DATA COLLECTION FORM

Ref. No.   **Date:**

In-patient no.

A. PATIENT DEMOGRAPHIES

   1. Name of the patient

   2. Age in years

B. PATIENT ADMISSION

   3. Date of hospital admission

   4. Time of hospital admission

C. YES OR NO QUESTIONS

   5. Caesarean section at last pregnancy

   6. Has the women been diagnosed with HIV Positive?

   7. Use of antibiotic treatment within one week prior to caesarean section

   8. For Caesarean section, please select the indication below

   a. Suspected fetal growth impairment

   b. Fetal distress

   c. Preclampsia/ Eclampsia

   d. Gestational age 41 completed weeks or more

   e. Cephalopelvic disproportion

   f. Dystocia

   g. Failure to progress

   h. Multiple pregnancy

   i. Suspected/imminenent uterine rupture

   j. Breech

   k. Failed induction

   l. Oligohydroaminos

m. Anterior placentation ⬚

n. Posterior placentation ⬚

o. Any other fetal indication ⬚

p. Any other fetal indication ⬚

q. Any other maternal medical complication ⬚

D. OTHER INFORMATIONS
   9. Total number of deliveries ⬚

   10. Date of delivery ⬚

       Time of delivery ⬚

   11. Did the woman receive prophylactic antibiotic treatment? ⬚

   12. Name of the antibiotics given ⬚

       Dose ⬚

       Route ⬚

       Frequency ⬚

   13. When were the antibiotics given? (If Q.10=Yes)

   a. Prophylactic before caesarean section ⬚

   b. Introperative (Just after cord clamping) ⬚

   c. Prophylactic after Caesarean section ⬚

   14. Time of antibiotic administration ⬚

   15. Date of discharge ⬚

   16. Length of hospital stay (in days) ⬚

   17. Any infection following antibiotic prophylaxis within the hospital stay? ⬚

   18. If Q. No. 17 = YES then, type of infection ⬚

   19. Type of delivery ⬚