

Woman's date of birth:

D	D	/	M	M	/	Y	Y
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Woman's study number:

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## Higher Level of Care data collection form WOMAN post study entry

Please complete this form for a woman who received a higher level of care and/or who had surgery following her delivery.

Please liaise with your local Principal Investigator (PI) to complete this form.

Please complete in black ballpoint pen.

### **BUMPES Co-ordinating Centre**

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## ICNARC HDU Definitions of Care

**Level 0:** patients whose needs can be met through general ward care

**Level 1:** patients who are at risk of their condition deteriorating, or those who have recently been relocated from higher levels of care whose needs can be met on the general ward with additional advice and support from the critical care team.

**Level 2:** patients requiring more detailed monitoring and support, including support for a single failing organ system, or postoperative care and those stepping down from higher levels of care.

**Level 3:** patients needing monitoring and support for two or more organs systems, one of which may be basic or advanced respiratory support.

## Section 1: Level of care details

**1.1 Please give details of this woman's higher level of care:**

	Level of care required <i>(please tick as appropriate - n.b. full day = 24 hrs)</i>							
	Level 0		Level 1		Level 2		Level 3	
<b>Day 1</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 2</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 3</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 4</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 5</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 6</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 7</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>
<b>Day 8</b>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>	Full day <input type="checkbox"/>	Partial day <input type="checkbox"/>

**1.2 Please state the primary reason for admission into higher care:**

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## Section 2: Surgery

2.1 Did the woman undergo any additional surgery at the time of, or following delivery (excluding initial perineum or anterior suturing) prior to her discharge or transfer from this hospital?

Yes  No

If Yes, please give details below:

**Surgery 1:** Date of surgery: .....   /   /

Type of surgery: \_\_\_\_\_

**Surgery 2:** Date of surgery: .....   /   /

Type of surgery: \_\_\_\_\_

**Surgery 3:** Date of surgery: .....   /   /

Type of surgery: \_\_\_\_\_

**Surgery 4:** Date of surgery: .....   /   /

Type of surgery: \_\_\_\_\_

Please use an additional form if necessary.

## Section 3: Investigations

3.1 Did the woman have any X-rays, CT scans or MRI scans following delivery and prior to her discharge or transfer from this hospital?

Yes  No

If Yes, please indicate which investigations were performed:

X-rays  If ticked, how many?

CT-scans  If ticked, how many?

MRI  If ticked, how many?

## Section 4: Outcome (Please complete **only one** of the outcome sections below)

### 4.1 Discharge home

Was the woman discharged home from this hospital? Yes

If Yes, please give date of discharge home:

/   /

### 4.2 Transfer to another hospital

Was the woman transferred to another hospital? Yes

If Yes, name of the transfer hospital: \_\_\_\_\_

Please specify how the woman was transferred:

Ambulance  Helicopter  Own transport  Other

If Other, please specify: \_\_\_\_\_

Date of transfer:

/   /

### 4.3 Death

Did the woman die during her stay in this hospital? Yes

If Yes, has the cause of death been identified? Yes  No

Principal cause of death:

\_\_\_\_\_

Date of death:

/   /

Form completed by: (Please print) \_\_\_\_\_ Date completed:   /   /

Name of hospital: \_\_\_\_\_

Principal Investigator's signature: \_\_\_\_\_

Please agree the content of this form with your local Principal Investigator (PI) then return this completed form to the BUMPES Co-ordinating Centre using the FREEPOST envelope.

**Thank you for completing this form**