University of BRISTOL UNIVERSITY OF BIRMINGHAM BiCOPS Birmingham Centre for Observational and Prospective Studies SOUTH WEST NEONATAL NETWORK NHS University Hospitals Bristol and Weston NHS Foundation Trust

TRANSFER

Data collection tool: Eligibility Criteria

Keep this document for site use only, do not send to the TRANSFER office team

REDCap record ID *e.g. XXXX-001* | | | | | | - | | | |

Please complete the REDCap record ID once the data has been entered on to REDCap

Section 1 - Patient Details

Patient Identifier will not be uploaded to the REDCap database, but should be kept on a link sheet at site with the corresonding REDCap record ID

Patient Identifier *Site use only* | | | | | | | | | | |

Is the patient over 16 years of Age ◯ Yes ◯ No

Patient must be 16 or over to be eligible

Section 2 - Patient presentation

Please confirm if the patient

◯ Presented at your hospital with threatened preterm birth

◯ Was received at your hospital after being transferred from another hospital with threatened preterm birth

If **received at your hospital** what was the name of the hospital they were transferred from _____

Section 3 - Gestational age at presentation - **to be completed if the patient presented at your site**

Gestation must be between 22+0 and 23+6 weeks to be eligible

Weeks *22, 23* w k

Days *0-6* d

Section 4 - Threatened preterm birth

Was the patient transferred to your unit because they were deemed to be at risk of threatened preterm birth (between 22+0-23+6 weeks' gestation) by the hospital they initially presented at ***Receiving sites only***

◯ Yes ◯ No

In the opinion of the assessing medical team is the woman admitted to an obstetric unit with threatened preterm birth ***Presenting site only***

◯ Yes ◯ No

Threatened preterm birth is defined as any woman presenting with regular uterine activity but no cervical change and/or ruptured membranes and/or vaginal bleeding who in the opinion of the assessing medical team is in threatened preterm birth

Regular uterine activity

Is the woman presenting with regular uterine activity ◯ Yes ◯ No

If **yes**, how frequent are her contractions *select one*

◯ 4 contractions in 10 minutes ◯ 2 contractions in 10 minutes ◯ 1 contraction in **15** minutes

◯ 3 contractions in 10 minutes ◯ 1 contractions in 10 minutes ◯ 1 contraction in **30** minutes

Cervical dilation

Evidence of cervical dilation ◯ Yes ◯ No

If **yes**, cervical dilation at presentation *select one*

◯ 0.5cm ◯ 2cm ◯ 4cm ◯ 6cm ◯ 8cm ◯ 10cm

◯ 1cm ◯ 3cm ◯ 5cm ◯ 7cm ◯ 9cm

and

If **yes**, cervical dilation at transfer *select one*

◯ 0.5cm ◯ 2cm ◯ 4cm ◯ 6cm ◯ 8cm ◯ 10cm

◯ 1cm ◯ 3cm ◯ 5cm ◯ 7cm ◯ 9cm ◯ Not Applicable

Ruptured membranes

Confirmed ruptured membranes ◯ Yes ◯ No

If **Yes**, Gestational age at ruptured membranes

Weeks w k | Days d

Vaginal bleeding

Significant vaginal bleeding ◯ Yes ◯ No

Other reason for threatened preterm birth

Was there another reason the woman was admitted to the obstetric unit with threatened preterm birth ◯ Yes ◯ No

If **yes**, please specify _____

Section 5 - Biomarkers

Fetal fibronectin test result ◯ Under 500 ◯ 500+ ◯ Not carried out

If **under 500** Fetal fibronectin (phosphorylated IGFBP-1) test result ☐☐☐

Actim Partus test result *select one* ◯ Positive ◯ Negative ◯ Not carried out

PartoSure test result *select one* ◯ Positive ◯ Negative ◯ Not carried out

Has a cervical length been measured in last 24 hours ◯ Yes ◯ No

If **Yes** cervical length in millimeters *0-70* m m

Section 6 - QUIPP App

Was The QUIPP App used to predict spontaneous preterm birth ◯ Yes ◯ No

if **Yes** probability of spontaneous pre term birth within one week *percentage* ☐☐☐.☐%

Section 7 - Estimated fetal weight

Was estimated fetal weight preformed by ultra sound at presentation within the decision making period of this episode ◯ Yes ◯ No

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Data collection tool: Patient pathway and outcomes

Section 8 - Care pathway

Was the decision for an active or expectant care pathway *select one* ◯ Active care pathway ◯ Expectant care pathway

If **active care pathway**, did active care pathway happen ◯ Yes ◯ No

Section 9 - Transfer Information - **to be completed if the patient presented at your site**

Did the patient require transfer to a unit with co-located NICU (level 3) ◯ Yes ◯ No

If **no**, what was the reason transfer was not required *select one*
- ◯ Active care pathway not considered at this gestation
- ◯ Active care considered but declined by parent(s) at this gestation
- ◯ Presented at a co-located NICU (level 3) unit
- ◯ Other, please Specify:

If **other**, please specify _____

If **yes**, was transfer achieved ◯ Yes ◯ No

If **yes**, which hospital was the woman transferred to _____

If **no**, why did the transfer not occur *select one*
- ◯ Advanced labour/no time
- ◯ No cot identified in region
- ◯ Cot identified deemed too far
- ◯ Patient declined
- ◯ Mother not medically fit for transfer
- ◯ Other, please specify:

If **other**, please specify _____

If **transferred** Month patient was transferred / patient received at your site _____

Gestation at transfer - **only complete if patient was transferred**

Weeks *22, 23* w k Days *0-6* d

Receiving sites: It is possible that a patient received at 24 weeks and 0 days will be eligible for the study, so please include these patients

Section 10 - Place of delivery

Delivery at your unit during this episode *select one* ◯ Yes ◯ No ◯ Not Applicable

If **no** confirm where the patient delivered *select one* ◯ Home ◯ Born before arrival at receiving site ◯ Another hospital presentation

If **delivery was during another hospital presentation** which hospital did this occur in *select one*
◯ New hospital presentation at presenting site ◯ New hospital presentation at receiving site ◯ Hospital presentation at different site

If **different site**, please specify name of hospital patient delivered in: _____

Section 11 - Singleton or mulitple Pregnancy

Is this a singleton pregnancy *select one* ◯ Yes ◯ No

If **no**, please confirm number of fetuses in this pregnancy ☐☐

Section 12 - Pregnancy Outcome

1st Outcome;

Was the baby born alive ◯ Yes ◯ No | If **yes** survival to admission to NICU ◯ Yes ◯ No ◯ Not Applicable

If **no**, what was the pregnancy outcome? *select one*

- ◯ Stillbirth (intrauterine death ≥ 24 weeks)
- ◯ Miscarriage (intrauterine death < 24 weeks of pregnancy)
- ◯ Termination due to fetal anomaly
- ◯ Termination due to maternal medical condition (not including infection)
- ◯ Termination due to maternal infection
- ◯ Termination other, please specify: _____

Gestation at delivery or gestation at fetal demise

Weeks *22-42* ☐☐ | Days *0-6* ☐

If you need to report any additional pregnancy outcomes, please see the end of the form to add the extra information required.

Section 13 - Length of antenatal stay at your hospital during this episode

Days ☐☐ | Hours ☐☐

Section 14 - Your details

Name: _____ | Today's Date: *e.g. 17-MAY-2021* D D - M M M - Y Y Y Y

Please enter the information from this Data collection tool into the TRANSFER online database https://bistc.redcap.bham.ac.uk

ONLY ANONYMISED DATA WILL BE UPLOADED TO THE TRANSFER DATABASE

Section 15 - Additional Outcomes for this pregnancy

2nd Outcome: if applicable

Was the baby born alive ◯ Yes ◯ No | If **yes** survival to admission to NICU ◯ Yes ◯ No ◯ Not Applicable

If **no**, what was the pregnancy outcome? *select one*

- ◯ Stillbirth (intrauterine death ≥ 24 weeks)
- ◯ Miscarriage (intrauterine death < 24 weeks of pregnancy)
- ◯ Termination due to fetal anomaly
- ◯ Termination due to maternal medical condition (not including infection)
- ◯ Termination due to maternal infection
- ◯ Termination other, please specify: _____

Gestation at delivery or gestation at fetal demise

Weeks *22-42* ☐☐ | Days *0-6* ☐

3rd Outcome: if applicable

Was the baby born alive ◯ Yes ◯ No | If **yes** survival to admission to NICU ◯ Yes ◯ No ◯ Not Applicable

If **no**, what was the pregnancy outcome? *select one*

- ◯ Stillbirth (intrauterine death ≥ 24 weeks)
- ◯ Miscarriage (intrauterine death < 24 weeks of pregnancy)
- ◯ Termination due to fetal anomaly
- ◯ Termination due to maternal medical condition (not including infection)
- ◯ Termination due to maternal infection
- ◯ Termination other, please specify: _____

Gestation at delivery or gestation at fetal demise

Weeks *22-42* ☐☐ | Days *0-6* ☐

If you need to report any additional pregnancy outcomes please use a new blank copy of this page to add the extra information required