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NINCDS COLLABORATIVE
PERINATAL PROJECT
A User's Guide to the Project and Data

Volume II: Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part B: Labor and Delivery

December 1983

Prepared for
the National Institute of Neurological
and Communicative Disorders and Stroke
under Contract 2311105150

Battelle
Pacific Northwest Laboratories

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NINCDS COLLABORATIVE PERINATAL PROJECT: A USER'S GUIDE TO THE PROJECT AND DATA

Volume II. Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part B. Labor and Delivery

NR Hinds
A Brix
JS Littlefield
CR Watson

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Battelle
Pacific Northwest Laboratories
Richland, Washington 99352

INTRODUCTION

DOCUMENT OBJECTIVES AND READER ASSUMPTIONS

Volume II, Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File, provides researchers with detailed documentation for how data were collected, coded and stored on the data base. Volume II will help investigators decide: if data were collected in a suitable way for addressing particular research questions; if revision of forms affected the collection of specific data items; if data were coded on master, variable or work files, or are available only on microfilm. The reader is assumed to be the principal investigator for a project in which data from the data base will be used.

DOCUMENT STRUCTURE

Because of its size, this volume is divided into ten separate parts, each containing material on a group of forms related by subject. Each part groups together similar study forms. Generally, a part covers a single time period. The parts do not correspond exactly to the hierarchical classification structure described in Volume I. The parts of Volume II include:

A. Prenatal Record and Medical History
B. Labor and Delivery
C. Pathological Exams and Autopsies
D. Family and Socioeconomic History
E. Neonatal Exams and Observations
F. Pediatric and Neurological Exams, Four Months - One Year
G. Pediatric Neurological Exams, Seven Years
H. Psychological Exams, Eight Months
I. Psychological Exams, Four Years and Seven Years
J. Speech, Language and Hearing Exams, Three Years and Eight Years (Final)

This part of Volume II contains Part B: Labor and Delivery and includes Forms OB-30, OB-50, OB-31, OB-51/52, OB-32, OB-33, OB-34, OB-55/56, OB-35/57, ADM-49, ADM-50, ADM-51, OB-58 and OB-60.

To allow easy access to the data as they appear on the master file, all documentation for each form or form grouping representing a card series on the master file is identified by form number appearing at the bottom of each page. Forms are arranged in what may appear to be illogical numerical order in some cases, but the arrangement presented here ties forms and their revisions together and allows an investigator to trace an item through all revision cycles. Thus, in Part A of Volume II, 08-42 follows 08-9 and 08-10 appears next to 08-44 and 08-45. (For an explanation of how the master file was organized to result in this ordering, see the next section of the Introduction.)

All material related to a form is organized as a single unit within each part of Volume II. The material included for each form is given below in the order it appears:

- Descriptive Summary of Form. Includes purpose of form, history of use, revisions and location of records stored on Master File. A table is provided for each form (except those on microfilm only) showing the number of records available for each revision.
- Data Items Referencing Form. A list of all data items in computer files originating from form. List ordered by data item identification with reference to item number on form.
- Form. Copy of last revision of form.
- Form item numbers linked to data items. A list organized by form item numbers of all computerized data items originating from the form.
- Definition of codes. Coding instructions detailing the codes assigned to each computerized data item from the form.
- Master File Card Image. Illustrates transfer of data on form to Master File card.
- Instructions for Completing Form. The instructions used by study personnel to complete the form for each case.
- Earlier Forms or Manuals. Copies of earlier versions of forms or manuals that were used during the study.

MASTER FILE ORGANIZATION AND REVISION OF FORMS

Some understanding of how the master file was organized should aid investigators who want to trace the entry of data into computerized study files. The numbering system used both on forms and cards provides information on how data may be retrieved from the master file.

Forms

The first forms used in the study were the OB forms; as a consequence, this group of forms underwent the most revision. At first glance, it appears that forms disappear from the file and reappear in strange or bewildering places. In actuality, revisions were made according to a specific method.

Two types of revision and subsequent recodes appear in the master file, both of which appear in the OB series. In the first type of revision, radical changes in the concept of a form created a need for new coding in the computer file. Form OB-9, for example, was replaced by forms OB-40 (an optional form retained by the institution), OB-42, and OB-43 in April 1962. Data for earlier patients were recorded on OB-9 and entered on cards 1309, 2309, 3309 and 4309 of the master file; after April 1962, data was recorded on OB-42 and OB-43 and were entered on cards 0342, 1343 and 2343 of the master file.

In the second type of revision, the Collaborative Perinatal Task Force considered revisions important enough to warrant the distinction of a new form number, but considered the data for both forms to be similar enough to allow combining of data from both the old and new forms on the same card series. An example of this type of revision is form OB-35, replaced by OB-57 in April 1962. Records for both OB-35 and OB-57 are entered on cards 0357, 1357, 2357, 3357, 4357, and 5357 in the master file.

In assigning numbers to forms and their revisions, designers of the study followed a plan: prenatal records, history, and summaries of the prenatal period received numbers 1 through 15; when revised, these forms were assigned numbers in the forties. Labor and hospital records appeared on the 30 series of forms. When these forms were revised, they were assigned numbers in the fifties. Some OB data in the master file were abstracted by NINCDS staff members from forms filled out at the hospital. Cards derived from this procedure were designated as coming from forms ADM-49, 50 and 51 (which were actually ABSTRACT SHEETS). Autopsy protocol and laboratory exams of the placenta were recorded on forms PATH-1, PATH-2 and PATH-3.

Forms for recording family health history and genetic information during pregnancy also received a fair amount of revision. Early records appear on forms FHH-1,2,3 and 4. With revisions in April 1963, form SE-1 replaces part of FHH-1 and FHH-3; FHH-2, FHP-4 and parts of FHH-1 and FHH-3 were replaced by

forms GEN-5 through GEN-8 in May 1961. Form FHH-9, initiated in November 1965 for collection of socioeconomic data at time the child was seven years of age, was not replaced or revised.

The PED series of forms underwent little revision. Records for newborn babies appeared in PED-1 through PED-8; records for children up to age one and interval records were placed on PED-10 through PED-29. Seven year records were included in the series numbered PED-74 and up. Only one pediatrics form was radically revised: PED-7 was replaced by PED-8 in March 1963.

No replacements occur in the PS series, where results of psychological and speech, language and hearing tests were recorded. The PS forms are divided into distinct groups based on time of testing and subject of testing. Psychological testing occurred at 8 months, 4 years and 7 years; speech, language and hearing exams were administered at ages 3 and 8. Only the 8 month psychological examination underwent substantial revisions.

Master File Card Number and NINDB Case Number Rationale

Computer cards for each NCPP study form are numbered to reflect their origin and possible revisions. Card numbers are assigned to identify the type of data (subject), the presence of multiple cards in a series, NCPP study form and form revisions. The first five digits of each card on the master file are the card number. The study forms and card numbers are given in Figure 1.

The first fourteen columns of each master file computer card contain the master file card number and the NINDB case number. Table 1 identifies the function of each of these columns.

Column 1 identifies multiple cards in a series. It contains a zero for cards unique to a particular form (that is, no other cards are present), for example OB-3, or for cards where repetitive data are contained. Cards for OB-2 are an example of this second type; no new categories of information are included on successive cards, but previous births in excess of four must be recorded on an add-on card. For card series where data entered are unique to a card and more than one card is required to complete the series, a "1" is used to designate the first card, for example OB-5. OB-57, PATH-7 and PED-14 are exceptions to these rules.

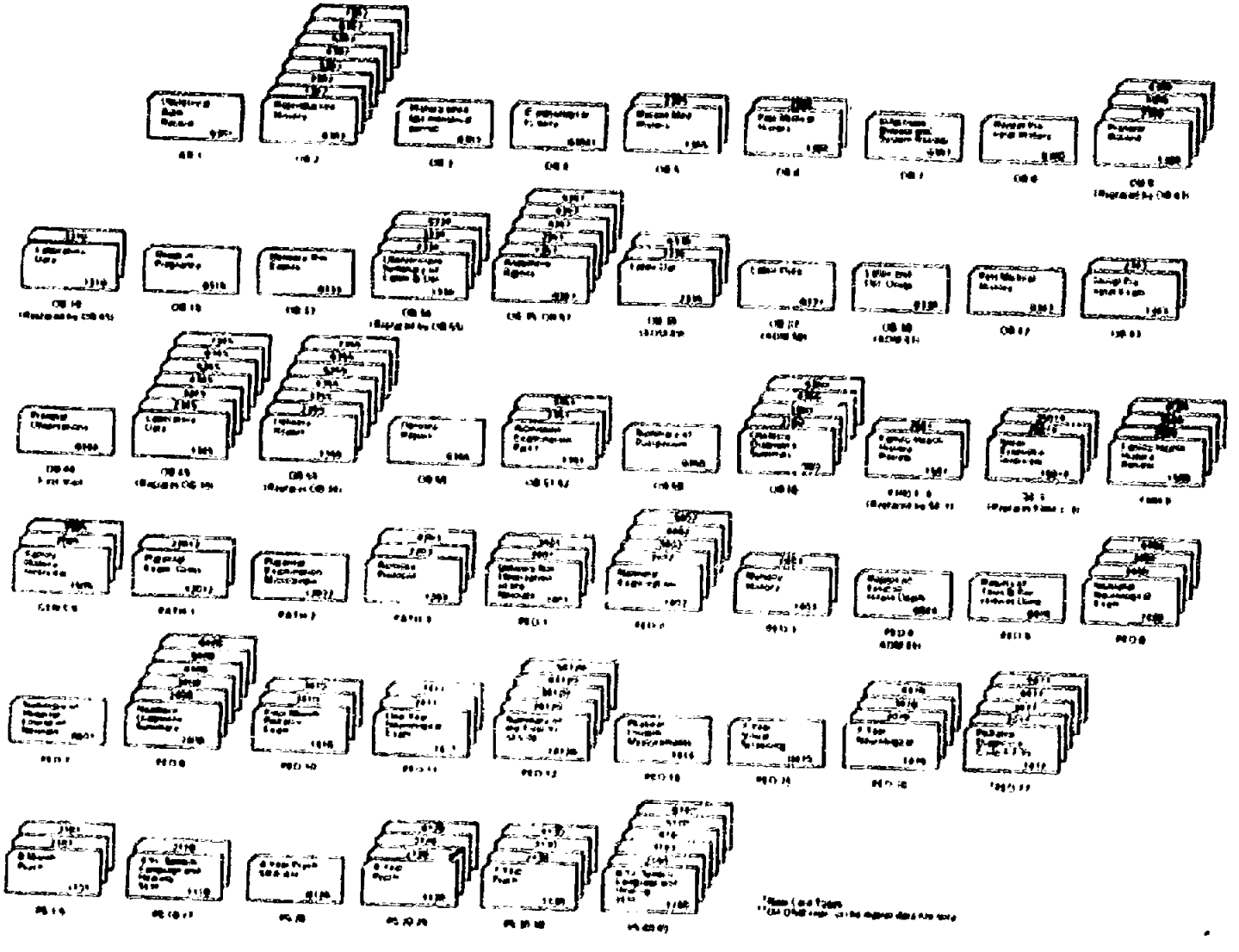


FIGURE 1. Cards on the Master Data File

TABLE 1. Derivation of Master File Card Number and NINDB Case Number.

Contents	Columns
Master File Card Number	
card identifier	1
general subject matter	2
form number	3-4
revision code	5
NINDB Case Number	
collaborating institution	6-7
type of patient selection	8
gravida identification number	9-12
order of the pregnancy	13
identifies child or gravida	14

The second digit on the card reveals the general subject matter covered by data on the card. All cards containing information pertaining to obstetrics, for example, are designated by a "3" in colum 2; family histories are designated by a "5"; pathology with a "2"; pediatrics, with a "4"; and psychological testing with a "1".

Columns three and four reveal the form number. In the case of forms where old and new forms having different numbers are included together, the number of the latest form appears on the master file. This rule does not apply to data abstracted from several forms by NINCDS staff (ADM forms).

Colum 5 of the card contains a revision code indicating which form or combination of forms was used in arriving at data on a particular card. A typical card will have one to three revision codes, with a zero indicating the first version of a form and "1", "2", and "3" indicating later revisions. As a rule, revision codes used on cards differ from card to card; investigators should check the definition of codes provided in Volume II to determine the meaning of revision codes used.

Each woman and child studied in the project received a unique case number (NINDB case number) composed of nine digits, recorded in columns 6 through 14 of all master file cards. The case number identifies the institution, the mother and the child. The first two digits represented the collaborating institution (see Table 2). The third digit indicated the type of patient

selection. A "1" was used for patients selected for the central core study; a "6" indicated that a patient had been transferred from one institution to another, and a "7" indicated that the patient was part of a special study undertaken by the collaborating institution. The fourth through seventh digits were used to identify the gravida, while the eighth digit identified the order of the pregnancy of a given gravida in the project. The ninth digit was used to identify the gravida or child of the pregnancy; "9" indicated the gravida, "0" indicated the child of a single birth, "1" indicated the first child of a multiple birth, "2" indicated the second child of a multiple birth, etc.

TABLE 2. Collaborating Institutions and Their Code Number (Columns six and seven of all master file cards.)

05 - Boston, Massachusetts
Harvard Medical School
Boston Lying-In Hospital
Children's Hospital Medical Center

10 - Buffalo, New York
University of Buffalo
Children's Hospital

15 - New Orleans, Louisiana
Charity Hospital
Tulane University School of Medicine Medical Center
Louisiana State University

21 - New York, New York
Columbia University College of Physicians & Surgeons
Columbia-Presbyterian Medical Center

37 - Baltimore, Maryland
The Johns Hopkins University School of Medicine
The Johns Hopkins Hospital

45 - Richmond, Virginia
Virginia Commonwealth University
Medical College of Virginia

50 - Minneapolis, Minnesota
University of Minnesota Hospital
Health Sciences Center

55 - New York, New York
New York Medical College
Metropolitan Hospital

60 - Portland, Oregon
University of Oregon
Medical School

66 - Philadelphia, Pennsylvania
University of Pennsylvania
Pennsylvania Hospital
The Children's Hospital of Philadelphia

71 - Providence, Rhode Island
Brown University
Child Study Center

87 - Memphis, Tennessee
University of Tennessee
College of Medicine
Collor Hospital

Data Item Identification and Naming

The NLPP data base contains over 6700 different data items and blank filler locations on computer files. We have assigned each of these a unique identification and a terse, stylized name. Because names were chosen to facilitate use of this guide, they do not duplicate names used by NIMDB during the active phase of the project. Users should consult appropriate documentation before using data items from the master, variable or work files (Volumes II, III and IV).

The data item identifiers consist of 11 characters. At the far left are four unique numbers that were assigned sequentially. The next character is always a period and is followed by up to six characters. For data items on the master file, these characters describe the data collection form from which a data item was derived; for data items on the variable (VAR) or work (WKx) files, these characters indicate the appropriate file. If the right side is less than six characters, periods are inserted as shown in these examples:

850..OB-34	an item from OB-34; on the master file
3650.PATH-3	an item from PATH-3; on the master file
5223....VAR	an item on the variable file
6340...W-10	an item on work file 10, Rupture of Membranes

We assigned the numbers sequentially as they appear in Volume V. For the master file, we followed the order in which the cards would be found within an NIMDB case. All card columns are accounted for by one of our data item identifications. For the variable and work files, the numbers were assigned in the order that data items appear within a case.

We categorized each data item according to the person to whom the data refer, by the time of measurement and/or the time to which the item applies and by general type or subject area (Table 3). Then we assigned names to the data items using the following guidelines:

- The name and the three associated categories had to stand alone - they must describe the data item out of context.
- The first word in the data item name had to be an important or key word when all names were listed alphabetically as in Volumes VI and VII. Thus "cry, abnormal" was used rather than "abnormal cry" because a

researcher is more likely to look for this item under "C" than under "A" in an alphabetic list.

- Secondary key words were preceded with a semicolon to facilitate preparation of the permuted index. For example, "abruptio; placenta" will be found under both the "A" and "P" portion of Volume VI.

- Qualifying words are delimited by commas and will not appear as keywords in Volume VI. Thus "abruptio; placenta, degree" will not be found in the "D" section.

- If medical terminology or usage has changed since the study was conducted, modern terms may be included and will be enclosed in brackets. Thus "mongolism; [Down's syndrome]" will appear under both the "M" and "D" portions of Volume VI.

- If measurement units are associated with a data item name, they are enclosed in parentheses and placed at the end of the name as in "Birthdate (yr)."

- The categories (person, time and subject) are appended to the right of the data item name.

Definitions for each category used in naming data items are given in Table 4 at the end of this introduction. Additional information is found in Chapter 4 of Volume I.

Data item names thus assigned are terse and highly stylized; as we have already indicated, they are <u>not</u> the names used by NINDS during the active phase of the project. Our aim was to develop standardized names that would stand alone. These names are intended to facilitate a user's search for data items potentially useful in a research project. Before an item is used, a researcher should consult its complete description. For a data item from the master files, e.g., 850..03-34, the data item should be traced to the appropriate study form, e.g., 03-34, located in Volume II. A variable file data item, e.g., 5223....VAR, is traced to Volume III, where it is defined and its original source given. A data item from a work file is traced to Volume IV for its description.

Some data items contained in the indexes may include the notation "DO NOT USE." These items are either inaccurate or an alternative data item is available that gives better information. Users will find more appropriate data items by consulting one of the indexes to the data items (Volumes, V, VI and VII).

Tables of Data Items: Column Headings

For each form, two sets of computer generated pages list all data items in either the master, variable or work files derived from this form. These lists enable a user to match form items to computerized data items listed in other volumes of the User's Guide and vice versa. The computer listings have the following information.

Column Heading	Description
DATA ITEM ID	A unique identifier for this data item. See Data Item Identification and Naming above for details.
ITEM ON FORM	An identifier used on the NCPP study form to identify the question or group of questions which was used to generate this data item.
CARD NUM	Identifies the master file card on which this data item is located. See Master File Card Number and NIMDS Case Number Rationale above for a description of card number.
FROM	Beginning card column for this data item.
TO	Ending card column for this data item.
DATA ITEM NAME	Terse stylized name for this data item. See Data Item Identification and Naming above for details.

ASSOCIATED DOCUMENTS

By examining the tables provided for each, investigators will be able to determine which computer files contain data of interest. For data contained in the variable file, see Volume III of this guide; for data contained in work files, see Volume IV.

TABLE 3. Abbreviations for Person, Time and Subject Categories

Person	Time	Subject
Mother	General	Administrative
Father	Preconception	Anesthesia
Placenta	Registration	Clin. Impression
Fetus	Prenatal	Clinical Lab
Child	Admission	Current Pregnancy
M Surrogate	Intrapartum	Environ. Exposure
Family	Delivery	Events
Sibship	Post Partum	Hearing
	Neonatal	Hospitalizations
	Four month	Language
	Eight month	Linkage
	One year	Malformations
	Three year	Diag. & Cond.
	Four year	Med. History
	Seven year	Medications
	Eight year	Neurological Exam
		Observations
		Pathology
		Physical Exam
		Procedure
		Psych. Exam
		Reproductive Hist.
		Serology
		Socioecon. Info
		Speech
		Vision
		Work History
		X-ray
		Summary
		Gyn. History
		Special Studies
		Fam/Genetic Hist.
		SLH Exam

TABLE 4. Definition of Person, Time and Subject Categories

PERSON	DEFINITION
Mother	Study registrant bearing the "study pregnancy"; biologic mother of the "study child"; gravida.
Father	Biologic father of the study child or study pregnancy; in the case of socioeconomic data, this category may indicate either the "father of baby" (not necessarily husband of the mother) or the "husband" (not necessarily related biologically to the study child).
Placenta	The organ of metabolic and gaseous interchange between the fetus and mother; also included in this category are gross and microscopic pathologic data from examination of the umbilical cord.
Fetus	Conceptus; the product of conception including the embryonic stage, i.e., from conception to the moment of birth.
Child	Product of the study pregnancy from the moment of birth onward; study child.
M Surrogate	Person or persons substituting for the mother of a study child, e.g., adoptive parents, foster parents or guardian.
Family	Person or persons biologically related to the mother or father of the study child.
Sibship	Child or children having one or both of the same biologic parents as the study child; siblings, half siblings; full siblings.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

TIME	DEFINITION
General	Data with no pertinent time period or data pertaining to more than one time period.
Preconception	Data pertaining to the period prior to conception of the study pregnancy.
Registration	Data collected at the time of study mother's registration in the study.
Prenatal	Data pertaining to the period from conception of the study pregnancy to delivery of the study child.
Admission	Data collected at the time of study mother's admission to the hospital for delivery of the study child.
Intrapartum	Data pertaining to the period from admission for delivery or onset of labor to delivery of the study child.
Delivery	Data pertaining to the time period during which delivery of the study child occurred.
Post Partum	Data (pertaining to the study mother) collected during the period immediately following birth of the study child.
Neonatal	Data pertaining to the study child during the period from birth to one month of age; the majority of these data were collected prior to or at the time a study child was discharged from the hospital.
Four Month	Data collected at the time of the four month examination of the study child.
Eight Month	Data collected at the time of the eight month examination of the study child.
One Year	Data collected at the time of the one year examination of the study child.
Three Year	Data collected at the time of the three year examination of the study child.
Four Year	Data collected at the time of the four year examination of the study child.
Seven Year	Data collected at the time of the seven year examination of the study child.
Eight Year	Data collected at the time of the eight year examination of the study child.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

SUBJECT	DEFINITION
Administrative	Data pertaining to the administrative aspects of the study.
Anesthesia	Data on medications and procedures used to obtain anesthesia.
Clin. Impression	Impression of abnormality or dysfunction gained by an examiner following evaluation of clinical signs and symptoms and including a subjective component.
Clinical Lab	Data obtained from laboratory examination of clinical specimens.
Current Pregnancy	Personal data and medically relevant information pertaining to the study pregnancy for which the mother is enrolled.
Environ. Exposure	Data on exposure to occupational or other environmental entities or hazards.
Events	Data related to a specific event, occurrence or incidence.
Hearing	Data obtained from examination and testing of hearing function.
Hospitalizations	Data on specific hospital admissions or the number of hospitalizations.
Language	Data obtained from examination and testing of language function.
Linkage	Data on the genetic relationships of family members to the study mother, father or child.
Malformations	Data on the conditions in which failure of normal development has resulted in abnormal physical traits existing at the time of birth.
Diag. & Cond.	Data on specific diagnoses or conditions obtained from past medical history or examination during the study.
Med. History	Data obtained from the study participant or medical records relevant to past or current medical diagnoses or conditions.
Medications	Data on drugs or medications used.
Neurological Exam	Data obtained from observation and physical examination of the central nervous system.
Observations	Data obtained from observations not categorized elsewhere.
Pathology	Data obtained from clinical and anatomical pathological examination.
Physical Exam	Data obtained from physical examination of the study participant.
Procedure	Data relating to specific procedures performed on the study participant prior to or during the period of enrollment in the study.
Psych. Exam	Data obtained from the psychological examinations and observations.

TABLE 4. Definition of Person, Time and Subject Categories. (Cont.)

SUBJECT	DEFINITION
Reproductive Hist.	Data pertaining to the outcome of pregnancies prior to and or during the period of enrollment in the study.
Serology	Data obtained from the laboratory examination of serum by specific immunologic methods.
Socioecon. Info	Data related to the social and economic characteristics and environment of the study participant.
Speech	Data obtained from examination and observation of speech function.
Vision	Data obtained from examination of the eyes.
Work History	Data pertaining to occupation and employment prior to and during the period of enrollment in the study.
X-Ray	Data on diagnostic x rays and diagnostic or therapeutic radiological procedures.
Summary	Data presented as a summary of data collected and recorded elsewhere.
Gyn. History	Medical history specifically related to the female genital tract, reproductive physiology and endocrinology.
Special Studies	Data pertaining to participation in other special organized studies conducted during the period of enrollment in the study.
Fam/Genetic Hist.	Data on the medical histories of family members genetically related to the study child.
SLH Exam	Data obtained from the speech, language and hearing examinations not specifically or exclusively related to one of these areas.

CONTENTS

OB-30 Admitting Record

Form OB-30 provided for the mandatory reporting of each study gravida admitted to the hospital obstetrical service. It was to be used when the patient was admitted for any obstetrical service, and could be used optionally when a patient was admitted for any other service. (OB-30 was considered an admission record; OB-12, Summary of Hospitalization for any Antepartum Condition, was considered a discharge summary.) Form OB-30 was introduced in January 1959, revised in July 1959, and was finally replaced in April 1962 by form OB-50, Admission History. Records of both forms are available on microfilm only, though some data from OB-30 was abstracted on the ADM-50 form and punched in card 0337 of the master file (see Table ADM-50.1, this volume).

ADMITTING RECORD BY OBSTETRICIAN

1. PATIENT IDENTIFICATION

[illegible] OB-50 [illegible]

2. RECORDED BY

3. DATE — Mo Day Year

4. TITLE OR POSITION

5. THIS FORM WAS (Check one)

☐ Filled out at time of admission ☐ Copied from other records

USE 24 HOUR CLOCK FOR ALL TIMES

6. TIME OF HOSPITAL ADMISSION

7. DATE — Mo Day Year

8. ONSET OF LABOR — This must be determined as accurately as possible at time of admission

9. TIME

10. DATE — Mo Day Year

11. ON ADMISSION

☐ MEMBRANES INTACT

☐ MEMBRANES RUPTURED

☐ UNKNOWN WHETHER MEMBRANES RUPTURED

IF RUPTURED

12. Time ____ ☐ UNKNOWN

13. DATE — Mo Day

14. BLEEDING BEFORE ADMISSION

☐ NONE

☐ SPOTTING OR "SHOW" ONLY

☐ FREE FLOW OF BLOOD

☐ BLEEDING, AMOUNT UNKNOWN

☐ UNKNOWN IF BLEEDING

IF FREE FLOW

15. Approximate time of onset ____

16. Date — Mo Day

17. REASON FOR HOSPITAL ADMISSION

☐ IN LABOR

☐ QUESTIONABLE LABOR

☐ FOR INDUCTION OF LABOR

☐ FOR ELECTIVE CESAREAN SECTION

IF FOR OTHER REASON USE OB-12

18. COMPLICATIONS AT ADMISSION

☐ TOXEMIA

☐ DIABETES

☐ BLEEDING

☐ PREMATURE RUPTURE OF MEMBRANES

☐ OTHER (Specify)

☐ *FALSE LABOR. If patient is admitted in false labor and is discharged undelivered, check here and forward this record, the prenatal history (OB-6) that was filled out at admission, the admitting examination (OB-31) and labor room record (OB-32) to Central Office. Use new history, admitting record and examination (OB-6, 30 and 31) for next admission.*

Department of Health, Education, and Welfare
Public Health Service

REV. [illegible] (OB-30)

Form OB-30 augmented by OB-30 (1961)
∴ This manual augmented by Instruction & Procedure Manual Each dated 1962 for use with OB-30 (1962)

INSTRUCTIONS

OB-30, ADMITTING RECORD

(Revised February, 1960)

(For Form Revision of July, 1959)

I. NOTES:

Purpose - This form provides for the mandatory reporting of each study gravida admitted to the hospital obstetrical service.

Examiner - Admitting physician.

When to use - At the time of any admission to the hospital obstetrical service. Optionally, it may be used when the patient is admitted to any other service of the hospital. In addition, OB-12 (summary of hospitalization for any antepartum condition) is to be used for summarizing any antepartum admission, to any service of any hospital, terminating in the discharge of a patient who is either undelivered or delivered of a fetus of 400 grams weight or less, or less than 20 weeks gestational age (based on L.M.P.). Therefore, OB-30 is an admission record while OB-12 is a discharge summary. (However, OB-12 is not required for admissions for false labor).

II. INSTRUCTIONS FOR USE OF OB-30:

Note: Use a 24-hour clock for all times recorded.

Item No.

1. Patient identification. Print first and last name of patient and patient NINDB No. Use addressograph stamp whenever possible.
2. Recorded by. First and last name of the admitting physician.
3. Date. Record numerically the date this form is filled out.
4. Title or position. Give your official title, such as "intern," resident," "attending obstetrician," etc.
5. This form was. Check whether this form was filled out at the time of admission or copied from other records. (As a matter of routine, the information on this form should not be copied from other records.)
6. Time of hospital admission. Use 24-hour clock.
7. Date. Enter numerically the date patient was admitted to the hospital.
8. Onset of labor. Determine at the time of admission, as accurately as is then possible. Do not change this date or time, even if subsequent events prove it to be incorrect.

Instructions, OB-30 (con't)

Item No.

9. Time. Use the 24-hour clock.

10. Date. Record numerically.

11. On Admission. Attempt to determine whether or not the membranes have ruptured and check the appropriate box.

12. Time. Fill in only if membranes have ruptured. Check "unknown" if time of rupture unknown.

13. Date. Fill in only if membranes have ruptured.

14. Bleeding before admission. This refers to vaginal bleeding only. "Bleeding, amount unknown" should be checked only when the patient has bled prior to admission and you are unable to determine whether spotting or free flow has taken place.

15. Approximate time of onset. Record only if patient reports free flow of blood. Use 24-hour clock.

16. Date. Record only if patient reports free flow of blood.

17. Reason for hospital admission. Check appropriate box. When a patient is admitted for a reason other than those stated in the boxes under Item 17, write in "other" and specify. Disregard the statement: "If for other reason use OB-12."

NOTE: If the patient is known not to be in labor, progress notes are to be made on Form CP-5 (Continuation Sheet). Continue these notes until the patient is discharged from the hospital, unless labor starts, at which time OB-32 (Labor Room Record) is initiated.

18. Complications at admission. Check appropriate box. If box for "other" is checked, specify the complication.

Unnumbered item

False labor.

A. Check this box if patient is admitted in false labor and is discharged from the hospital undelivered.

B. Forward any of the following forms that have been filled out to the Central Office:

(1) OB-30, Admitting Record.
(2) OB-8, Repeat prenatal history (obtained at time of admission).
(3) OB-31, Admitting physical examination.
(4) OB-32, Labor room record.
(5) CP-5, Progress notes (if any)

C. When the patient is next admitted, a new set of forms must be used.

Grade

ADMITTING RECORD BY OBSTETRICIAN

RECORDED BY

DATE (Mo-Da-Yr) TITLE OR POSITION

Encephalocele 7-54 mo
5

THIS FORM WAS (Check one)
☐ Picked out of file at admission ☐ Copied from other record

USE 24 HOUR CLOCK FOR ALL TIMES

1. TIME OF HOSPITAL ADMISSION 3. DATE (Mo-Da-Yr)

2. ONSET OF LABOR (This must be determined as accurately as is possible at time of admission) TIME DATE (Mo-Da-Yr)

ON ADMISSION

☐ 4. MEMBRANES INTACT

☐ 5. MEMBRANES RUPTURED TIME _____ DATE (Mo-Da-Yr) _____

☐ 6. UNKNOWN WHETHER MEMBRANES RUPTURED

BLEEDING BEFORE ADMISSION

☐ 7. NONE

☐ 8. SPOTTING OR "SHOW" ONLY

☐ 9. FREE FLOW OF BLOOD 10. APPROXIMATE TIME OF ONSET _____ 11. DATE (Mo-Da-Yr) _____

REASON FOR HOSPITAL ADMISSION

☐ 12. IN LABOR

☐ 13. FOR INDUCTION OF LABOR

☐ 14. FOR ELECTIVE CESAREAN SECTION

COMPLICATIONS

☐ 15. TOXEMIA

☐ 16. DIABETES

☐ 17. BLEEDING

☐ 18. PREMATURE RUPTURE OF MEMBRANES

☐ 19. OTHER (Specify)

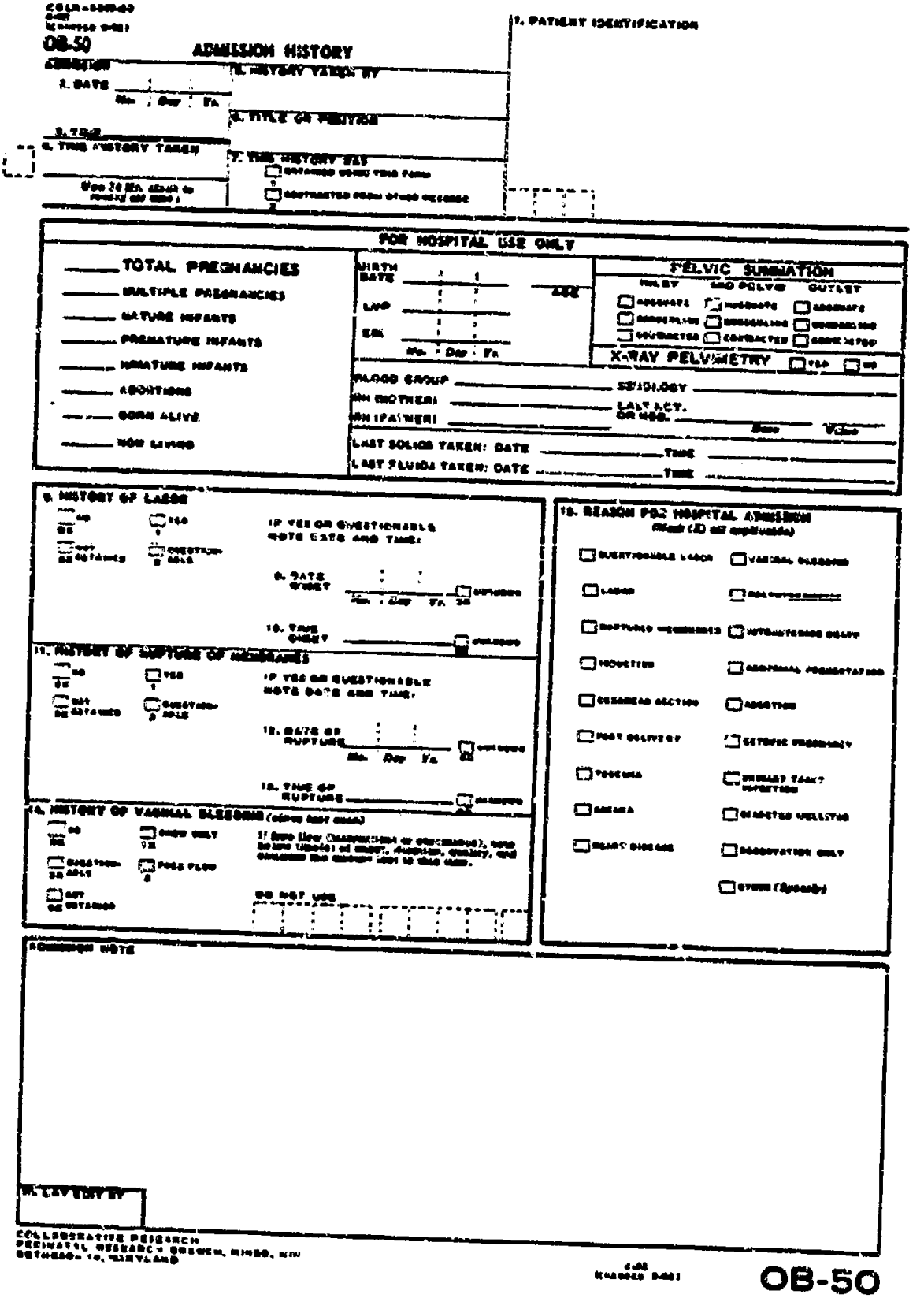
☐ FALSE LABOR. If patient is admitted in suite labor and is discharged undelivered, check here and complete this record, the prenatal history (OB-3) that was filled out at admission, the admitting examination (OB-4), the labor room record (OB-12) to Central Office. Use any history, admitting record and examination (OB-4 if used) you have at admission.

Department of Health, Education and Welfare
Public Health Service

OB-30

OB-50 Admission History

Form OB-50 was used to record the admission history of a patient, as well as the physician's admitting impression. It was first implemented in April 1962 as a replacement for OB-30, Admitting Record; changes in September 1962 did not alter the form. Records for both of these forms are available on microfilm only.


OB-50
ADMISSION HISTORY
1. PATIENT IDENTIFICATION
FOR HOSPITAL USE ONLY
TOTAL PREGNANCIES
MULTIPLE PREGNANCIES
MATURE INFANTS
PREMATURE INFANTS
IMMATURE INFANTS
ABORTIONS
BORN ALIVE
NOW LIVING
PELVIC SUMMATION
X-RAY PELVIMETRY
BLOOD GROUP
SEROLOGY
LAST SOLIDS TAKEN: DATE
TIME
LAST FLUIDS TAKEN: DATE
TIME
9. HISTORY OF LABOR
10. DATE ONSET
11. TIME ONSET
11. HISTORY OF RUPTURE OF MEMBRANES
12. DATE OF RUPTURE
13. TIME OF RUPTURE
14. HISTORY OF VAGINAL BLEEDING
DO NOT USE
15. REASON FOR HOSPITAL ADMISSION
ADMISSION NOTE
16. ENTERED BY
COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDS, NIH
BETHESDA 14, MARYLAND
OB-50

OB-50 ADMISSION HISTORY

I. Purpose of form To record the admission history and physician's admitting impressions.

II. General Instructions

A. Regardless of subsequent events or findings, data entered on this form are to reflect the patient's history at the time admission history is taken on the hospital service.

B. Items labeled "For Hospital Use Only" are provided to record information at those institutions utilizing this form as a hospital record. Directions for completion are provided locally.

III. Specific Instructions

Item Number

2, 3. Admission date and time. Record the date and time of admission or transfer to that service of the Study hospital.

4. Time history taken. Record time this history is actually obtained from the patient.

5, 6. History taken by. Record the first initial and last name and title or position of the interviewing physician.

7. This history was. Mark appropriate box.

On admission, determine by history the following items:

8. History of Labor. Mark box which best indicates the patient's status regarding labor on admission.

9, 10. If the patient is in labor or in questionable labor, record the date and time of onset. To historically estimate the onset of labor, use the following guide:

Item Number

"Regular uterine contractions occurring every 5-10 minutes of increasing intensity and duration."

If date and/or time cannot be determined, mark the box(es) labeled "unknown."

11. History of rupture of membranes. Record the status of membranes by history.

12, 13. If the patient's history indicates that membranes have ruptured or may have ruptured, record the date and time. If unable to ascertain, mark the box(es) labeled "unknown."

14. History of vaginal bleeding. Record the history for the interval since the patient was last seen. Mark only one box.

Any amount of bleeding other than "show" is considered "free flow."

If there is a questionable or definite history of free flow, mark the appropriate box and describe in "Admission note," including time(s) of onset, duration, and estimation of blood loss to the time the history is taken. Such estimate may be made in terms most familiar to the patient; i.e., pint, cupful, soaked towel, etc.

15. Reason for hospital admission. Mark all boxes which describe the reason for the patient's admission to the hospital. If all reasons cannot be found in the list provided, mark "other" and specify the reason below.

Admission note: Utilize this space to:

a. Elaborate upon significant events leading to hospitalization.

b. Record information as prescribed by the local institution.

CHLO-[illegible]

OB-50 ADMISSION HISTORY

[illegible]

2. DATE ________ Mo. Day Yr.

3. TIME ________

4. TIME HISTORY TAKEN ________

[illegible]

5. HISTORY TAKEN BY ________

6. TITLE OR POSITION ________

7. THIS HISTORY WAS
- [ ] OBTAINED USING THIS FORM
- [ ] ABSTRACTED FROM OTHER RECORDS

8. PATIENT IDENTIFICATION

superseded by OB-56 (9-62) (changes 9-62)

FOR HOSPITAL USE ONLY

____ TOTAL PREGNANCIES
____ MULTIPLE PREGNANCIES
____ MATURE INFANTS
____ PREMATURE INFANTS
____ IMMATURE INFANTS
____ ABORTIONS
____ BORN ALIVE
____ NOW LIVING

BIRTH DATE ________ AGE ____

LMP ________

EDC ________ Mo. Day Yr.

PELVIC SUMMATION

INLET	MID PELVIS	OUTLET
ADEQUATE	ADEQUATE	ADEQUATE
BORDERLINE	BORDERLINE	BORDERLINE
CONTRACTED	CONTRACTED	CONTRACTED

X-RAY PELVIMETRY [ ] YES [ ] NO

BLOOD GROUP ________ SEROLOGY ________

RH (MOTHER) ________ LAST HCT. OR HGB. ________

RH (FATHER) ________

LAST SOLIDS TAKEN: DATE ________ TIME ________

LAST FLUIDS TAKEN: DATE ________ TIME ________

9. HISTORY OF LABOR

- [ ] NO
- [ ] YES
- [ ] NOT OBTAINED
- [ ] QUESTIONABLE

IF YES OR QUESTIONABLE NOTE DATE AND TIME:

9. DATE ONSET ________ Mo. Day Yr. [ ] UNKNOWN

10. TIME ONSET ________ [ ] UNKNOWN

11. HISTORY OF RUPTURE OF MEMBRANES

- [ ] NO
- [ ] YES
- [ ] NOT OBTAINED
- [ ] QUESTIONABLE

IF YES OR QUESTIONABLE NOTE DATE AND TIME:

12. DATE OF RUPTURE ________ Mo. Day Yr. [ ] UNKNOWN

13. TIME OF RUPTURE ________ [ ] UNKNOWN

14. HISTORY OF VAGINAL BLEEDING [illegible]

- [ ] NO
- [ ] SHOW ONLY
- [ ] QUESTIONABLE
- [ ] FREE FLOW
- [ ] NOT OBTAINED

[illegible]

DO NOT USE

15. REASON FOR HOSPITAL ADMISSION (Check all applicable)

- [ ] QUESTIONABLE LABOR
- [ ] [illegible]
- [ ] LABOR
- [ ] [illegible]
- [ ] RUPTURED MEMBRANES
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] CESAREAN SECTION
- [ ] ABORTION
- [ ] POST DELIVERY
- [ ] ECTOPIC PREGNANCY
- [ ] TOXEMIA
- [ ] URINARY TRACT INFECTION
- [ ] [illegible]
- [ ] [illegible]
- [ ] HEART DISEASE
- [ ] OBSERVATION ONLY
- [ ] OTHER (Specify)

ADMISSION NOTE

16. [illegible] BY

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDB, NIH
BETHESDA 14, MARYLAND

OB-50

OB-31 Admitting Examination by Obstetrician

The purpose of form OB-31 was to provide information gathered by an obstetrician during the admission physical examination. It was completed whenever form OB-30, Admitting Record, was filled out. First implemented at the beginning of the study, form OB-31 was revised once in July 1959 and replaced in April of 1962 by form OB-51 (General Examination) and form OB-52 (Obstetric Examination). Records for form OB-31 are available on microfilm only, although some data from OB-31 were abstracted on the ADM-50 form and punched on card 0337 of the master file (see Table ADM-50.1, this volume).

ADMITTING EXAMINATION BY OBSTETRICIAN

1 PATIENT IDENTIFICATION

2 EXAMINED BY

3 TYPE OR POSITION

4 DATE Mo Day Year

5 WEIGHT ON ADMISSION 6 TEMP 7 PULSE 8 FETAL HEART RATE

8 THIS FORM WAS (Check one)
1 Filled out at time of admission
2 Copied from other records

replaced by 08-51 (9-64) and 08-52 (9-64)

10 PELVIC EXAMINATION

1 RECTAL 2 VAGINAL 3 NOT DONE

12 EFFACEMENT ____ % 13 DILATATION ____ cm.

14 PRESENTATION ____ 15 STATION ____

16 GENERAL EXAMINATION

17. GENERAL CONDITION
1 NORMAL
2 ABNORMAL
1 Shock
2 Coma
3 Other (Specify)
3 NOT EVALUATED

18. EYES
1 NORMAL
2 ABNORMAL
1 Inflammation
2 Other (Specify)
3 NOT EVALUATED

19. UPPER RESPIRATORY
1 NORMAL
2 ABNORMAL
1 Inflammation of Pharynx
2 Abnormal Breath Sounds
3 Rales
4 Cyanosis or Wheezes
5 Other (Specify)
3 NOT EVALUATED

20. LYMPH NODES
1 NORMAL
2 ABNORMAL
1 Enlarged Inguinal
2 Enlarged Generally
3 Other (Specify)
3 NOT EVALUATED

16 GENERAL EXAMINATION (Continued)

21. HEART
1 NORMAL
2 ABNORMAL
1 Murmur
2 Irregular Rhythm
3 Other (Specify)
3 NOT EVALUATED

22. BLEEDING NOTED ON EXAMINATION
1 NONE
2 PRESENT
1 Spotting or "Show" only
2 Free Flow of Blood
3 NOT EVALUATED

23. MECONIUM
1 MEMBRANES INTACT
2 MEMBRANES RUPTURED — NO MECONIUM
3 MEMBRANES RUPTURED — MECONIUM PRESENT

24. SKIN
1 NORMAL
2 ABNORMAL
1 Jaundice
2 Rash
3 Lesion
4 Other (Specify)
3 NOT EVALUATED

25. EXTREMITIES
1 NORMAL
2 ABNORMAL
1 Edema
2 Varicosities
3 Other (Specify)
3 NOT EVALUATED

26 OTHER SYSTEM NOT EVALUATED ABOVE
1 NONE
2 ABNORMAL (Describe System and Abnormality Below)

27. LIST BY ITEM NUMBER AND DESCRIBE ANY ABNORMAL FINDINGS.

28 RECORD ANY CLINICAL DIAGNOSIS MADE

DATE OF ORDER Mo Day Year DO NOT USE

Department of Health, Education, and Welfare
Public Health Service

REV. 7-67

(OB-31)

Form OB-31 superseded by OB-51 and OB-52
This manual superseded by Obstetrical Procedures Manual each dated 10-62 for use with OB-51 and OB-52 (7-64)

INSTRUCTIONS

OB-31, ADMITTING EXAMINATION BY OBSTETRICIAN

(Revised June, 1960)

(For Form Revision of July, 1959)

I. NOTES:

Purpose - This form provides for the admission physical examination by an obstetrician.

Examiner - Admitting obstetrician.

When to use - This form is to be used for a general and pelvic examination whenever a patient is admitted to the obstetrical service. Whenever Form OB-30 is filled out, OB-31 should also be completed.

II. INSTRUCTIONS FOR USE OF OB-31

Item No.

1. Patient identification. Print first and last name of patient and patient NINDB No. Use addressograph stamp whenever possible.

2. Examined by. The first and last name of the examining physician, clearly printed.

3. Title or position. Give your official title, such as "intern," "resident," "attending obstetrician," etc.

4. Date. Record numerically the date of the examination.

5. Weight on admission. Attempt to secure this weight if at all possible. It should be recorded in pounds.

6. Temperature. Temperature may be recorded as either fahrenheit or centigrade. If obtained orally, no notation is necessary. If obtained rectally, follow the value with an "R", if axillary, with an "A".

7. Pulse. Obtain at least a 30-second count.

   Blood pressure. Obtain and note under Item 27.

8. Fetal heart rate. The fetal heart rate should be obtained between contractions. Start counting at least 30 seconds after the end of a contraction. Attempt to count for 30 seconds in order to obtain a good estimate of the rate, and record as beats per minute. If after a thorough attempt fetal heart cannot be heard, check the box labelled "Not Heard." If for any reason no attempt can be made to obtain a fetal heart rate at the time of admission, check the box labelled "Not Checked."

Instructions, OB-31 (con't)

Item No.

9. This form was. Check whether this form was filled out at the time of admission or copied from other records. (As a matter of routine, the information on this form should not be copied from other records.)

10. Pelvic examination - ("Rectal, Vaginal, Not done"). Check the appropriate box. If both rectal and vaginal examinations are done, check both boxes but record only the findings of the vaginal examination. Any abnormal findings noted during the pelvic examination should be reported in detail under Item 27 on this form.

12. Effacement. Express this as a percentage.

13. Dilatation. Record this to the nearest centimeter.

14. Presentation. Be as exact as possible as to presentation and position. If an abnormal presentation is encountered, describe it fully under Item 27.

15. Station. This is expressed as centimeters above (negative values) or below (positive values) the ischial spines. If the vertex or breech is more than 3 centimeters above the spines, record this as "floating." If an estimate of the station is not obtained, write unknown in this space. If the station has no meaning, write "NA" (not applicable) in this space.

16. General examination. This includes Items 17 through 26. If no general examination is made, each of these items should be checked "not evaluated." If any abnormality is found, it should be described in as much detail as seems necessary in Item 27 at the bottom of this form.

17. General condition. If any abnormalities are noted, be as specific as possible in describing them.

18. Eyes. If a funduscopic is done, note this fact under Item 18. If any abnormality is found on funduscopic examination, check the box marked "Other abnormal" and describe findings in detail under Item 27. If a funduscopic is done and no abnormalities are noted, check the box marked "normal."

22. (Vaginal) Bleeding noted on examination. This refers only to vaginal bleeding. Any history of bleeding obtained at this time if not confirmed by observation should be reported as no bleeding on examination.

23. Meconium. Check the condition of the membranes and whether or not meconium is present in the amniotic fluid. If meconium is noted, describe in Item 27 the quantity and quality.

26. Other system not evaluated above. If no other abnormalities are found, check "none." If any special examinations (neurological,

Item No.

etc.,) are done, note in this space what these examinations were. If the findings were normal, check Item 26 as "none;" if the findings were abnormal, check "abnormal" and report findings in Item 27.

27. List by item number and describe any abnormal findings. If additional space is needed Form CF-5 (continuation sheet) should be used.

28. Record any clinical diagnoses made. All diagnoses and impressions, (including all obstetrical diagnoses) made or confirmed at the time of this examination should be recorded in Item 28. Be as specific as possible. For each diagnosis record your best estimate of the date of onset.

EXAMPLE: Normal intra-uterine pregnancy, 40 weeks.
Not in labor.
Ruptured membranes.
Healed pulmonary tuberculosis.
Iron-deficiency anemia.

ADMITTING EXAMINATION BY OBSTETRICIAN

EXAMINED BY

TITLE OR POSITION DATE

1. WEIGHT ON ADMISSION 2. TEMP 3. PULSE 4. FETAL HEART RATE

THIS FORM WAS (Check one)

— Filled out at time of admission — Copied from other records

superseded by 7-57.rev

5. PELVIC EXAMINATION

— RECTAL
— VAGINAL
EFFACEMENT _____ %
DILATATION _____ cm.
PRESENTATION _____
STATION _____

GENERAL EXAMINATION

6. GENERAL CONDITION
— NORMAL
— ABNORMAL
— Shock
— Coma
— Other
— Not Evaluated

7. EYES
— NORMAL
— ABNORMAL
— Jaundice
— Other
— Not Evaluated

8. UPPER RESPIRATORY
— NORMAL
— ABNORMAL
— Inflammation of Pharynx
— Abnormal Breath Sounds
— Rales
— Croup and Rhonchi
— Other
— Not Evaluated

9. LYMPH NODES
— NORMAL
— ABNORMAL
— ENLARGED LOCALLY
— ENLARGED GENERALLY
— OTHER
— NOT EVALUATED

GENERAL EXAMINATION (Continued)

10. HEART
— NORMAL
— ABNORMAL
— MURMUR
— IRREGULAR RHYTHM
— OTHER
— Not Evaluated

11. BLEEDING NOTED ON EXAMINATION
— NONE
— PRESENT
— Spotting or "Show" only
— Free flow of blood
— Not Evaluated

12. MECONIUM
— MEMBRANES INTACT
— MEMBRANES RUPTURED – NO MECONIUM
— MEMBRANES RUPTURED – MECONIUM PRESENT

13. SKIN
— NORMAL
— ABNORMAL
— Jaundice
— Rash
— Lesion
— Other
— Not Evaluated

14. EXTREMITIES
— NORMAL
— ABNORMAL
— Edema
— Varicosities
— Other
— Not Evaluated

15. OTHER SYSTEM, NOT EVALUATED ABOVE
— ABNORMAL (Describe System and Abnormality below)

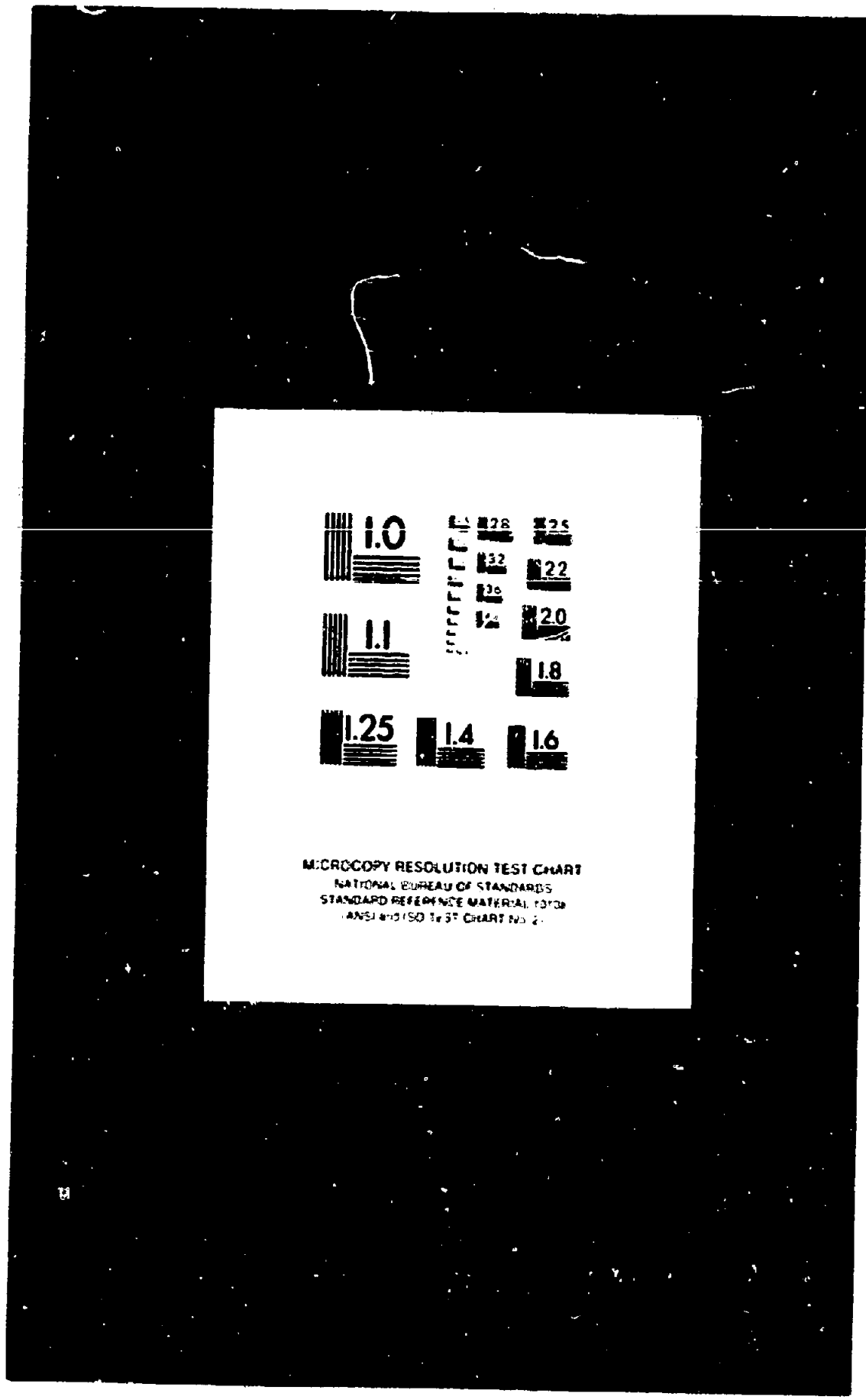
LIST BY SOX NUMBER AND DESCRIBE ANY ABNORMAL FINDINGS:

RECORD ANY CLINICAL DIAGNOSES MADE

DATE OF ONSET DO NOT USE

Department of Health, Education and Welfare,
Public Health Service

(OB-31)


1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

CONTINUED ON NEXT FICHE