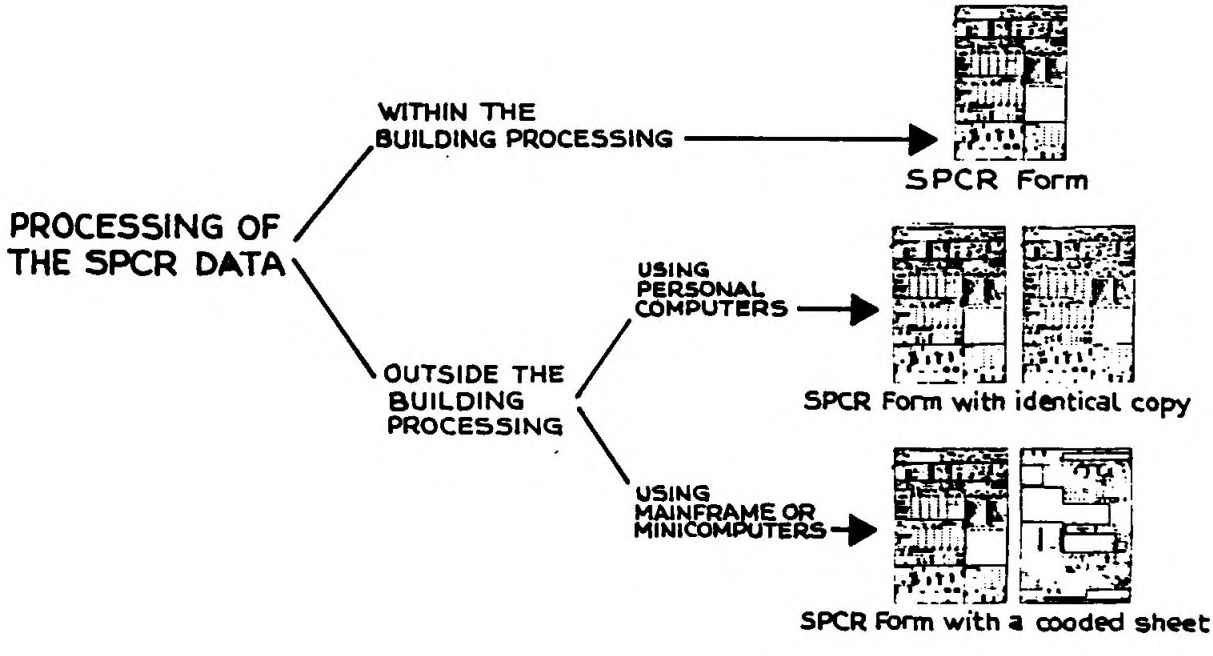


Figure 1 - SPCR forms needed

The health care centre may undertake local processing of the data included in the SPCR form. For this purpose the C.L.A.P. has developed an easy-to-use processing system to be operated with a personal computer. The System may be used in any computer that can run the D.O.S. operating system version 2.1 or later (IBM PC, PC/XT, PC/AT, EPSON Equity, Televideo, and all 100% compatibles).

Data is entered directly to the personal computer by the health care personnel in the health care centre on a daily basis. Data processing and analysis can also be done in the institution with the software package developed by C.L.A.P.. Information is thus available whenever it is required to facilitate evaluation of perinatal care and decision-making.

On turning the computer on , the operator selects a task to be performed from the following menu:

0 List of variables
1 Record Entry
2 Inspection of Records
3 Modification of Records
4 Completeness Control
5 Consistency
6 Basic Statistics
7 Description of Variables
8 Selection of Records
9 Estimation of Risk
10 Birthweight/Gest age (selected)
11 Birthweight/Gest age (total)
12 Maternal Pathologies
13 Mortality and Maternal Pathologies
14 Neonatal Mortality and Birthweight
15 Neonatal Pathologies
16 Apgar and Method of Delivery
17 Copying of Record Files
18 End of Session

The operator enters the SPCR data by answering to the questions asked by the computer; this job requires very little training.

Data processing results in a collection of printed documents which either summarize the activities of the institution during a given period (Basic Statistics) or provide the basis for more specific research (Estimation of Risk, Description of Variables, etc.).

In the appendix, sample documents of Basic Statistics and Description of Maternal Age as printed by the System are shown. Further details about the software package may be found in C.L.A.P. Scientific Publication N.1110 (3).

For outside-the-building processing a copy of the SPCR form is sent to a computer centre which processes the data (Figure 1). An SPCR form with an identical copy of carbonless paper is shown in the appendix.

To process SPCR data the software package developed by C.L.A.P. may be used in a personal computer operating in a distant location. A copy of the SPCR form should be sent for this purpose after the clinical record is closed. The copy to be sent is an identical copy with the one remaining in the place where perinatal care is given and may be obtained by means of a carbon paper or using an SPCR form with carbonless copy.

To process SPCR data in an already operating computer centre using mainframe or minicomputers the form with a coded sheet may be employed instead of the identical copy (4) (Figure 1). The coded sheet has been designed to be transcribed onto magnetic media (a diskette, for instance) by professional operators.

2.4 The Perinatal Passport

The lack of data at whatever stage of medical care jeopardizes the quality of future care. This is the case, for instance, whenever delivery takes place in a different institution from that where prenatal control visits are made. It is also the case when postpartum and pediatric examinations are carried out outside the health care centre where the baby was born.

The Perinatal Passport (see Appendix) is an instrument intended to link the different stages of care (Figure 2). The pregnant woman should keep this Passport and use it for all steps related with health care during pregnancy and puerperium. The general layout of the SPCR was maintained so as to make data transcription easier. Controls during labour were left out of the Passport as they are not considered relevant information for follow-up after discharge.

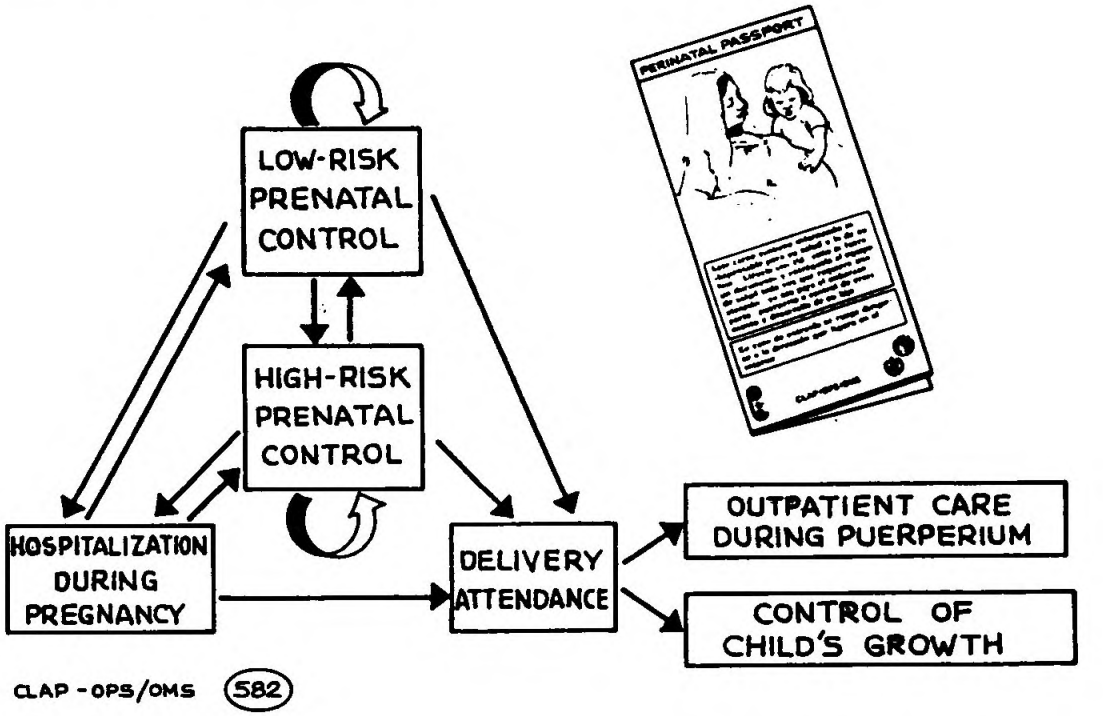


Figure 2 - Flow of information when using the Perinatal Passport

The Perinatal Passport ensures:

1) That basic information collected during prenatal controls, sistematically registered at each visit, reach the person in charge of providing later health care either in another peripheral consulting room or in the health centre where the pregnant woman is admitted.

2) That the most relevant facts about hospitalization during pregnancy, labour, delivery and postpartum come to be known by the person in charge of health care during puerperium.

3) That the most relevant data for the follow-up of the newborn come to be known by the person in charge of the child's health control.

The cover of the Passport may be used to convey simple messages such as those appearing in the appended model. The space was also employed in this example to record the evolution of uterine height and maternal weight gain during pregnancy using standard curves.

3 INSTRUCTIONS FOR FILLING IN THE SPCR

3.1 General Remarks

The SPCR form is only to be filled in after the patient's pregnancy has been confirmed during the first visit to the Health Care Centre. To fill in the form please use "x" marks to check square boxes and use numbers to fill in the rectangular boxes.

It is important that all variables are filled in. This leads to better interpretation and making the most of the data to be processed.

"X" marks should be clearly written and legible. They should occupy the corresponding box without going beyond its boundaries. For instance:

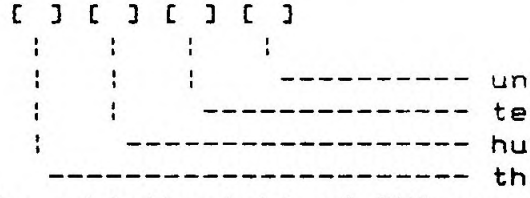
YES [ ] NO [x]

Vertex [x]
Breech [ ]
Transv. [ ]

In the rectangular boxes, the answer is indicated by writing a number. Numbers should be legible and confined to the corresponding boxes. Be careful to distinguish between 0 and 6, 1 and 7, 3 and 8, etc. since they are often mistaken when badly written and this may lead to register the wrong data. Please remember that only one digit (0 to 9) should be entered in each box. For example:

[2][5][0] [0][8] [1][3]

Numbers must be justified to the right in case there are several boxes. Units must be entered in the first right-hand box, tens in the second one, and so on. The remaining boxes on the left-hand side are filled in with zeros.



For example a birthweight of 850 grams is entered as:

[0][8][5][0]

Time of day must be recorded in the range 0000 to 2400. For example a time of 3:45 pm is coded as 1545, and in case it has to be rounded to the nearesrt hour it is 1600.

Arabic numerals (1, 2, ... 11, 12) must be used to record the month. Do not use roman numerals.

All items must be answered including those with answer NO or NONE. This answer is usually registered as zeros in the rectangular boxes or "x" mark in the corresponding square box.

When filling in the form, you may find redundant questions. This is to ensure the completeness and accuracy of the records. Failure to register any data may result in misinterpretation. For example, in a nullipara the following items of the history must be answered with zeros:

- abortions
- vaginal deliveries
- cesarean-section deliveries
- stillborn
- live born babies still alive
- live born babies who died in the 1st. week
- live born babies who died after the 1st. week

Items left blank are taken as MISSING DATA. The codification for lack of information is no marks or written signs at all (boxes left blank). It is important to stress that every item must be answered because blanks are not meaningless: they mean that the particular data is missing or has not been obtained.

3.2 Woman's Identification

INSTITUTION: Refers to the code number that has been assigned to each institution.
FILE N.: Write the medical record number assigned by the institution to the patient.
SURNAME - OTHER NAMES: Enter the family name of the pregnant woman's father and mother and then her first and middle names.

ADDRESS: Write street and number where the mother usually lives.
COUNTRY: Write the name of the city, village or location.
AGE: Write the woman's age in completed years. For patients under 15 or over 35 years old, mark the yellow box.
LITERATE: If the mother can read and write, mark "YES"; otherwise mark "NO".
EDUCATIONAL LEVEL: This refers to the level of formal instruction attained.
YEARS COMPLETED: Enter the last completed year of schooling (e.g., if the pregnant woman completed the 2nd year of secondary school mark "x" in the box corresponding to secondary level and write "2" in the box under "years completed"). In case of no study done check "none" for "Educational level" and write "0" for "years completed".
MARITAL STATUS: "Common-law wife" refers to the fact of living permanently with a person without being legally married.
SMOKES: Indicate whether the patient has been smoking during the current pregnancy by checking the appropriate box. If the answer is "YES", please write down the average number of cigarettes smoked per day.

3.3 History

Only those items of the history which were diagnosed by a member of the health team are considered. Check the corresponding box and if it were a yellow box, give more details for your answer.

FAMILY HISTORY: This refers to persons related in the first degree to the pregnant woman and her husband (parents, brothers, sisters, children). TB stands for tuberculosis.
PERSONAL HISTORY: This section refers to the pregnant woman.
OBSTETRICAL HISTORY: Put the questions to the pregnant woman in the stated order and fill in the corresponding boxes. For either a multipara (more than three previous deliveries) or a nullipara, place an "x" in the square yellow box below "deliveries". Each previous multiple pregnancy should be recorded as 1 pregnancy, 2 or more deliveries and 2 or more children.
DATE OF TERMINATION OF LAST PREGNANCY: Enter the month and year the previous pregnancy ended, even if it ended in abortion.
ANY PREVIOUS NEONATE OF LESS THAN 2500 g: Check the corresponding box. Remember that 2500 grams are just over 5 lb.
HIGHEST PREVIOUS BIRTHWEIGHT: Enter the birthweight of the heaviest baby born to the patient.

3.4 Pregnancy

This section is designed to register data during the first prenatal control visit and to complete them during later visits.

NORMAL WEIGHT: Write down the woman's weight in the months preceding the current pregnancy. The weight should be given in kilograms. Remember that 1 lb = 454 grams.

HEIGHT: Measure her height in stocking feet. Height should be given in centimetres. Remember that 1 foot = 31 cm.
LAST MENSTRUAL PERIOD (L.M.P.): Enter the day, month and year when the woman's last menstrual period started.
DOUBT: It refers to doubts as for the Last Menstrual Period.
ESTIMATED DELIVERY OF CHILD (E.D.C.): It refers to the day, month and year of the estimated termination of gestation. This should be calculated by taking the 10th day after the first day of the last menstrual period and subtracting three monthes. For example: L.M.P.12/10/86 (Octobre 12, 1986) E.D.C.:23/07/87 (July 23, 1987)
TETANUS TOXOID: If the pregnant woman was previously inoculated, mark the "YES" box. If she was not or if more than 10 years have elapsed since she was last inoculated, mark "NO".

If she was vaccinated during pregnancy, enter the months of pregnancy in which she received the first inoculation in the box marked "1o" and the months of pregnancy corresponding to the second inoculation in the box under "2o/B".
BLOOD GROUP AND RH: Note the blood group (A, B, AB, or O) and mark "x" in the corresponding boxes to indicate the patient's Rh type and sensitization.
HOSPITALIZATION: Write the total number of days she stayed in hospital during pregnancy (admission to the hospital during labour is not considered as an admission during pregnancy). For this item and for the "referral" section, the "No" box should not be marked untill the clinical record is closed.
REFERRAL: Indicate whether the patient was referred to another health centre. If a referral occurred write down the date and the place of referral.
CLINICAL EXAMINATION (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
BREAST EXAMINATION (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
DENTAL EXAMINATION (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
PELVIS (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
PAP SMEAR (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
COLPOSCOPY (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
CERVIX EXAMINATION (NORMAL): Mark the appropriate box. If you check a yellow box, give more details.
V.D.R.L.: Give the result and date of the first examination carried out during pregnancy. If either a positive result is found or further examinations are carried out give more details.
HB: Write down the result of the first determination of hemoglobin done during pregnancy. If an abnormal result is obtained, record the value in the free space. Do it also if the result should recur.
VISIT NUMBER: The numbers indicate the order of the visits. Some room is left so that you can enter the code number or the initials of the person providing medical advice at each prenatal control. Space is supplied for documenting 6 visits.

If there are more than 6 control visits, you may add vertical lines to the already existing horizontal lines and

record five more visits. In case the space is filled out, you may enclose another SPCR form with the pregnant woman's name and surname, the institution number and the file number on it.
DATE: Write day, month and year of the control visit.
WEEKS OF AMENORRHEA: State the number of full weeks elapsed between the first day of the patient's last menstrual period and the date of the control visit.
WEIGHT: Weigh the woman in underclothes and in stocking feet. The weight should be expressed in kilograms with one decimal figure, e.g. 68.3 kg.
BLOOD PRESSURE: Record the systolic and dyastolic pressures which should be taken with the patient in a sitting position.
UTERINE HEIGHT: Enter the distance in centimeters from the upper edge of the pubic symphisis to the fundus.
FETAL HEART RATE: Record the fetal heart rate measured in absence of contractions in heartbeats per minute.
FETAL MOVEMENT: Enter + if movement is detected and - otherwise
PRESENTATION: Indicate whether the presentation is vertex, breech or transverse. If the presentation cannot be determined, mark a dash in the corresponding box.
BLANK LINE: This line is intended for any data about pregnancy considered relevant apart from those being listed.

There is a lined section which is intended for the user to write any relevant laboratory results and/or brief observations or comments on the SPCR data whenever it is required, particularly when a yellow box has been checked. For instance, if you have marked yes for Diabetes in the Family History section then you should use this space to specify which member of the family is affected. It may also be used to give more details about prenatal control visits.

3.5 Labour or Abortion

This section is intended to include all relevant data for the control of the dilation period as well as all the information about labour and delivery.

REFERRED FROM: Indicate where the pregnant woman comes from in order to establish the place where prenatal control visits were carried out. A code number may be assigned to each health care centre so that apart from writing down the name of the institution you can record the corresponding number.
GESTATIONAL AGE: Enter the number of completed weeks elapsed since the start of the patient's last menstrual period untill her admission to the hospital in labour. If it is less than 37 weeks (prematurity) or more than 42 weeks mark the yellow box below.
FETAL SIZE CORRESPONDS TO G.A.: Determine whether fetal size clinically evaluated by palpation, uterine height, etc. agrees with amenorrhea.
ONSET: Check the corresponding box (Spontaneous or Induction)
MEMBRANES: Indicate whether the membranes were intact or ruptured at the onset of labour. Record the hour, day and month of the rupture even if it occurs during the dilation period.

Minutes are rounded up to the nearest hour. For instance, 4:40 is equivalent to 05; 4:25 is written as 04. If the figure corresponding to minutes is 30 and that corresponding to hours is an odd number, the following hour must be recorded. If it is an even number, you should record the hour as stated. For instance, 4:30 is rounded to 04 and 5:30 is rounded to 06.

VERTEX, BREECH, TRANSVERSE: It refers to the position of fetus (presentation) as diagnosed at the onset of labour.

LABOUR: Write the data corresponding to a control in each column. It is not necessary to fill out all items during every control.

TIME: Record the hour of the control period (0000 to 2400 hours). For example: 2:30 p.m. should be recorded as 14:30.

MATERNAL HEART RATE: Record the mother's heart rate in heartbeats per minute, in absence of contractions.

BLOOD PRESSURE: Record the systolic and diastolic pressures measured in absence of contractions in millimeters of mercury.

CONTRACTILITY: Indicate the number of contractions occurring in 10 minutes. After the slash enter the duration in seconds of the contraction -as determined by abdominal palpation- from the moment hardening begins to the relaxation phase.

STATION/POSITION: Record the height of the presentation and the position in abridged form. **FETAL HEART RATE:** Record the basal fetal heart rate in absence of contractions in beats per minute. Take the fetal heart rate during and after the contraction too so that any lessening of the frequency in the relaxation phase may be detected. For example: 160/II indicates that 160 beats per minute is the basal fetal heart rate and type II dips or late decelerations showing.

DILATION CX. (in cm): Use the white part of the box to enter the dilation of the internal orifice of the cervix, estimating it to the nearest centimetre.

MECONIUM: If meconium es present, mark the yellow triangle. Otherwise, leave it blank.

DELIVERY: Mark the box corresponding to the method of delivery employed. Also enter the time of delivery.

EPISIOTOMY: Mark the appropriate box.

LACERATIONS: Mark the appropriate box.

EXPULSION OF PLACENTA: Mark the appropriate box.

COMPLETE PLACENTA: Mark the appropriate box.

FETAL DEATH: Indicate whether fetal death occurred or not. If it did, specify if it occurred during pregnancy, during labour or at an uncertain time ("not sure when").

LEVEL OF CARE: It refers to the place of delivery. The level of care provided should be specified (1st level, 2nd level, 3rd level, home or other). If you check "Other" please give details.

NEONATAL CLINICAL RECORD NUMBER: In case a clinical record is opened to register all data about the newborn, enter the number assigned to it by the institution.

DELIVERY/NEWBORN ATTENDED BY: Indicate the qualification of the person in charge of the delivery and who took care of the newborn at birth (Physician, nurse or midwife, auxiliary, traditional birth attendant or other).

NEWBORN'S NAME: As soon as the baby is given a name, record it.

DELIVERY/Name: Write down the name of the person who attended the delivery.

NEWBORN/Name: Write down the name of the person who attended the newborn inmediately after birth.
INTRAPARTUM MEDICATION: Check the appropriate box.
PROBLEMS OF PREGNANCY/DELIVERY/PUERPERIUM: A list of 18 possible pathologies is given. Mark an "x" in the corresponding boxes as pathologies are diagnosed. The "None" box shall be marked at the mother's discharge if no problems were diagnosed up to then. If the "Other" box is checked, please specify in the free space.

3.6 Newborn

SEX: Mark "x" in the appropriate box.
V.D.R.L.: Check the corresponding box.
APGAR SCORE: Enter the Apgar score at the first and the fifth minutes. If the Apgar score is 0 to 6 at the first minute, mark the yellow box below.
RESUSCITATION: Indicate whether it was performed or not.
BIRTHWEIGH: Record the nude infant's weight in grams. Remember that 1lb = 454 grams. If birthweight is less than 2500 grams mark the yellow box below.
GESTATIONAL AGE ESTIMATED BY EXAM.: Enter the gestational age in completed weeks as estimated by physical examination of the newborn. If this gestational age is less than 37 weeks, mark the yellow box.
WEIGHT/G.A.: Is the birthweight appropriate to the gestational age ? Mark the appropriate box using a standard fetal growth curve.
1st NEONATAL EXAM.: It refers to the physical examination performed immediately after birth. Check the corresponding box.
LENGTH: Record the length of the infant in cm. 1 inch = 2.4 cm
HEAD CIRC.: Record the circumference of the infant's head in cm.
DISCHARGE EXAM.: This refers to the physical examination undergone by the newborn immediately before discharge.
NEUROLOGICAL EXAM.: Check the corresponding box.
PROBLEMS: A list of 10 pathologies is given. Mark the boxes as neonatal pathologies are diagnosed. The "None" box is be marked at discharge only in case no problems were detected. If the "Other" box is checked please give details.
ROOMING-IN: If the newborn is roomed with his or her mother, mark "YES". Check "NO" if the newborn is kept in a neonatal care room.
DISCHARGE NEONATE: Mark the appropriate box to indicate the condition of the infant at discharge.
AGE AT DISCHARGE OR REFERRAL: Enter the infant's postnatal age at discharge or referral in hours and days.
AGE AT DEATH: In case of neonatal death, write the age at death in hours and days.
FEEDING: Check the box corresponding to the type of feeding at discharge.

3.7 Puerperium

This section includes three columns to be filled during postpartum control examinations.

TIME ELAPSED SINCE DELIVERY OR ABORTION: This refers to the hours and days elapsed between the delivery or abortion and the current control.
TEMPERATURE: Enter temperature using three digits (tenths of a degree - e.g. 36.4 degrees Celcius). Add the letter "R" if the temperature was rectal, "B" if it was buccal and "A" if it was axillary.
PULSE: Enter the cardiac frequency in beats per minute.
BLOOD PRESSURE: Record the systolic and diastolic pressure of the patient in milimetres of mercury (mm Hg). For example: 110/70.
UTERINE RETRACTION: State whether the retraction was good, poor or absent. According to local standards, the uterine height is measured either in cm or otherwise.
LOCHIA: Note the characteristics of the lochial flow according to local standards.
MATERNAL DISCHARGE: Indicate whether the mother was healthy, ill or referred elsewhere at discharge. If she died before discharge, you must specify at which moment (pregnancy, delivery or puerperium).
CONTRACEPTIVE ADVICE: If contraceptive advice was provided, indicate the selected method.

3.8 Multiple Pregnancy

In case of multiple pregnancy, each delivery is registered in a separated SPCR form no matter whether the product was dead or alive. All common data such as the mother's file number, history, etc. are repeated in the second clinical record.

The records will differ in the data of the delivery and the newborn sections. Distinction between records will be possible during data processing on the basis of the neonatal clinical record number.

3.9 Abortions

Fill in only the following sections:

- Woman's identification
- History
- Pregnancy
- Problems
- Labour or Abortion, except for:
  - Presentation
  - Fetal heart rate
  - Meconium
  - These items should be left blank.
- Newborn: Only Sex and Birthweight must be completed.
- Puerperium

3.10 Stillborn

When "YES" is marked for "fetal death", only the following items must be filled out in the "Newborn" section:

- Sex
- Apgar Score 1st minute and 5th minute (Write zero in both boxes)
- Birthweigth

The other sections must be completed in the usual way.

4. TRAINING IN THE FILLING IN OF THE SPCR FORM

4.1 General Instructions for Group Work

The group chooses a coordinator among its participants. The coordinator will encourage the members of the group to participate in the discussion. A speaker of the group will also be chosen so that the conclusions drawn by the group on the advantages of this model of clinical record, the difficulties that may arise during the filling of the SPCR form and possible solutions to eventual difficulties can be presented at the final plenary session.

The group will be asked to take into account the following criteria for evaluation of the SPCR:

- Time needed for completion
- Comprehension of the items included and feasibility of completion of the SPCR.
- Reliability of the collected data.
- Usefulness of the form in the training of health personnel, in helping them observe standards and in supervising.
- Quality of the instruction manual.
- Advantages over preceding models.

The group will discuss these points during activities 1, 2, and 3. The group will together find a way to relinquish any doubts. In this way the instruction manual will be evaluated for its accuracy. The questions not answered in group discussion will either be presented to the instructor or analyzed in the plenary session.

4.2 Activity 1

Estimated duration: 15 minutes

The group will choose two members; one will play the role of a pregnant mother and the other will play the role of a physician. The physician will interview the mother and fill out

the data corresponding to identification, age, sociocultural status, family history, personal history and obstetric history. Before drawing the final conclusion, the group will read the instruction manual and verify if all boxes were filled in correctly.

4.3 Activity 2

Estimated duration: 20 minutes

The group will fill out the SPCR with data from the Pregnancy section of the case example included in this manual for the purpose of this exercise. The group will verify if the data were correctly entered. After drawing the conclusions the group will continue with the following activity.

4.4 Activity 3

Estimated duration: 35 minutes

The group will:

a) Enter the data included in the Labour or abortion section of the SPCR form example included in the appendix.

b) Read section 4.5 and fill in an SPCR form with the data included in the text.

4.5 Description of a case

On .../.../..., at 4:43 a.m., after a bearing down efforts period of 15 minutes, the mother delivered a baby boy in the delivery room. The onset and the termination of labour were spontaneous. Presentation was vertex. Episiotomy and a local anaesthetic were required. The placenta was expelled intact at 5:00 on the same day, according to the testimony of Miss Mary Brown, the midwife who was present at the delivery, and no tearing was observed.

The newborn was immediately cared for by Miss Lucy White, the nurse on duty, who gave him an Apgar score of 8 at the 1st minute and 9 at the 5th minute.

Baby Jorge weighed 3200 grams at birth and at 7 minutes he was pink, breathing normally, with normal muscle tone and crying vigorously. By physical exam, gestational age was estimated to be 38 weeks. V.D.R.L. exam was made on blood from the umbilical cord with a normal result.

The abdominal and cardiovascular examination was normal and the baby urinated normally. Rectal patency was also confirmed and meconium was present in the rectum. The baby's length was 47 cm and its head circumference was 33 cm.

The newborn was given to his mother after birth with the recommendation that he should be put to breast immediately. Two days later the baby and his mother were discharged and an

appointment was made for both to undergo follow-up controls. At discharge, the mother was informed about the different contraceptive methods and decided to reinitiate the use of oral contraceptives.

5. REFERENCES

1. SCHWARCZ R., DIAZ A.G., FESCINA R.H., DIAZ ROSSELLO J.L., MARTELL M. y TENZER S.M. "Historia Clínica Perinatal Simplificada. Propuesta de un Modelo para la Atención Primaria de Baja Complejidad", Boletin de la O.P.S., volumen 95, pàginas 163 a 172, 1983.

2. BELIZAN, J.M., DIAZ, A.G., GIACOMINI, H., HORCHER, R., MaARTELL M., QUARANTA, P., SSCWARCZ, R. "Historia Clinica Perinatal. Propuesta de un modelo", Ministerio de Bienestar Social, Secretaria de Estado de Salud Publica. Direccion Nacional de Maternidad e Infancia, Argentina. Organizacion Mundial de la Salud. Publicado por el Centro Latinoamericano de Administracion Medica, Buenos Aires, Noviembre de 1976.

3. SIMINI, F., SCHWARCZ, R., DIAZ, A.G., LOPEZ, R., BELITZKY, R., TENZER, S.M. and FESCINA, R. "Perinatal Information System. User's manual", C.L.A.P. Scientific Publication No 1110, November 1986

4. TENZER, S.M., LOPEZ, R. "Historia Clinica Perinatal Simplificada. Instructivo de llenado y aclaraciones para la implantacion de la HPCS", Doc. Int. C.L.A.P. - 10/84, Noviembre 1984.

CLAP - PAHO/WHO Perinatal Information System 16/85 21-NOV-1986
Latin American Center for Perinatology and Human Development
AP1040/Vers.3

BASIC STATISTIC : FROM 1-AUG-85 TILL 31-DEC-85

Total records.....	648	
Live births >499g.....	620	(<2500g: 91 14.7% <1500g: 18 2.9%)
Stillbirths>499or >19w.	16	Live births >999g..... 613
Abortions<500g or <20w.	6	
Int.fetal D>499<1000g	4	rate 6.3 per 1000 b. live or dead>499g
Late fet. death>999 g	12	rate 19.0 per 1000 b. live or dead>999g
Early neonat.de>499 g	5	rate 8.1 per 1000 born live > 499g
>999 g	3	rate 4.9 per 1000 born live > 999g
Late neonat. de>499 g	1	rate 1.6 per 1000 born live > 499g
>999 g	1	rate 1.6 per 1000 born live > 999g
Neonatal deaths>499 g	11	(<2500g: 10 <1500g: 9)
Perinatal deaths>499g	17	rate 26.7 per 1000 b. live or dead>499g
>999 g	15	rate 24.0 per 1000 b. live or dead>999g
Maternal deaths.....	0	

MOTHER

With pathology.....	290	44.8%
Multiple pregnancy....	30	4.6%
Previous hypertension.	40	6.2%
Preeclampsia.....	28	4.3%
Eclampsia.....	1	0.2%
Cardiac disease.....	4	0.6%
Diabetes.....	10	1.5%
Urinary infection.....	28	4.3%
Other infection.....	2	0.3%
Parasitosis.....	2	0.3%
Threat premat. labour.	45	6.9%
Ceph. pelv. dispr.....	9	1.4%
Bleeding 1st.trim.....	15	2.3%
Bleeding 2nd.trim.....	10	1.5%
Bleeding 3rd.trim.....	10	1.5%
Chronic anaemia.....	8	1.2%
Premat. rupture memb..	68	10.5%
Puerperal infection...	0	0.0%
Puerperal bleeding....	2	0.3%
Other problems.....	82	12.7%
No toxoid in pregn....	413	63.7%
With antenatal visits.	632	97.5%
1st. in 1st.trim..	93	14.7%
1st. in 2nd.trim..	308	48.7%
1st. in 3rd.trim..	194	30.7%
No antenatal visits...	16	2.5%
and hospitalized.....	0	0.0%
and not hospitalized.	15	93.8%

LABOUR AND DELIVERY

Rupture membranes>24 hs.	355	55.8%
Induced onset.....	60	9.4%
Delivery: spontaneous...	345	54.2%
forceps.....	31	4.9%
cesarean sec.	241	37.9%
other.....	0	0.0%
Apgar score 4 - 6.....	16	2.5%
0 - 3.....	43	6.8%

NEWBORN

With pathology.....	25	4.0%
Hyaline membrane dis....	2	0.3%
Aspirative syndrome.....	0	0.0%
Other RDS.....	1	0.2%
Apnoeas.....	7	1.1%
Bleeding.....	1	0.2%
Hyperbilirubinaemia.....	10	1.6%
Infection.....	0	0.0%
Neurologic problems.....	1	0.2%
Congenital anomalies....	3	0.5%
Other pathologies.....	3	0.5%
Contraceptive advice....	56	8.6%

Comments:_____

_____Signature:_____

N.B.: The validity of these figures depends heavily upon the entered information. Check the COMPLETENESS CONTROL document for this period.

CLAP - PAHO/WHO Perinatal Information System 16/85 21-NOV-1986
AP1060/vers.3

Latin American Center for Perinatology and Human Development

| DESCRIPTION OF AGE | FROM 1-AUG-85 TILL 31-DEC-85

Total records..... 648

AGE
In years

Values	Cases	Percent.	
10 - 14	2	0.3 %	!
15 - 19	92	14.2 %	!******
20 - 24	147	22.7 %	!**********
25 - 29	163	25.2 %	!***********
30 - 34	102	15.7 %	!*******
35 - 39	87	13.4 %	!******
40 - 44	54	8.3 %	!****
45 - 49	1	0.2 %	!
	0	0.0 %	!

Total 648 100.0 %

N.B.: An asterisk is represented by 3.3 records

Cases for calculations: 648 100.0 %

First Minimum: 14 in record number: 2748274
First Maximum: 47 in record number: 1729072

Mean: 27.8 Standard Deviation: 7.5 Coef.variation: 3.7
Percentiles: P10= 19.0 P25= 24.0 P50= 29.0 P75= 34.0 P90= 39.0

Comments:_____

_____

_____

_____Signature:_____

CLAP - PAHO/WHO **SIMPLIFIED PERINATAL CLINICAL RECORD** INSTITUTION FILE N°

SURNAME OTHER NAMES

ADDRESS

COUNTRY

AGE Years — Under 15 y s. — Over 35 y s.

LITERATE Yes No

EDUCATION/LEVEL None Second. Prim. Univ.

YEARS COMPLETED

CIVIL STATUS Com-law Married wife Single Oth

SMOKES No Yes How many cigarettes?

This color means ALERT

HISTORY

FAMILY — No Yes: Diabetes; Pulmonary TB; Twins; Others

PERSONAL — No Yes: Pulmonary TB; Diabetes; Hypertension; Uter-pelvic - surgery; Infertility; Others

OBSTETRICAL

Write total number of PREGNANCIES: ABORTIONS; DELIVERIES (None or more than 3 deliveries); VAGINAL; C - SECTION

LIVE BORN — STILL ALIVE; DIED in 1st week; DIED after 1st week

STILLBORN

ANY PREVIOUS NEONATE OF LESS THAN 2500 g. No Yes

HIGHEST PREVIOUS BIRTHWEIGHT g

DATE OF TERMINATION OF LAST PREGNANCY Month Year

PREGNANCY

Pre-preg-weight Kg Height (cm) 1

EDC / LMP Day Month Year

Doubt. No Yes

TETANUS TOX. PREVIOUS Yes No — ACTUAL 1° 2°/B — Month of Pregn.

BLOOD GROUP Rh + − Sensitiz. No Yes

HOSPITALIZATION No Yes Days

REFERRAL No Yes (Place) Day Month Year

CLINICAL Exam. (NORMAL)	BREAST Exam. (NORMAL)	DENTAL Exam. (NORMAL)	PELVIS (NORMAL)	PAPSMEAR (NORMAL)	COLPOSCOPY (NORMAL)	CERVIX CLIN. Exam. (NORMAL)	VDRL − + Day Month	Hb g Day Month
Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No		

VISIT N°	1	2	3	4	5	6	
DATE							
WEEKS OF AMENORRHEA							
WEIGHT (Kg.)							
BLOOD PRESSURE Syst/Diast (mm Hg)							
UTERINE HEIGHT Pubis - fundus (cm)							
Foetal hear rate/movements	/	/	/	/	/	/	
PRESENTATION Vertex Breech or Transv							

LABOUR/ABORT

Referred From

GEST AGE Under 37 Over 42

FETAL SIZE CORRESP TO G.A. Yes No

ONSET Spont. Ind.

MEMBRANES Time of Rupture — Int. Rupt. — Hr. Day Month

Vertex Breech Transv.

LABOUR

Time							
Maternal Heart Rate							
BLOOD PRESSURE Syst/Diast (mm Hg)							
CONTRACTILITY FREQ. 10 min/DURATION sec.	/	/	/	/	/	/	
STATION/POSITION	/	/	/	/	/	/	
Foetal Heart Rate							
DILATION CX. (in cm.) / MECONIUM	/	/	/	/	/	/	

PROBLEMS OF PREGNANCY/DELIVERY/PUERPERIUM

- Multiple pregnancy
- Previous hypertension
- Pre-eclampsia
- Eclampsia
- Cardiac Disease
- Diabetes
- Urinary infection
- Other infections.
- Parasitosis
- Threatened Premature Labor.
- Ceph. Pelv. Disproportion.
- 1sr. trim. bleeding
- 2nd. trim. bleeding
- 3rd. trim. bleeding
- Chronic anaemia
- Premature rupture of membr.
- Puerperal infection
- Puerperal bleeding
- Other
- None

DELIVERY Spont. C-Sec. Forc. Oth. — Hr. Min Day Month Year

LEVEL OF CARE 3° 2° 1° Home Other

Attended by Physician Nurse/ Midw. Auxil. Student/ T.B.A. Other

DELIVERY

NEWBORN

NEON.CLIN. RECORD N°

NEON. Name

Name

Name

Episiotomy No Yes — Lacerations No Yes

Expuls of placenta Yes No — Complete placenta Yes No

Foetal Death No Yes Preg. — Yes in Labor Yes not sure when

INTRAPARTUM MEDICATION Local Anest. Reg. Anest. Gen. Anest. Analges. Tranquil. Oxytocin. Antibiot. Other None

NEWBORN

SEX F M — VDRL − + — APGAR score 1°m 5°m 0-6 at 1° m.

Resuscitation Yes No

BIRTHWEIGHT g Less than 2500 g

GEST. AGE estimated by exam. Weeks Less than 37 w

Weight/G.A. Approp. Small Large

1st. neon. Exam. Normal Abnormal

Length Cm

HEAD CIRC. Cm

DISCHARGE EXAM. Normal Abnormal

NEURO.EXAM. Normal Abnormal Doubtful

PROBLEMS: H.M.D. Aspirat. Synd. — Other RDS Apnoea Bleeding — Hiperbili. Infection NeuroL — Congen. Anom. Other None

ROOMING-IN Yes No

DISCHARGE (neon) Healthy Referr ILL Dead

AGE AT DISCHARGE or REFERRAL Ds. Hs.

AGE AT DEATH Ds. Hs.

FEEDING Breast Br.+Bott. Bottle

PUERPERIUM

TIME ELAPSED SINCE DELIVERY/ABORT			
TEMPERATURE			
PULSE (b.p.m.)			
BLOOD PRESSURE Syst/diast (mm Hg.)			
UTERINE RETRACTION			
LOCHIA			

Maternal discharge: Healthy Referral ILL

Maternal death. during: Pregnancy Delivery Puerperium

Contraceptive advice: Condom I.U.D. Oral — None Tubal ligation Rythm Other

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This color means ALERT

CLAP - PAHO/WHO **SIMPLIFIED PERINATAL CLINICAL RECORD** INSTITUTION FILE Nº

SURNAME OTHER NAMES

ADDRESS

COUNTRY

AGE Years — Under 15 y s. — Over 35 y s.

LITERATE Yes No

EDUCATION/LEVEL None Second. Prim. Univ.

YEARS COMPLETED

CIVIL STATUS Com-law Married wife Single Oth

SMOKES No Yes How many cigarettes?

HISTORY

FAMILY — No Yes
Diabetes
Pulmonary TB
Twins
Others

PERSONAL — No Yes
Pulmonary TB
Diabetes
Hypertension
Uter-pelvic - surgery
Infertility
Others

OBSTETRICAL
Write total number of
PREGNANCIES
ABORTIONS
DELIVERIES
None or more than 3 deliveries
VAGINAL
C - SECTION
LIVE BORN — STILL ALIVE — DIED in 1st. week — DIED after 1st. week
STILLBORN

ANY PREVIOUS NEONATE OF LESS THAN 2500 g No Yes

HIGHEST PREVIOUS BIRTHWEIGHT g

DATE OF TERMINATION OF LAST PREGNANCY Month Year

PREGNANCY

Pre-preg-weight Height (cm) Kg

EDC Day Month Year
LMP Day Month Year

Doubt. No Yes

TETANUS TOX. PREVIOUS Yes No — ACTUAL 1º 2º/B — Month of Pregn.

BLOOD GROUP Rh + − Sensitiz. No Yes

HOSPITALIZATION No Yes Days

REFERRAL No Yes (Place) Day Month Year

CLINICAL Exam. (NORMAL)	BREAST Exam. (NORMAL)	DENTAL Exam. (NORMAL)	PELVIS (NORMAL)	PAPSMEAR (NORMAL)	COLPOSCOPY (NORMAL)	CERVIX CLIN. Exam. (NORMAL)	VDRL	Day Month	Hb	Day Month
Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	− +		g	

VISIT Nº	1	2	3	4	5	6
DATE						
WEEKS OF AMENORRHEA						
WEIGHT (Kg.)						
BLOOD PRESSURE Syst/Diast (mm Hg)						
UTERINE HEIGHT Pubis - fundus (cm)						
Foetal hear rate/movements	/	/	/	/	/	/
PRESENTATION Vertex Breech or Transv						

LABOUR/ABORT

Referred From

GEST AGE Under 37 Over 42

FETAL SIZE CORRESP TO G.A. Yes No

ONSET Spont. Ind.

MEMBRANES Time of Rupture — Int. Rupt. — Hr. Day Month

Vertex Breech Transv

LABOUR							
Time							
Maternal Heart Rate							
BLOOD PRESSURE Syst/Diast (mm Hg)							
CONTRACTILITY FREQ. 10 min/DURATION sec.	/	/	/	/	/	/	/
STATION/POSITION	/	/	/	/	/	/	/
Foetal Heart Rate							
DILATION CX. (in cm.) / MECONIUM	/	/	/	/	/	/	/

PROBLEMS OF PREGNANCY/DELIVERY/PUERPERIUM

- Multiple pregnancy
- Previous hypertension
- Pre-eclampsia
- Eclampsia
- Cardiac Disease
- Diabetes
- Urinary infection
- Other infections.
- Parasitosis
- Threatened Premature Labor.
- Ceph. Pelv. Disproportion
- 1sr. trim. bleeding
- 2nd. trim. bleeding
- 3rd. trim. bleeding
- Chronic anaemia
- Premature rupture of membr.
- Puerperal infection
- Puerperal bleeding
- Other
- None

DELIVERY Spont. C-Sec. Forc. Oth. — Hr. Min Day Month Year

LEVEL OF CARE 3º 2º 1º Home Other

Attended by Physician Nurse/ Midw Auxil. Student/ T.B.A. Other

DELIVERY

NEWBORN

Episiotomy No Yes — Lacerations No Yes

Expuls of placenta Yes No — Complete placenta Yes No

Foetal Death No Yes Preg. — Yes in Labor Yes not sure when

NEON.CLIN. RECORD Nº

NEON. Name

Name

Name

INTRAPARTUM MEDICATION Local Anest. Reg. Anest. Gen. Anest. Analges. Tranquil. Oxytocin. Antibiot. Other None

NEWBORN

F M *SEX — − VDRL +

APGAR score 1º m 5º m — 0-6 at 1º m

Resuscitation Yes No

BIRTHWEIGHT g — Less than 2500 g

GEST. AGE estimated by exam. Weeks — Less than 37 w

Weight/G.A. Approp. Small Large

1st. neon. Exam. Normal Abnormal

Length Cm

HEAD CIRC. Cm

DISCHARGE EXAM. Normal Abnormal

NEURO.EXAM. Normal Abnormal Doubtful

PROBLEMS: H.M.D. Aspirat. Synd. — Other RDS Apnoea Bleeding — Hiperbili. Infection Neurol. — Congen. Anom. Other None

ROOMING-IN Yes No

DISCHARGE (neon) Healthy Referr ILL Dead

AGE AT DISCHARGE or REFERRAL Ds. Hs

AGE AT DEATH Ds. Hs.

FEEDING Breast Br. + Bott. Bottle

PUERPERIUM

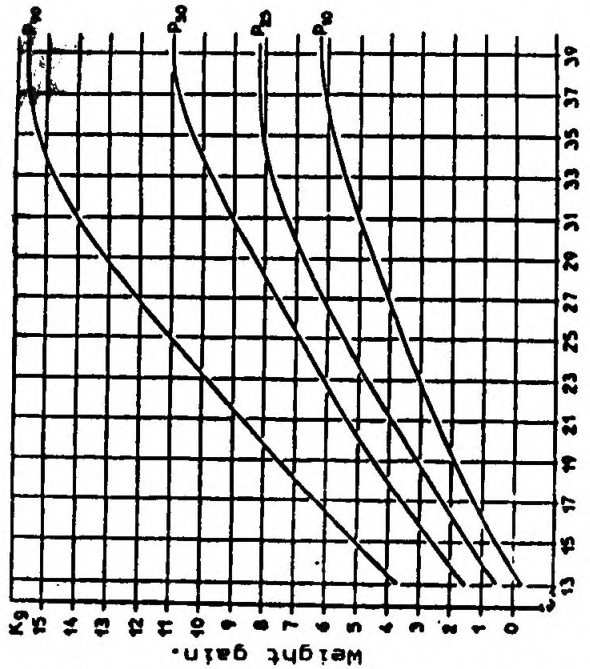
TIME ELAPSED SINCE DELIVERY/ABORT			
TEMPERATURE			
PULSE (b.p.m.)			
BLOOD PRESSURE Syst/diast (mm Hg.)			
UTERINE RETRACTION			
LOCHIA			

Maternal discharge: Healthy Referral ILL

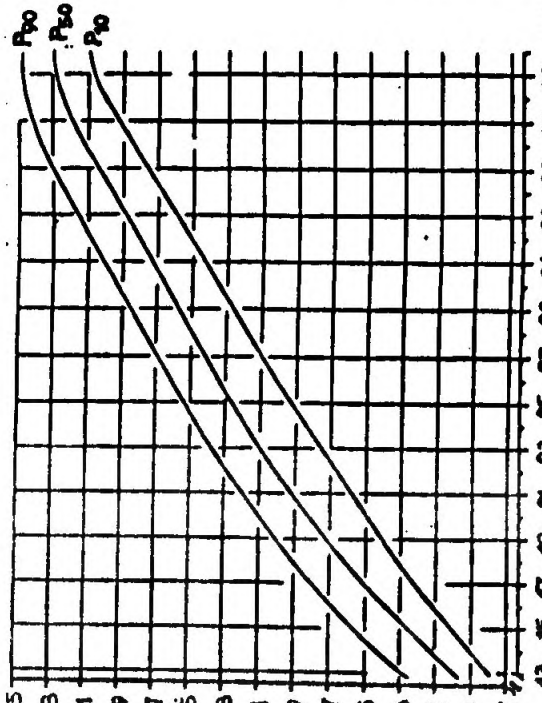
Maternal death. during: Pregnancy Delivery Puerperium

Contraceptive advice: Condom I.U.D. Oral — None Tubal ligation Rythm Other

Doc. Int. CLAP 21/88 - INTERGRAF S.A. RUC. 2108190900018



Bol. Ofic. Sanit. Panamer. 95: 156 - 162. 1983.



Bol. Ofic. Sanit. Panamer. 96: 377 - 386. 1984.

You will become a mother and you should bear in mind that :
- Pregnancy is not an illness. Yet it needs health care control to prevent problems.
- Your first control visit to the health care center be as soon as possible.
- You should attend your scheduled visits and follow the physician's advice.

Illness may result from want of love in your child.
You should show him or her all your love from pregnancy.

Remember that breast-fed babies are seldom ill.
Alcohol and tobacco are bad formother and baby. Heed personal hygiene and avoid physical excesses.

You should refer to the Health Institution in case: - Signs that labour has begun, at any stage of gestation.
- Bleeding or any other discharge from your genitals.
- Swelling (edema) of the legs, the hands or the face.
- Fever or shivers.
- Persistent headaches accompanied by visual problems or ear suppuration.

Please pass this message on to every pregnant woman you know

C.L.A.P. Int.Doc 21/86

PERINATAL PASSPORT

This passport contains essential data for your child's health as well as yours. Keep it with you and hand it in to the health care personnel whenever you refer to them during pregnancy, delivery and puerperium.

In case of loss, please return it to the address appearing inside.

C.L.A.P. PAHO/WHO

CLAP - PAHO/WHO **SIMPLIFIED PERINATAL CLINICAL RECORD** INSTITUTION

FILE Nº

SURNAME OTHER NAMES

ADDRESS

COUNTRY

AGE Years — Under 15 y s. — Over 35 y s.

LITERATE Yes No

EDUCATION LEVEL None Prim Second. Univ.

YEARS COMPLETED

CIVIL STATUS Com-law Married wife Single Oth

SMOKES No Yes How many cigarettes?

HISTORY

FAMILY — No Yes

Diabetes

Pulmonary TB

Twins

Others

PERSONAL — No Yes

Pulmonary TB

Diabetes

Hypertension

Uter-pelvic - surgery

Infertility

Others

OBSTETRICAL

Write total number of PREGNANCIES: ABORTIONS, DELIVERIES (None or more than 3 deliveries)

DELIVERIES: VAGINAL, C - SECTION

LIVE BORN: STILL ALIVE, DIED in 1st week, DIED after 1st week

STILLBORN

DATE OF TERMINATION OF LAST PREGNANCY Month Year

ANY PREVIOUS NEONATE OF LESS THAN 2500 g No Ye

HIGHEST PREVIOUS BIRTHWEIGHT g

PREGNANCY

Pre-preg-weight Height (cm) Kg 1

	Day	Month	Year	Doubt.
EDC				No
LMP				Yes

TETANUS TOX. PREVIOUS Yes No — ACTUAL 1º 2º/B — Month of Pregn.

BLOOD GROUP Rh + − Sensitiz. No Yes

HOSPITALIZATION No Yes — Days

REFERRAL No Yes (Place) — Day Month Year

CLINICAL Exam. (NORMAL) Yes No

BREAST Exam. (NORMAL) Yes No

DENTAL Exam. (NORMAL) Yes No

PELVIS (NORMAL) Yes No

PAP SMEAR (NORMAL) Yes No

COLPOSCOPY (NORMAL) Yes No

CERVIX CLIN. Exam. (NORMAL) Yes No

VDRL − +

Day Month

Hb g — Day Month

VISIT Nº	1	2	3	4	5	6
DATE						
WEEKS OF AMENORRHEA						
WEIGHT (Kg.)						
BLOOD PRESSURE Syst/Diast (mm Hg)						
UTERINE HEIGHT Pubis - fundus (cm)						
Foetal hear rate/movements	/	/	/	/	/	/
PRESENTATION Vertex Breech or Transv						

PROBLEMS OF PREGNANCY/DELIVERY/PUERPERIUM

- Multiple pregnancy
- Previous hypertension
- Pre-eclampsia
- Eclampsia
- Cardiac Disease
- Diabetes
- Unnary infection
- Other infections.
- Parasitosis
- Threatened Premature Labor
- Ceph Pelv Disproportion
- 1st. trim. bleeding
- 2nd. trim. bleeding
- 3rd. trim. bleeding
- Chronic anaemia
- Premature rupture of membr
- Puerperal infection
- Puerperal bleeding
- Other
- None

LABOUR/ABORT

Referred From

GEST AGE — Under 37 — Over 42

FETAL SIZE CORRESP TO G.A. Yes No

ONSET Spont. Ind

MEMBRANES Time of Rupture — Int. Rupt. — Hr. Day Month

Vertex Breech Transv

DELIVERY Spont. C-Sec. Forc. Oth. — Hr. Min Day Month Year

LEVEL OF CARE 3º 2º 1º Home Other

Attended by Physician Nurse/ Midw. Auxil. Student/ T.B.A. Other

DELIVERY

NEWBORN

NEON.CLIN. RECORD Nº

NEON. Name

Name

Name

Episiotomy No Yes — Lacerations No Yes

Expuls of placenta Yes No — Complete placenta Yes No

Foetal Death No Yes Preg. — Yes in Labor Yes not sure when

INTRAPARTUM MEDICATION Local Anest. Reg. Anest. Gen. Anest. Analges. Tranquil. Oxytocin. Antibiot. Other None

NEWBORN

SEX F M

VDRL − +

APGAR score 1'm 5'm 0-6 at 1'm

Resuscitation Yes No

BIRTHWEIGHT g — Less than 2500 g

GEST. AGE estimated by exam. Weeks — Less than 37 w

Weight/G.A. Approp. Small Large

1st neon. Exam. Normal Abnormal

Length Cm

HEAD CIRC Cm

DISCHARGE EXAM. Normal Abnormal

NEURO.EXAM. Normal Abnormal Doubtful

PROBLEMS: H.M.D. Aspirat. Synd. — Other RDS Apnoea Bleeding — Hiperbili. Infection Neurol. — Congen. Anom. Other None

ROOMING-IN Yes No

DISCHARGE (neon) Healthy Referr ILL Dead

AGE AT DISCHARGE or REFERRAL Ds. Hs

AGE AT DEATH Ds. Hs.

FEEDING Breast Br.+Bott. Bottle

PUERPERIUM

TIME ELAPSED SINCE DELIVERY/ABORT			
TEMPERATURE			
PULSE (b.p.m.)			
BLOOD PRESSURE Syst/diast (mm Hg.)			
UTERINE RETRACTION			
LOCHIA			

Maternal discharge: Healthy Referral ILL

Maternal death. during: Pregnancy Delivery Puerperium

Contraceptive advice: None Condom I.U.D. Oral — Tubal ligation Rythm Other

Standards of Uterine height and maternal weight gain

These curves can only be used when gestational age is known. Using these standards and the measures at each control visit you may locate a point in the corresponding graph.