Pregnancy Outcome Tracking

Date Completed: ____/____/_____ **Name:** _____

Completed By: ☐ Head Start Staff Specify: _____

☐ Medical Provider Specify: _____

Pregnancy Outcome: ☐ Live birth ☐ Spontaneous abortion ☐ Fetal death/stillborn

☐ Ectopic pregnancy ☐ Induced abortion ☐ Other

Outcome date: ____/____/_____ **Maternal hospital discharge date:** ____/____/_____

(Live Birth Only)

Delivery location: ☐ Hospital ☐ Birthing center ☐ At home ☐ Other: _____

Delivery type: ☐ Vaginal ☐ C-section

Plurality: ☐ Singleton ☐ Twin ☐ Triplet ☐ Quad or higher

***Infant Outcome:**

Child Name	Date of Birth	Gender Male	Gender Female	Birth Order	Birth Weight	Admitted to NICU/SCN Yes	Admitted to NICU/SCN No	Infant Died Yes	Infant Died No	Date of Death
		☐	☐	1st	__|__|lb __|__|oz	☐	☐	☐	☐	
		☐	☐	2nd	__|__|lb __|__|oz	☐	☐	☐	☐	
		☐	☐	3rd	__|__|lb __|__|oz	☐	☐	☐	☐	
		☐	☐	4th	__|__|lb __|__|oz	☐	☐	☐	☐	

Complications associated with this delivery:

☐ Pre-eclampsia/Eclampsia ☐ Pre-term labor ☐ Premature membrane rupture
☐ Placenta previa ☐ Abruptio placentae ☐ Fetal distress
☐ Postpartum hemorrhage ☐ Other: Specify _____
☐ None of the above

Comments _____

_____

_____

_____

_____

HSFIS
____/____/____ ____

docStar

____/____/____ ____