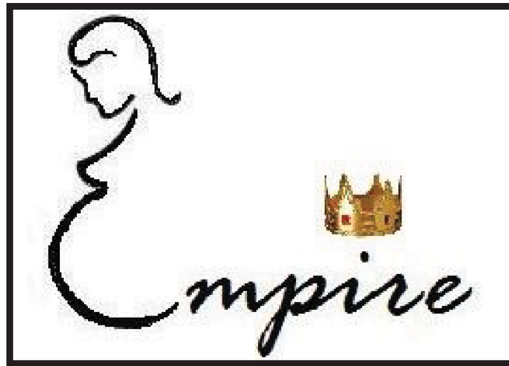

DELIVERY BOOKLET
Patient UTIN: __ __/__ __ __

DELIVERY BOOKLET	Visit checklist	Participant UTIN	**Visit date**
		__ __/__ __ __	DD / MMM / YYYY

CHECKLIST		ACTION
Has a blood sample been taken?	**Yes** ☐	Centrifuge and package sample according to Blood Processing SOP no.3 Send EMPIRE trial blood request form to trial office
	No ☐	Please take blood sample and package according to Blood Processing SOP no.3 Send EMPIRE trial blood request form to trial office Or Document reason why blood sample was not taken ***Please state here:***
Has the cord blood sample been taken?	**Yes** ☐	Centrifuge and package sample according to Blood Processing SOP no.3 Send EMPIRE trial blood request form to trial office
	No ☐	Please take cord blood sample and package according to Blood Processing SOP no.3 Send EMPIRE trial blood request form to trial office Or Document reason why the sample was not taken ***Please state here:***
Has cord pH sample been taken?	**Yes** ☐	Documented result in CRF.
	No ☐	Take cord pH according to routine practice at site and document the result in CRF. Or Document reason why the sample was not taken ***Please state here:***
Have the delivery booklet been completed?	**Yes** ☐	File **Delivery Booklet** is in participant's CRF file.
	No ☐	Complete **Delivery Booklet** and file in participant's CRF file

DELIVERY BOOKLET	Delivery details	Participant UTIN	Visit date
		__ __/__ __ __	DD / MMM / YYYY

DELIVERY DETAILS

Gestational age at delivery	___________weeks ____________days			
Delivery mode	Spontaneous Vaginal ☐	Forceps ☐	Ventouse ☐	Caesarean Section ☐

MATERNAL COMPLICATIONS

Pre-clampsia	Yes ☐ No ☐	Gestation Diabetes Mellitus	Yes ☐ No ☐	Blood transfusion	Yes ☐ No ☐

Preterm delivery (<37 weeks)	Yes ☐ No ☐	*If yes,* Spontaneous ☐ Induced ☐	
Post partum haemorrhage	Yes ☐ No ☐	*If yes,* Atonic ☐ Trauma ☐ Both ☐	
Ante partum haemorrhage	Yes ☐ No ☐	**Preterm rupture of membranes (<37 weeks)**	Yes ☐ No ☐
Induction of labour *(If yes, please specify reasons for induction)*	Yes ☐ No ☐	Seizure deterioration	Yes ☐ No ☐
		Post dates	Yes ☐ No ☐
		Pre-eclampsia	Yes ☐ No ☐
		Maternal request	Yes ☐ No ☐
		Spontaneous rupture of the membranes	Yes ☐ No ☐
Admission to HDU/ITU	Yes ☐ No ☐	*If yes, was it **seizure related?***	Yes ☐ No ☐
Infection *(if yes, please specify)*	Yes ☐ No ☐	Genital	Yes ☐ No ☐
		Urinary	Yes ☐ No ☐
		Chorioamnionitis	Yes ☐ No ☐
		Wound	Yes ☐ No ☐
		Respiratory	Yes ☐ No ☐
		Other (*if yes, please specify below*)	Yes ☐ No ☐
Any other maternal complications	Yes ☐ No ☐	*If **yes**, please specify*	

HOSPITAL ADMISSION

Date & Time of admission	DD / MMM / YY	HH : MM	Date & Time of discharge	DD / MMM / YY	HH : MM

BREASTFEEDING INTENTION

Sole breast feeding	☐	Mixed breast & bottle	☐	Bottle only	☐

DELIVERY BOOKLET	Baby details	Participant UTIN	Visit date
		__ __/__ __ __	DD / MMM / YYYY

BABY DETAILS

Please use the following sheets to document information about all of the participant's births/children. One sheet should be used per child. Please specify child number between booklet name and participant UTIN.

Birth Weight	kg	Baby's sex	Female ☐ Male ☐
Birth weight in customised centiles	________ centiles	Head Circumference	cm
Apgar score	1'	Cord pH	A
	5'		V

Stillbirth	Yes ☐ No ☐	Neo-natal death	Yes ☐ No ☐
Small for gestational age *(defined as weight less than 10th centile)*	Yes ☐ No ☐	Admission to neonatal unit	Yes ☐ No ☐

CONGENITAL MALFORMATIONS					
Diaphragmatic hernia	Yes ☐ No ☐	Gastroschisis	Yes ☐ No ☐	Hydrocephalus	Yes ☐ No ☐
Spina bifida	Yes ☐ No ☐	Duodenal atresia	Yes ☐ No ☐	Cleft lip	Yes ☐ No ☐
Cleft palate	Yes ☐ No ☐	Congenital Cystic Adenomatoid Malformation	Yes ☐ No ☐	Anencephaly	Yes ☐ No ☐
Congenital heart disease	Yes ☐ No ☐	*If yes, please specify*			
Tumours	Yes ☐ No ☐	*If yes, please specify*			
Limb abnormalities	Yes ☐ No ☐	*If yes, please specify*			
External genital abnormities	Yes ☐ No ☐	*If yes, please specify*			
Any other malformation	Yes ☐ No ☐	*If yes, please specify*			

DELIVERY BOOKLET	Baby details	Participant UTIN	Visit date
		__ __/__ __ __	DD / MMM / YYYY

BABY DETAILS

Please use the following sheets to document information about all of the participant's births/children. One sheet should be used per child. Please specify child number between booklet name and participant UTIN.

Birth Weight		**kg**	**Baby's gender**	**Female** ☐ **Male** ☐	
Birth weight in customised centiles			________ **centiles**	**Head Circumference**	**cm**
Apgar score	**1'**		**Cord pH**	**A**	
	5'			**V**	

Stillbirth	**Yes** ☐ **No** ☐	**Neo-natal death**	**Yes** ☐ **No** ☐
Small for gestational age *(defined as weight less than 10th centile)*	**Yes** ☐ **No** ☐	**Admission to neonatal unit**	**Yes** ☐ **No** ☐

CONGENITAL MALFORMATIONS					
Diaphragmatic hernia	**Yes** ☐ **No** ☐	**Gastroschisis**	**Yes** ☐ **No** ☐	**Hydrocephalus**	**Yes** ☐ **No** ☐
Spina bifida	**Yes** ☐ **No** ☐	**Duodenal atresia**	**Yes** ☐ **No** ☐	**Cleft lip**	**Yes** ☐ **No** ☐
Cleft palate	**Yes** ☐ **No** ☐	**Congenital Cystic Adenomatoid Malformation**	**Yes** ☐ **No** ☐	**Anencephaly**	**Yes** ☐ **No** ☐
Congenital heart disease	**Yes** ☐ **No** ☐	*If yes, please specify*			
Tumours	**Yes** ☐ **No** ☐	*If yes, please specify*			
Limb abnormalities	**Yes** ☐ **No** ☐	*If yes, please specify*			
External genital abnormities	**Yes** ☐ **No** ☐	*If yes, please specify*			
Any other malformation	**Yes** ☐ **No** ☐	*If yes, please specify*			

DELIVERY BOOKLET	Baby details	Participant UTIN	Visit date
		__/___	DD / MMM / YYYY

BABY DETAILS

Please use the following sheets to document information about all of the participant's births/children. One sheet should be used per child. Please specify child number between booklet name and participant UTIN.

Birth Weight	kg	**Baby's gender**	**Female** ☐ **Male** ☐	
Birth weight in customised centiles		_______ **centiles**	**Head Circumference**	**cm**
Apgar score	**1'**	**Cord pH**	**A**	
	5'		**V**	

Stillbirth	**Yes** ☐ **No** ☐	**Neo-natal death**	**Yes** ☐ **No** ☐
Small for gestational age *(defined as weight less than 10th centile)*	**Yes** ☐ **No** ☐	**Admission to neonatal unit**	**Yes** ☐ **No** ☐

CONGENITAL MALFORMATIONS					
Diaphragmatic hernia	**Yes** ☐ **No** ☐	**Gastroschisis**	**Yes** ☐ **No** ☐	**Hydrocephalus**	**Yes** ☐ **No** ☐
Spina bifida	**Yes** ☐ **No** ☐	**Duodenal atresia**	**Yes** ☐ **No** ☐	**Cleft lip**	**Yes** ☐ **No** ☐
Cleft palate	**Yes** ☐ **No** ☐	**Congenital Cystic Adenomatoid Malformation**	**Yes** ☐ **No** ☐	**Anencephaly**	**Yes** ☐ **No** ☐
Congenital heart disease	**Yes** ☐ **No** ☐	*If yes, please specify*			
Tumours	**Yes** ☐ **No** ☐	*If yes, please specify*			
Limb abnormalities	**Yes** ☐ **No** ☐	*If yes, please specify*			
External genital abnormities	**Yes** ☐ **No** ☐	*If yes, please specify*			
Any other malformation	**Yes** ☐ **No** ☐	*If yes, please specify*			