PERINATAL INFORMATION SYSTEM

PERINATAL CLINICAL RECORD

Complementary form for women undergoing abortion

Filling Instructions and Definition of Terms

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PERINATAL ELECTRONIC SYSTEM
Perinatal Clinical Record
Filling instructions and definition of terms

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The United Nations Millennium Development Goals pose a significant challenge concerning monitoring of indicators for the sexual and reproductive health-related goals. Information systems should aim at facilitating meeting those commitments, while guaranteeing the quality of the care provided. This quality of care is based on the organization of the departments and an adequate data system that should include an appropriate Clinical Record. Furthermore, the flow of information should ensure the availability of any data required for the correct management of a patient to the health care professional in charge of the patient in question.

The Clinical Record must facilitate care, monitoring and supervision of compliance with standards, to provide the health system with precise and timely data for decision making.
The wealth of data in the Perinatal Clinical Record pools the most valuable data bank and makes it available to the health team. That information may be used either to learn about the characteristics of the population receiving care or to evaluate the outcomes of the care provided, to identify priority issues, to monitor key indicators and to conduct operational and epidemiological research.

The Perinatal Electronic System (PES) developed by CLAP/SMR in 1983 includes software to collect and analyze the clinical information built into the health care process in the various levels of complexity; it consists of the Perinatal Clinical Record (PCR) the delivery-gram, the Perinatal Card (PC) and the software for personal computers.

The objectives of the PES are to:

- serve as a basis to plan care
- check and monitor the implementation of evidence-based practices
- unify data collection by adopting standards
- facilitate communication between the various levels
- obtain reliable statistics locally
- favor compliance with norms
- foster training of health professionals
- record legally relevant data
- facilitate the audits
- define the characteristics of the population receiving care
- evaluate the quality of care
- categorize problems
- conduct operational epidemiological research

This handbook gives a detailed description of the way the Perinatal Clinical Record should be filled, as well as the definition and interpretation of each of its variables.

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PERINATAL ELECTRONIC SYSTEM: PERINATAL CLINICAL RECORD

Introduction

The Latin American Center of Perinatology/Women and Reproductive Health (CLAP/SMR) is a center and technical unit of the Pan American Health Organization (PAHO) that provides technical advice to Latin American and Caribbean countries in the field of sexual and reproductive health.

In 1983, CLAP/SMR published the Perinatal Electronic System (PES) and many health care facilities both in Latin America and the Caribbean have used it ever since. The PES consists of a set of tools originally designed to be used at the obstetrics and neonatology departments of institutions that provide care to healthy women and newborns or those presenting minor complications.
The instruments available include the Perinatal Clinical Record (PCR), t|nt woman and her child and to streamline the operation of perinatal services.

- To normalize and unify data collection.
- To facilitate implementation of standards of care of the pregnant women and their newborns by health professionals.
- To offer the elements required for the supervision and evaluation of the centers providing care to the mother and newborn.
- To support the health team's training.
- To learn about the characteristics of the population receiving care.
- To create a perinatal data registry for research purposes in health services.
- To create a data record legally relevant to the pregnant woman, her child, the health team and the institution responsible for their care.

The PES enables the staff at the maternity department to enter the PCR data into a database created with the PES software, so they can use it to produce local reports. The data from several maternities may be consolidated and analyzed within a country or region, to describe the situation of several indicators over time, by geographical areas, service networks or other specific characteristics of the population. At a central level, the PCR becomes a useful tool in the surveillance of maternal/neonatal events and for the assessment of national and regional programs.

The PCR has undergone several changes since its inception. These modifications derive from the need to keep its contents updated with the best scientific evidence available, and to incorporate the national and international priorities as defined by the Ministries of Health in the Region. Its format and design, however, have undergone few changes. Clinical data from gestation to puerperium are presented on a single page, most clinical data requiring only ticking previously defined spaces; the data requiring further information, analysis or follow-up (warning) are presented in yellow.

In this document, CLAP/SMR presents the latest release of the PCR, developed as an instrument aimed at meeting the current priorities in the region. This handbook intends to facilitate training and the use of the PCR, informing PES users about the terms, definitions and the ways valid clinical data should be obtained.

An additional record form for women suffering an abortion has been developed in cooperation between PAHO/WHO-CLAP/WR and IPAS. This new tool is aimed to reduce abortion related disease and death. It is also a guideline to support health care personnel by simplifying diagnosis and promoting quality of care in every stage of an abortion and to produce relevant information for decision making.

Contents of the current handbook

As explained in the previous section, the PCR is an instrument designed to help in the decisions related with the woman's individual clinical management (during prenatal control, the control of delivery and puerperium) and the management of the neonate (from birth to discharge). The inclusion of its contents as part of a database renders the PCR a useful tool for the surveillance of maternal and neonatal events.

For both purposes, it is essential for data recorded in the PCR to be complete, valid, reliable and standardized. The current handbook includes the information below to assist PES users reach this ideal:

- Concise explanation of the definition and concepts related with the terms included in the PCR
- Whenever relevant, the use of validated forms is suggested to obtain the data (either through questions, observation or measurement)
- Concise description of the justification for the inclusion of the variable in the PCR

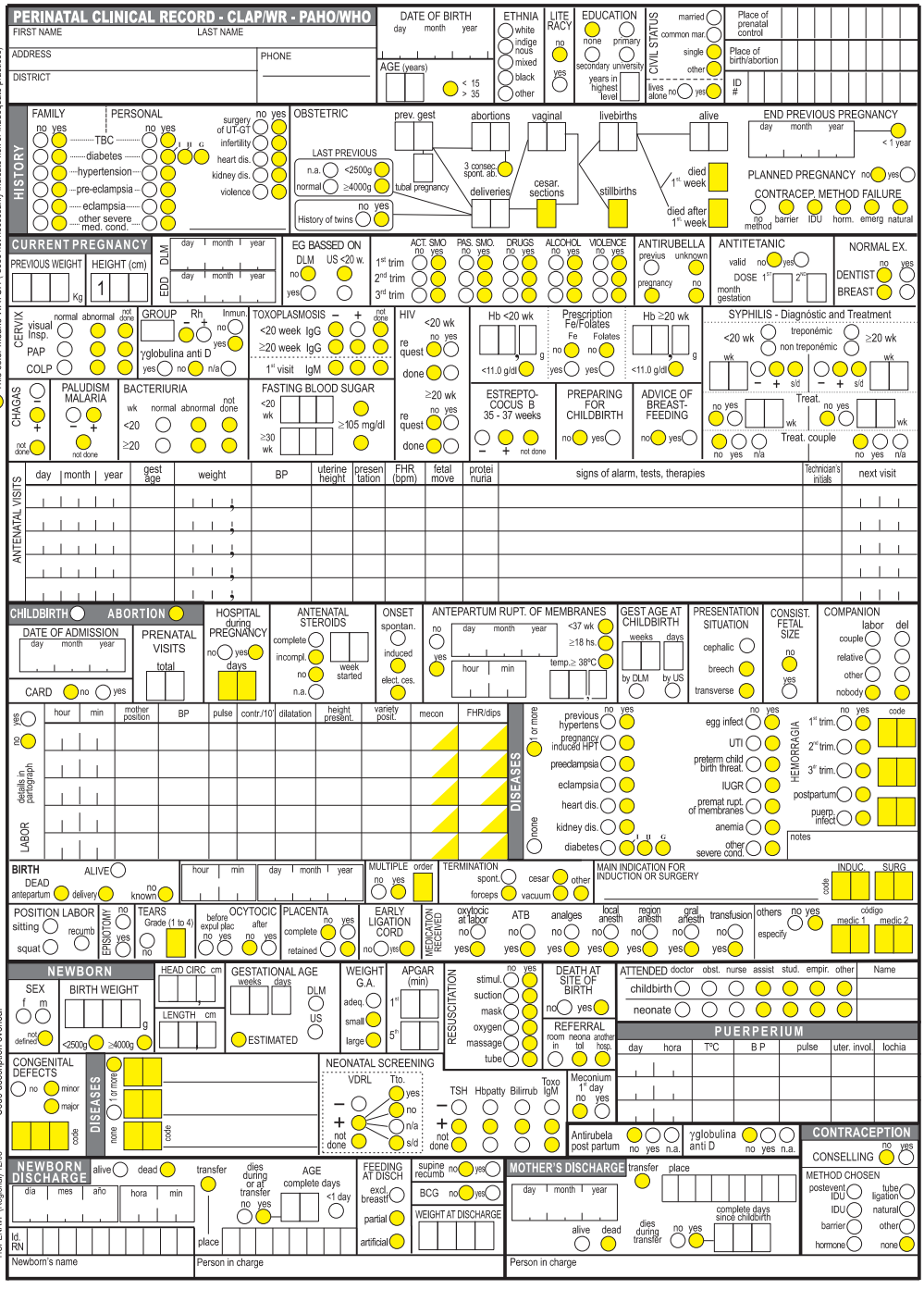
This information is presented in the various sections of the PCR. The terms herein are presented both in their complete denomination as in its abbreviated version or initials.

The sections of the PCR make use of various ways to collect data.	
In some sectors there are blanks that admit letters and numbers, as in the example:	ADDRESS 6937 América Ave
Other sectors use rectangular boxes and only allow numbers:	years in highest level 6
Finally, some data are recorded by checking a circle	no ○ yes ●
Numbers should be written completing all boxes. Do not leave empty boxes	previous gestations = 3 [0][3] Hb = 9,5 [0][9] leucocites = 5000 [0][5][0][0][0]

The circles should be filled as follows:	⊗ ✓
Any other way of filling the circles should be avoided, e.g.:	●

The (Regional) Perinatal Clinical Record (front and back) and the complementary form for women undergoing abortion are presented in the pages below.

Regional Perinatal Clinical Record (front)



Regional Perinatal Clinical Record (back)

CLAP/WR (PAHO/WHO)

CODE LISTING

Perinatal Electronic System

Number at left correspond to codes as used in this form. Codes at right are the International Code of Diseases. Rev. 10 (ICD - 10) PAHO/WHO 1992

CONDITIONS OF PREGNANCY, CHILDBIRTH & PUERPERIUM (PCP)

50	**MULTIPLE GESTATION**	O30
51	**PRE-EXISTING HYPERTENSION**	O10
01	Essential pre-existing hypertension complicating pregnancy childbirth and the puerperium	O10.0
02	Secondary pre-existing hypertension complicating pregnancy childbirth and the puerperium	O10.4
52	**PREECLAMPSIA**	O13 and O14
04	Transient gestational (pregnancy-induced) hypertension	O16
05	Mild pre-eclampsia	O13
06	Severe and moderate pre-eclampsia	O14
53	Pre-existing hypertension with superimposed proteinuria	O11
54	**ECLAMPSIA**	O15
55	**CARDIOPATHY**	Z86.7
56	**DIABETES**	O24
57	Pre-existing insulin-dependent diabetes mellitus	O24.0
58	Pre-existing non-insulin-dependent diabetes mellitus	O24.1
59	Diabetes mellitus of gestational onset	O24.4
07	Abnormal glucose tolerance test	R73.0
60	**URINARY TRACT INFECTION**	O23.0-23.4
08	Asymptomatic gestational bacteriuria	R82.7
61	**OTHER INFECTIONS**	O98, B50-B54,A60
62	Infections of the genital tract in pregnancy	O23.5
09	Syphillis complicating PDP	O98.1
10	Gonorrhea complicating PDP	O98.2
11	Malaria	B50-B54
12	Ano-genitalHerpes Infection (herpes simplex)	A60
63	Viral hepatitis	O98.4
64	TBC complicating PDP	O98.0
80	Rubella complicating PCP	B06.O, B06.8 y B06.9
65	**PARASITIC INFECTION complicating PDP**	O98.8
77	Chagas	O98.6
78	Toxoplasmosis	O98.6
66	**INTRAUTERINE GROWTH RETARDATION**	P05
67	**PREMATURE CHILDBIRTH THREAT (PREMATURE DELIVERY)**	O60
13	Cervical incompetence	O34.4
68	**CEPHALOPELVIC INCONSISTENCY**	O64, O65, O69
14	Obstructed labour due to malposition and mal presentation of fetus	O64
15	Obstructed labour due to maternal pelvic abnormality	O65
16	Other obstructed labour due to the fetal cause	O66
69	**HEMORRHAGETHE FIRST TRIMESTER**	O20
17	Hydatiform mole	O01
18	Spontaneous abortion and retained	P021.1, O03
19	Ectopic pregnancy	O00
20	Induced or medical abortion	O06,O04
21	Threatened abortion	O20.0
70	**HEMORRHAGE THE 2nd & 3rd TRIMESTER**	
22	Placenta previa with hemorrhage	O44.1
23	Premature separation of placenta (abruptio placentae)	O45
24	Antepartum hemorrhage with coagulation defect	O46
25	Uterine rupture before or during delivery	O71.0, O71.1
26	Obstetric laceration of cervix	O71.3
71	**ANEMIA**	O99.0
27	Iron deficiency anemia	D50
79	Sickle cell anemia	D57.0-D57.2 y D57.8
72	**PREMATURE RUPTURE OF MEMBRANES**	O42
28	Infection of amniotic sac and membranes	O41.1
73	**PUERPERAL INFECTION**	O85, O86
29	Puerperal sepsis	Q85
30	Infections of breast associated with childbirth	O91
74	Postpartum hemorrhage	O72
31	Retained placenta	O72.0, O72.2
32	Atonic uterus	O72.1
33	1st & 2nd degree perineal lacerations	O70.0, O70.1
34	3rd & 4th degree perineal lacerations	O70.2, O70.3
75	**OTHER MATERNAL CONDITIONS**	(Min O00-O99)
35	Placenta praevia without hemorrhage	O44.0
36	Pregnancy-related excessive vomoting	O21
37	Unspecified renal disease in pregnancy, without mentioning of hypertension	026.8, O99.8 (conditions in N00-N39)
38	Drug dependency	F10-F19
39	Fetal distress	Q68
40	Polyhidramnios	O40
41	Oligoahydramnios (without mention of rupture of membranes)	O41.0
42	Labor and delivery complicated with umbilical cord complications	O69
43	Complication of anesthesia during childbirth and puerperium	O74
44	Obstetric embolism	O88
45	Failed closure of cesarian section wound	O90.0
46	Failed of episiotomy closure	O90.1
47	AIDS	B20-B24
76	HIV Positive	R75
48	Malignant neoplasia of cervix	C53
49	Malignant neoplasia of breast	C50

MAIN INDICATION OF SURGICAL DELIVERY OR INDUCTION

01	Previous cesarean section	14	Transverse position
02	Fetal distress	15	Premature rupture of membranes
03	Cephalo pelvic disproportion	16	Eggs infection (suspected or confirmed)
04	Contractility disorders	17	Placenta praevia
05	Prolonged delivery	18	Abruptio placentae
06	Failed of induction	19	Uterine rupture
07	Arrested descent of presentation	20	Preeclampsia and eclampsia
08	Multiple pregnancy	21	Anogenital herpes
09	Retarded intrauterine growth	22	Condylomatosis of the genitalia
10	Preterm childbirth	23	Other maternal conditions
11	Pos term childbirth	24	Fetal death
12	Breech presentation	25	Exhausted mother
13	Posterior position	26	Others **76** HIV

MEDICATION DURING LABOUR

01	Lidocaine or the like	16	Prostaglandin inhibitors		
02	Sympathomimetic amines	17	Calcium antagonists		
03	Anesthetic gases (pentrane-fluorane-nitrous oxide)	18	Magnesium sulphate		
04	Barbiturates	19	Hydralazin		
05	Muscle relaxants	20	Beta blockers		
06	Diazepoxides	21	Other anti hypertensives		
07	Meperidine	22	Blood and derivatives		
08	Spasmolytics	23	Heparine		
09	Oxytocin	24	Corticosteroida		
10	Prostaglandins	25	Cardiotonics		
11	Betalactamics (Penicillins-cephalosporins)	26	Diuretics		
12	Aminoglycosides (gentamicin-amykacin)	27	Aminophyllin		
13	Erithromycin	28	Insulin	31	Antiretrovirals
14	Metronidazole	29	Diphenylhydantoine	32	Sulphadoxin-Pirimetamine
15	Beta mimetics	30	Others	33	Chloroquines

NEONATAL CONDITIONS

50	**HIALINE MEMBRANE DISEASE**	P22.0
51	**ASPIRATION SYNDROME**	P24
52	**PREMATURITY-INDUCED APNEAS**	P28.3-P28.4
53	**OTHER RDSs**	Q25.0, P29.3, P23, P25, P22, P27
01	Patent ductus arteriosus	Q25.0
02	Persistence of fetal circulation	P29.3
03	Congenital pneumonia	P23
04	Pneumothorax and intestinal emphysema	P25
05	Transient tachypnea	P22.1
06	Chronic respiratory disease originated in the perinatal period	P27
	HEMORRHAGES	
07	Hemorrhagic disease of the newborn	P53
55	Pulmonary hemorrhage originated in the perinatal period	P26
56	Umbilical hemorrhage (not including omphalitis with hemorrhage)	P51
	HYPERBILIRUBINEMIA	
08	Hemolytic disease due to Rh inmunization	P55.0
09	Hemolytic disease due to ABO inmunization	P55.1
10	Preterm-associated neonatal jaundice	P59.0
58	**HEMATOLOGICAL** (Excluding P50-P59)	P60-P61
11	Neonatal polycytemia	P61.1
12	Congenital anemia	P61.3
79	Sickle cell anemia	D57.0-D57.2 y D57.8
13	Other hematological conditions	(rest of P60-P61)
	INFECTIONS	
14	Diarrhea	G00
15	Meningitis	P38
16	Onphalitis	P39.1, A54.3
17	Conjunctivitis	P39.4,L00
59	Newborn's skin infections	P38
18	Septicemia	(rest of P35-P39)
20	Necrotizing enterocolitis	P77
49	Neonatal tetanus	A33
60	Congenital syphilis	A50
61	Viral congenital diseases	P35
68	Congenital rubella syndrome (SRC)	P35.5
69	Cytomegalovirus (CMV)	P35.1
70	Congenital Toxoplasmosis	P37.1
39	HIV positive	R75
80	Chagas	B57
19	Other perinatal period infections	(rest of P60-P61)
	NEUROLOGICAL (EXCLUDING MALFORMATIONS)	
33	Acquired hydrocephalus	G91
34	Periventricular and brain leukomalacia	P91.1,P91.2
35	Obstetric trauma with intracranea injury of the CNS and the PNS	P10,P11,P14
36	Intracranial hemorrhage unrelated to trauma	P52
37	Seizures	P90
71	Hypoxic-Ischemic encephalopathy	P21
38	Other conditions of the brain	P91
	METABOLIC-NUTRITIONAL	
43	Child born to diabetic mother	P70.0, P70.1
45	Hypoglycemia	P70.3, P70.4, E16.2
46	Other metabolic and nutritional conditions	P75-PT8
66	**OTHER NEONATAL CONDITIONS**	
40	Prematurity retinopathy	H35
41	Inguinal hernia	K40
65	Cold injuty syndrome	P80.0 (excludes mild hypothermia P80.8)

CONGENITAL ABNORMALITIES

120	Anencephaly	Q00.0
121	Spina bifida/Myelomeningocele	Q05,Q07.0
122	Hydrancephaly	Q04.3
123	Hidrocephalus	Q03
124	Microcephaly	Q02
125	Holoprosencephaly	Q04.2
127	Other congenital malformations of the Central Nervous System	Q04,Q06
128	Troncus arteriosus	Q20.0
129	Transpositions of the large vessels	Q20.3
130	Tetralogy of Fallot	Q21.3
131	Single ventricle	Q20.4
132	Double autlet right ventricle	Q20.1
133	Complete atrio-ventricular canal	Q21.2
134	Pulmonary atresia	Q22.0
135	Tricuspid atresia	Q22.4
136	Left heart hypoplasia syndrome	Q23.4
137	Coarctaction of the aorta	Q25.1
138	Total anomalous pulmonary venous connection	Q26.2
139	Other circulatroy/respiratory abnormalities	Q24,28,34
140	Cleft palate	Q35
141	Tracheo-oesophageal fistula	Q39.1
142	Oesophageal atresia	Q39.0,Q39.1
143	Colon or rectal atresia	Q42.0,Q42.1,Q42.8,42.9
144	Imperforate anus	Q42.3
145	Omphalocele	Q79.2
146	Gastroschisis	Q79.3
147	Duodenal atresia	Q41.0
148	Jejunal atresia	Q41.1
149	Ileal atresia	Q41.2
150	Other GI malformations	Q40,43,45
151	Malformation of the genitalia	Q50-56
152	Bilateral renal agenesia	Q60.1
153	Poly or multicystics or dysplastic kidneys	Q61.1-61.9
154	Congenital hydronephrosis	Q62.0
155	Bladder extrophy	Q54
156	Other nephrourinary abnormalities	Q63,64
157	Trisomy 13	Q91.4, Q91.5,Q91.6
158	Trisomy 18	Q91.0, Q91.1,Q91.2
159	Down syndrome	Q90
160	Other chromosomal abnormalities	Q92,97-99
126	Cleft lip	Q36
161	Polydactily	Q69
162	Syndactily	Q70
163	Skeletal displasia	Q77-78
164	Talipes equinovarus - Talipes calcaneo varus/valgus (club foot)	Q66.8
165	Diaphragmatic hernia	Q79.0
166	Hydrops fetalis	P56,P83.2
167	Severe oligoamnios	P01.2
168	Other musculo skeletal abnormalities	Q68,74,75,79
169	Tegumentary abnormalities	Q82,84

HCPENR(P-11/07

Perinatal Card (front)

PERINATAL CARD

Place of antenatal visits (Prenat. Clinic) .....

.....

Maternity Hospital (Institution) STAMP .....

Pregnancy is not a disease, but needs surveillance by the health team in order to avoid complications.

It is important to make your first visit to the health center without delay.

Keep your appointments and follow the health team advice.

This card contains important information for your health and you child's health. Take it with you as your identification document and hand it to the health team whenever you need care, whether during pregnancy, labor, puerperium or when monitoring the growth and development of your child.

In case of loss please notify:

NAME

ADDRESS

TELEPHONE

TOWN or CITY

Pan American Health Organization

Latin American Center for Perinatology Woman and Reproductive Health CLAP/WR www.clap.ops-oms.org

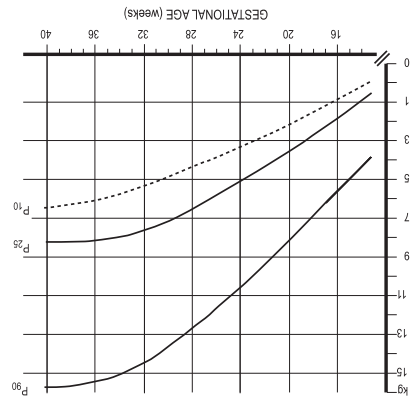
CPEENAVP-10/03

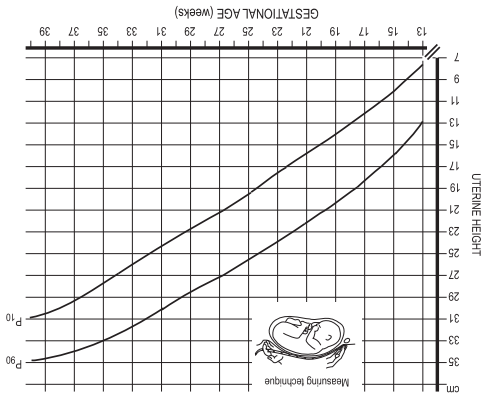
ANTENATAL VISITS	1st visit <12 weeks	2nd visit 28 weeks	3th visit 32 weeks	4th visit 36 weeks
Safe sex				
Tobacco / Alcohol	advise to stop use tobacco			
Breast feeding	If lactating		Preparation	
EMERGENCY				
Delivery plan				
Family	During pregnancy	during labour		
Next visit planned	26 weeks	32 weeks	36 weeks	41w / postpartum
Bacteriuria	All	if 1st test is positive		
Proteinuria	All	only in case of high blood pressure		
Hemoglobin test	If clinical anemia			
Fe / Folic acid		if necessary		
Syphilis test				
Tetanus toxoid	Current or 1st dose		2nd dose	
Malaria				

HOSPITALIZATION	ADMITTED		DISCHARGED	
	Day	Month	Day	Month

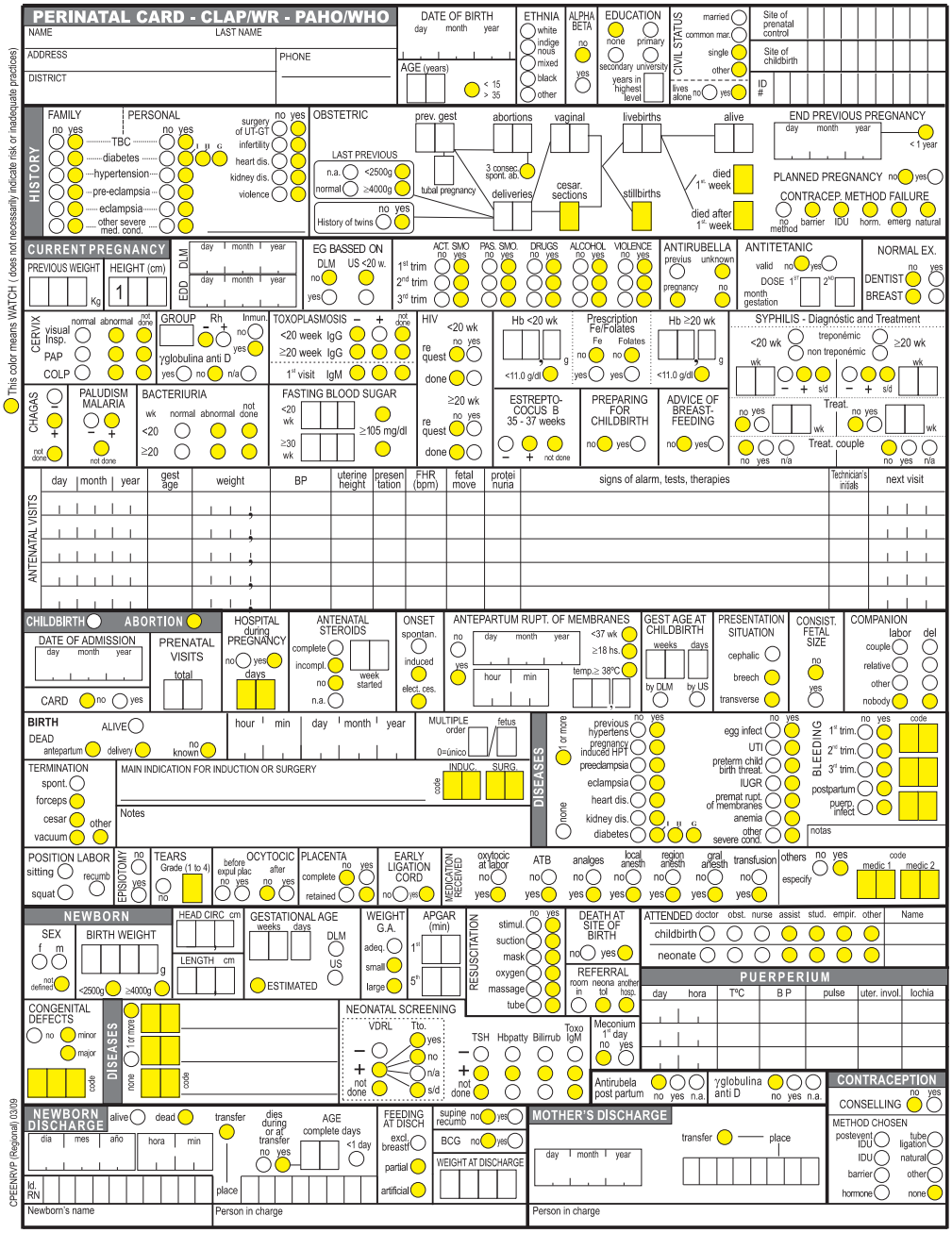
NOTES

The information contained herein is the property of the patient and must not be disclosed to any third party, without the patient's explicit consent



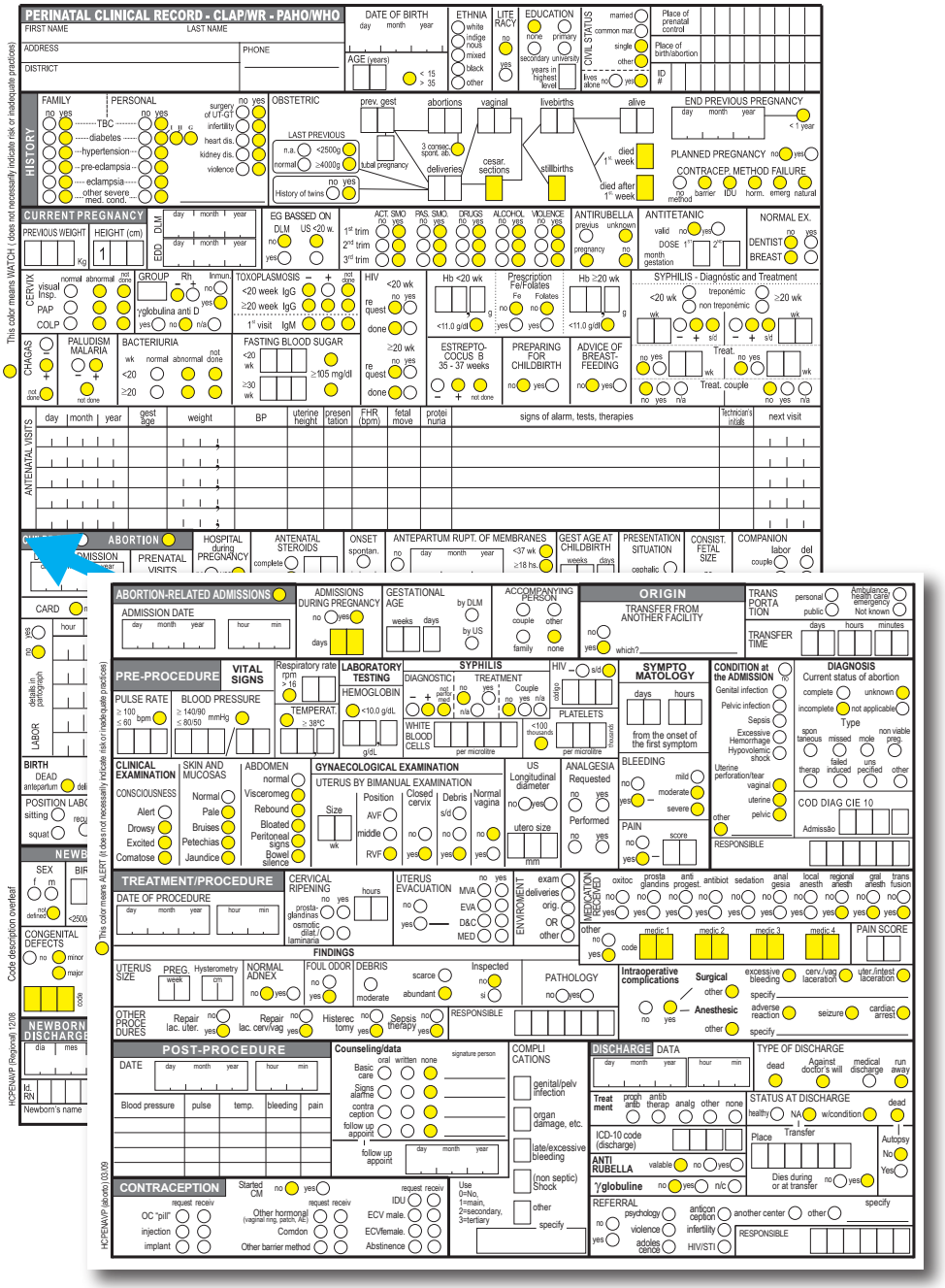


Perinatal Card (back)



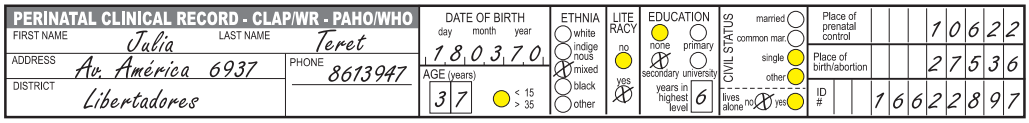
Patterns of uterine heigth and increase in maternal weight according to gestation age. Once the gestational age in known, graph both values on the charts overleaf.

Complementary form for women undergoing abortion



Sections of the Perinatal Clinical Record for women undergoing abortion

Sectión: IDENTIFICATION



FIRST NAME – LAST NAME

The pregnant woman's Christian name and first and second family names (father's and mother's) should be entered in this field.

ADDRESS – DISTRICT

The pregnant woman's usual home. Record street, house number and district (name of city, town, village, etc.). If the address cannot be identified with these data, write down any other reference to make it possible to find it. (E.g. Km 5 Route 3)

TELEPHONE (PHONE)

Record the telephone of usual address. If the woman had no telephone, write down an alternative telephone to enable the staff to communicate with the patient's family.

DATE OF BIRTH

Record pregnant woman's birth day, stating day, month and year.

AGE (years)

At the initial visit ask:

How old are you?

Record the answer in the two spaces available. If she is under 15 years or older than 35 years of age, the yellow box should also be filled.

ETHNIC GROUP

This information has been included in the PCR because the indigenous people and African American communities account for more than 40% of the population in the region. This important group of the population presents unfavorable living conditions and poor health and education services.

Although there is only one Race (Human), synonym of human species,

The populations are grouped in ethnicities. The ethnicities are human groups that share myths, ancestors, religion, territory, clothing, language and memories of a collective past that rule the relations of a human community.
One of the strategies to improve the situation of these populations is by making their needs visible through the presentation of health indicators broken down by Race and ethnic group.

Most countries have initiated efforts or have already incorporated questions in that regard in their national censuses. The ways data are obtained vary from one country to another. They are all filled by the subject him/herself, although in some cases they make reference to the color of the skin and in others they ask which indigenous group the person feels identified with. In all cases the choices include the names of ethnic groups and races specific to that country.

For instance, the PCR includes the variable Ethnic group with 5 choices: white, indigenous, mixed, black, others.

One way to obtain data could be: *What do you consider yourself to be?. White? Indigenous? Mixed?, Black?, Others?* Check the appropriate answer.

LITERACY

Ask: Can you read and write?
Write down the answer (YES or NO), as appropriate

SCHOOLING

Studies completed within the formal education system. Ask *What was the highest level of schooling you attended? Primary? Secondary? University?*
Record only the highest level reached.

YEARS COMPLETED IN THE HIGHEST LEVEL

Ask: *What was the highest grade/year you passed at that level?* Record only the highest year passed. For instance, if the pregnant woman reports she completed up to the third year of high school, check High School and record “3” in the space corresponding to ‘years in the highest level’.

CIVIL STATUS

Record the civil status as appropriate: Married, common law marriage, single, some other. Also record whether she lives alone or not.

PLACE OF PRENATAL CONTROL

Write down the code assigned by the national health authorities to the premises where prenatal control was performed.

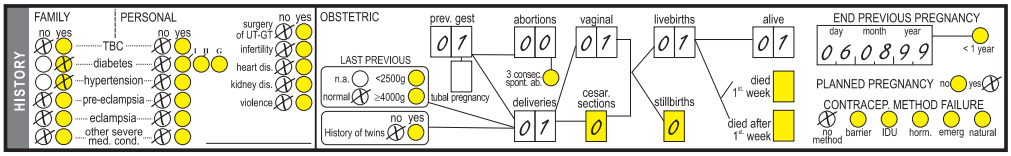
DELIVERY/ABORTION SITE

Write down the code assigned by the national health authorities to the premises where delivery occurred. If the prenatal control and delivery took place at the same premises, then the code is repeated in both variables.

IDENTITY NUMBER (Identity #)

The pregnant woman's identification number (for example, Clinical Record Number or Identity Card Number).

Section:
FAMILY, PERSONAL AND OBSTETRIC HISTORY



These data are obtained at the first prenatal visit. If the woman is admitted (either for abortion or some condition) at an institution or premises other than the center where prenatal control was done, the data in this section may be obtained from the PERINATAL CARD or through direct queries at time of admission.

FAMILY HISTORY

History of couple, parents or siblings.

Ask: *Has anyone in your family ever had… (mention each of the conditions of the PCR)?* If the answer is positive, ask Who?

PERSONAL HISTORY

This refers to the pregnant woman's personal history. Note that the list includes the conditions mentioned in the family history plus 5 additional conditions (genital and/or urinary tract surgery, infertility, heart disease, kidney disease and violence).

<u>The term genital and/or urinary tract surgery does not include cesarean sections</u>.

With regard violence, the recommendation is to ask both about the history of violence or the presence or absence of violence in the current pregnancy (see Section on Current Pregnancy)

Check the circle "YES" or "NO" as appropriate

OBSTETRIC HISTORY

PREVIOUS PREGNANCIES

This refers to the number of previous pregnancies, not including the current one.

Enter 00 if this is the first pregnancy.

DELIVERIES / VAGINAL – CESAREAN SECTIONS

This refers to the number of deliveries.
If appropriate, record the number of deliveries and ask:
How many were vaginal deliveries and how many were Cesarean Sections?

Additionally, ask about the last newborn's birth weight. Record if the newborn weighed less than 2,500 g or more than or equal to 4,000 g, if it was normal or n/a (not applicable) if there were no earlier births.
Finally, with regard the earlier pregnancies, record if there is history of twin births (YES/NO) as appropriate.

ABORTIONS

Abortion is defined as the expulsion of the product of gestation dead or with a weight under 500 grams before Week 22. Spontaneous or induced abortions will be recorded equally. Ectopic pregnancies will be recorded as abortions.

With regard the number of abortions, if the woman reports having had 3 consecutive spontaneous abortions, then check the appropriate yellow box.

LIVE BIRTHS

According to the ICD 10, a newborn will be classified as alive if it shows any vital signs following expulsion or complete extraction from the mother's body, regardless the duration of pregnancy. The newborn will be considered to have vital signs if it breathes, shows heart beats, if the umbilical cord pulsates or if there is evidence of movement of voluntary muscles.

Classifying a newborn as alive does not depend on the section of the umbilical cord or whether the placenta continues to be attached or not.

ECTOPIC PREGNANCY

Write the number of previous pregnancies that were implanted outside of the uterine body.

STILLBIRTHS

In accordance with ICD 10, a newborn will be classified as dead if it shows no evidence of vital signs after complete expulsion or removal from the mother's body, regardless of the length of pregnancy.

ALIVE

This refers to the number of children alive at the time of the visit.

DEAD AT FIRST WEEK

Newborns that were born alive but died between birth and the seventh day (6 days, 23 hours, 59 minutes) and that will be recorded in the appropriate box.

DEAD AFTER THE FIRST WEEK

This refers to newborns that were born alive but died after the first week (7 days or more). There is no upper limit and in theory this includes deaths occurring up to the same day of the visit, which will be recorded in the appropriate box

END OF PREVIOUS PREGNANCY

Write down day, month and year of termination of the pregnancy immediately previous to the current one, either a delivery or an abortion.

Leave this box blank if this is the woman's first pregnancy. Check the yellow circle if the end of the previous pregnancy occurred within the last year of the onset of the current pregnancy.

Check the yellow circle in the cases below:

- Interval between the previous delivery and current pregnancy shorter than 1 year;
- Interval between the previous abortion and current pregnancy shorter than 1 year.

The intergenesic interval is a controversial issue; see new contributions at CLAP/SMR Scientific Publication Nº 1562.

PLANNED PREGNANCY

This refers to a wanted or timely pregnancy; when both conditions are met, mark YES; when one of them is not met, mark NO (in yellow).

It might be helpful to ask one of the questions below to detect unplanned pregnancy: *When you learned you were pregnant, did you wish to become pregnant? did you wish to wait longer? Or, didn't you want to have any (more) children?*

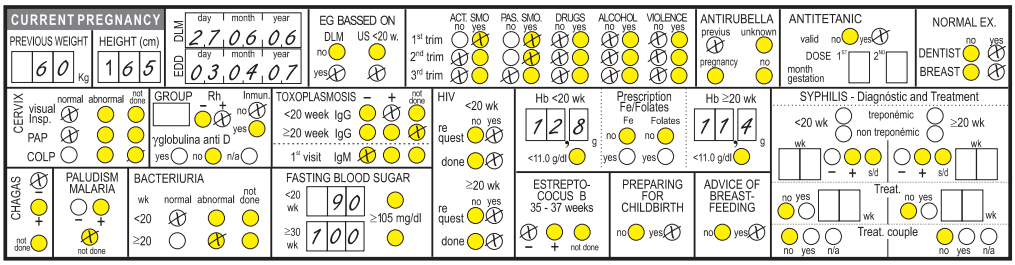
FAILURE OF THE CONTRACEPTIVE METHOD BEFORE THE CURRENT PREGNANCY (Failure of the Contraceptive Method.)

Ask: *When you found out you were pregnant, were you using any methods to prevent pregnancy?*

The potential answers are classified as:

(1) She did not use any methods
(2) Barrier: male condom, female condom, diaphragm, cervical cap.
(3) Intrauterine Device (IUD)
(4) Hormones: oral (pills), transdermal (patch) vaginal, subdermal implant or injections.
(5) Emergency contraception (emergency): Levonorgestrel alone or combined estrogens and progestin.
(6) Natural methods (natural): fixed day method, breastfeeding amenorrhea method, periodical abstinence, rhythm, Billings, among others.

Section: CURRENT PREGNANCY



This section is used to record all the data about the current pregnancy.

PREVIOUS WEIGHT

This refers to the woman's usual weight before the current pregnancy.

Ask: *What was your weight before this pregnancy?* Record the weight expressed in kilograms.

This information is useful to evaluate the woman's nutritional status before pregnancy. The most popular measurement is the Body Mass Index (BMI), which is calculated by dividing the weight in kilograms (Kg) over the square of height, expressed in meters (m2). For example, if the pregnant woman weighs 60 Kg and is 1.60 m tall, the calculation will be:

$$60 / 1.602 = 23.44 \text{ Kg/m2}.$$

HEIGHT (cm)

This has to be measured directly at the first control visit. The measurement technique requires that the pregnant woman stand barefoot, heels together, straight, shoulders backwards, looking forward, and the back touching the measuring tape. The data obtained will be recorded in centimeters.

DATE OF LAST MENSES (DLM)

This information is essential to estimate the gestational age and expected date of delivery. Many clinical decisions are based on gestational age, so getting reliable data is a critical issue.

Ask: *What was the first day of your last menses?*

Write down the information in the PCR using the day-month-year format

ESTIMATED DATE OF DELIVERY (EDD)

The use of the gestogram developed by CLAP/SMR is recommended to estimate the EDD. By matching the red arrow of the gestogram that says “date of onset of the last menses” with the date of the first day of the menses, it indicates the EDD on the calendar, marking the point of Week 40 in the gestogram. If there is a gestogram available, the use of the 280 day rule is recommended; starting on the date of the first day of the menses, count 280 consecutive days in the calendar, and day 280 will indicate the FPP. There are mathematical formulas that facilitate the calculation of the EDD (Rules by Naegele, Pinard, Wahl, etc.); they are described in detail in the CLAP/SMR scientific publication Nº 1562.

Use the day-month-year format to record the information in the PCR.

The FPP is not required in the case of women admitted for abortion without any prenatal controls.

RELIABILITY OF GESTATIONAL AGE (Reliable GA by DLM, US <20weeks)

The health care professional is required to give a subjective assessment about the reliability of the calculation of gestational age, either by DLM or by ULTRASOUND.

Ultrasound: When the date of the last menses is not available, one of the possibilities is to estimate the DLM on the basis of an early fetal ultrasound.

Record whether the gestational age is considered a reliable datum based on the DLM and/or the Ultrasound (YES/NO), as appropriate. Leave it blank if no ultrasound is performed.

ACTIVE SMOKER (Fuma Act)

The pregnant woman is smoking <u>at the time</u> of the visit. The smoker status may change over pregnancy. The suggestion is to find out what happens each trimester and write down the answer if appropriate (NO/YES)

PASSIVE SMOKER (Fuma Pas.)

<u>Current</u> exposure to cigarette smoke because another person smokes at her home or working place.
This information should also be investigated (asked) in every trimester since the LMP and until termination and the response should be recorded as appropriate (NO/YES)

DRUGS.

Current use of drugs that cause dependence, such as: marihuana, cocaine, amphetamines, hallucinogens, heroin, among others. In case of abortion 2nd and 3rd trimester will not be assessed.

ALCOHOL

Report current intake of any kind of alcoholic drink such as wine, beer, tequila, pisco, whisky, etc. Specifically mention all traditional local drinks.

Ask: *Have you taken any alcoholic beverages during this pregnancy?* Write down in the PCR if the woman has taken alcohol in this pregnancy (NO/YES). In case of abortion 2nd and 3rd trimester will not be assessed.

Alcohol consumption may change over pregnancy, so the PCR suggests investigating this information at least once in a trimester, by asking: *Since your last visit, have you taken any alcoholic drinks?*

VIOLENCE

This term involves physical, mental, psychological and sexual violence occurring during the current gestation. The aggressor may be the current couple, earlier couples, parents, or other people.

Obtaining this information may be difficult and there is no standard way to ask about this. Local relevant standards should be reviewed to choose the way questions are asked and the actions to be followed if a case is detected. If there is no regulated way to interrogate about emotional, physical, sexual and psychological violence, the following model is recommended for the first prenatal visit:

"I would like to ask some questions about your current relations with your couple. I know that some of these questions are very personal and let me assure you that your answers will be completely confidential:

1. *This last year, have you ever been humiliated, ashamed, not allowed to see your friends, or do things you are interested in? If the answer is positive, go on to ask:*
   (1st) Have you been humiliated, ashamed, not allowed to see your friends, or do things you are interested in since you are pregnant?

2. *Were you beaten, or physically injured by anybody over the last year?*
   If the answer is positive, go on to ask:
   (2nd) Have you been beaten, or physically injured by anybody since you are pregnant?

3. *Have you been forced to have sexual relations over the last year?*
   If the answer is positive, go on to ask:
   (3ª) Since you are pregnant, have you been forced to have sexual relations?

4. *Have you been worried about your children over the last year?*
   If the answer is positive, go on to ask:
   (4ª) Have you been worried about your children since you are pregnant?

5. *Have you been afraid of your couple or of anybody else over the last year?*
   If the answer is positive, go on to ask:
   (5ª) Have you been afraid of your couple or of anybody else since you are pregnant?

In subsequent visits there is no need to investigate what happened in the last year and the phrase "Since you are pregnant …." should be replaced by *"Since your last visit….."*

Positive replies to any of the questions querying about violence the previous year must be recorded in the section Personal History. If there is a positive response to the questions related with the current pregnancy, mark "YES" in the appropriate box.

ANTIRUBELLA

The elimination of Rubella and the Congenital Rubella Syndrome (CRS) is one of the pending challenges in the region of the Americas. One of the ways people can contribute to this national and regional effort is to routinely investigate the rubella vaccination status during prenatal control, as well as in those women being cared during abortion.

Ask: *Have you ever received the vaccine against rubella? If the answer is positive, ask When?*

Check the box “previous” if she received the vaccine any time before the current pregnancy. Check the circle “pregnancy” if the vaccine was administered during this pregnancy unnoticed; mark “Unknown (UK)” (“she doesn’t know”) when she does not remember if she received the vaccine; “NO” if she was never immunized.

If she has not been vaccinated, the immunization must be postponed until immediately after the baby is born (before discharge), or in the immediate post-abortion period. Check validity status of the patient’s vaccination schedule enforced in your country and the dates at which mass vaccination campaigns were conducted.

ANTITETANIC VACCINE

Elimination of neonatal tetanus represents another challenge for this region.
One of the key strategies to reach this goal is to vaccinate all the women in child-bearing age. To identify the women requiring antitetanic immunization, the PCR reminds the health care worker to ask about the patients’ vaccination status at the first prenatal visit.

It is important to ask the pregnant women to show their vaccination card, the perinatal card of the previous pregnancy or some other record or document where the number and interval between the dosages can be verified.

If the woman shows the documentation, check the number and interval between the boosters, as well as the time elapsed from the last vaccination, and decide if she must receive an additional dose.
The women that do not have any papers showing they have received immunization against tetanus must be vaccinated with an initial dose at the first prenatal visit. The second dose must be administered not earlier than 4 weeks after the first dose or at least 3 weeks before the estimated date of delivery. The administration of the subsequent boosters must follow the national standards.

Ask: *Have you ever received the vaccine against Tetanus?* If the answer is positive, request the appropriate document and check the number and interval between the boosters. If not, prescribe a dose at the current visit.

Record *Valid= Yes* in the cases below:

- She received two dosages and the current pregnancy is within the 3-year protection period.
- She received three dosages and the current pregnancy is within the 5-year protection period.
- She received 5 dosages.

Record *Valid= NO* in the cases below:

- No dosages were administered. *Action:* Administer two dosages during the current pregnancy: the first dosage at the first prenatal visit and the second one not earlier than 4 weeks after the first dosage or at least 3 weeks before the date of delivery.
- Unreliable information about the number and dates of administration of the previous dosages: *Action:* Administer two dosages during the current pregnancy.
- She received two dosages and the current pregnancy starts after 3 years of protection. *Action:* Administer only one dosage (the third one).
- She received three dosages and the current pregnancy starts after 5 years of protection. *Action:* Administer only one dosage (the fourth one).

When a non vaccinated woman receives tetanus toxoid after an abortion she is protected as well as protects her offspring of future pregnancy.

DENTIST AND BREAST EXAMINATION (NORMAL EXAMINATION)

For many women prenatal control implies their first contact with the health services and therefore, it offers the opportunity to asses the general status, apart from that related to their current pregnancy. That is why the PCR includes variables such as dentistry and breast examination, which reinforce this concept.

These tests should also be included in the case of women receiving care for an abortion, to ensure they receive comprehensive care whenever they contact the health team, regardless of the reason.

Dentistry Examination (Dentistry)

The dentistry examination has become significant because of the potential association between periodontal disease with premature delivery, low birth weight, pre-eclampsia and fetal death and transmission of streptococcus mutans from the mother to the child and its effect on the incidence of tooth decay in small children.

Periodontal disease includes diagnoses such as gingivitis (inflammation of the soft tissues around teeth) and periodontitis (destruction of the tooth support structures – bone, ligaments, cement, etc.).

Examine the oral cavity and record any decayed teeth or changes in the soft tissues around the teeth. Check as appropriate. If the examination were abnormal, refer to the dentist.

Breast Examination:

Breast examination is suggested in many countries as part of the examination of all pregnant women. It is aimed at identifying problems that may affect future breastfeeding (such as inverted or flat nipples and eventual malignancies).

The PCR includes the Normal Examination data; mark 'YES' when breast examination is normal, and NO when it is not.

CERVIX

Examination of the vagina with a speculum is recommended as part of the prenatal assessment, to detect abnormalities or cervix infections. The health care provider will choose the most appropriate time to conduct this examination, considering each pregnant woman's individual situation.

VISUAL INSPECTION (Insp. visual)

If a cervix abnormality is observed during the examination with the speculum, it should be marked as abnormal on visual inspection, and if the examination was not conducted that should also be recorded.

PAPANICOLAU SMEAR (PAP)

If the cervix shows any abnormal findings, or if there are any doubts as to whether the pregnant woman will come back after delivery, consider getting a PAP smear during the prenatal control. Interpretation of the results may be difficult when the PAP smear is performed during pregnancy. If a cervical lesion is observed in a woman during postabortion care, PAP smear should be postponed. Record the result of the PAP smear when appropriate: Normal/Abnormal. If the PAP smear was not performed, record it was not performed.

COLPOSCOPY (COLP)

Record as 'Normal' if the Colposcopy shows no malignant lesions or lesions precursor of cervix cancer. If not, mark "Abnormal" or that it was not performed, as appropriate. Colposcopy should be postponed in women during immediate post abortion care.

Rh GROUP

Write down the appropriate **blood group (Grupo)** (A, B, AB, O) in the box. For **"Rh"** mark (+) if the woman is RH positive and (-) if she is Rh Negative. The woman is said to be **immunized** when she has anti-D antibodies. If the woman is immunized (she will have a positive test for irregular antibodies, also called the indirect Coombs test) and in that case it has to marked as (yes); if not, mark (No).

ANTI D GAMMAGLOBIN

This variable applies to the use of Anti D Gammaglobin during pregnancy according to national standards. Some countries recommend systematic administration of gammaglobin to all Rh negative women at 28 weeks gestation.

Other countries restrict its use only to women with genital bleeding or previous to invasive procedures like amniocentesis: in cases of abortion none of these two apply. Mark YES if a non immunized woman received Anti D Gammaglobin during pregnancy and NO if she did not. Mark not applicable (N/A) in Rh positive mothers.

TOXOPLAMOSIS

If the standards in your country or your department include this test in the prenatal control, record the value of the test (IgG or IgM) as appropriate.

It is always advisable to convey educational/ preventive messages to reduce the risk of congenital toxoplasmosis. Please, refer to the Scientific Publication CLAP/SMR 1562. In cases of abortion Toxoplasmosis Test box, should not be filled alter 20 weeks.

ACQUIRED IMMUNODEFICIENCY VIRUS INFECTION (HIV)

The Region of the Americas is included in the global strategies for generating HIV- and congenital syphilis-free children ant to guarantee universal access to therapy to all individuals living with HIV/AIDS. Both strategies try to meet part of the Millennium Development Goals and Objectives, and for that purpose it is necessary to offer HIV screening to all pregnant women and to ensure prophylactic therapy to prevent vertical transmission of HIV.

Record HIV Test: Ordered: YES or NO, Performed: YES or NO, as appropriate.

To preserve confidentiality of a positive HIV result and to avoid stigmatization of these women, CLAP/SMR has included no boxes in the PCR indicating HIV status, either positive or negative, but health professionals providing care to an HIV positive woman still have the information required to provide the best care to the woman, her child and the health team members. Hence, the recommendation is to record the HIV code in the place reserved for disease codes (R75 in ICD 10 or 76 in CLAP/SMR).

HEMOGLOBIN TEST (Hb)

Anemia is a public health problem because of its impact on human health, especially in pregnancy, where it is associated with an increase in the risk of maternal and perinatal mortality (especially in cases with severe anemia); prematurity and low birth weight.

A pregnant woman is considered to present anemia when her hemoglobin value is under 11.0 g/dl in the course of the first or third trimester of pregnancy, or when the hemoglobin value in the second trimester is under 10.5 g/dl. If hemoglobin ranges from 7.0 to 9.0 g/dl, anemia is considered moderate, and when it is under 7.0 g/dl, anemia is severe.

The hemoglobin test is recommended at the first visit, and clinical signs of severe anemia (pale conjunctives, palms, and oral mucosa) should be ruled out.
Review your specific country's guidelines for the management of anemia in pregnancy; for further information refer to Scientific Publication CLAP/ SMR 1562.

The PCR offers two instances to record the results of the hemoglobin test; one at the first antenatal visit and the other after Week 20. The values obtained shall be recorded in the appropriate boxes. Mark the yellow circle if the levels are under 11 grams.

Prescription of Fe/FOLATES

There is consensus that iron and folic acid requirements increase during pregnancy and that it is difficult for a pregnant woman to meet this greater demand just with diet, except in those countries where there are specific programs for food fortification. The strategies for preventing iron deficiency anemia are based on:

- Changing diet to increase the consumption of iron and those elements that facilitate its absorption, while trying to reduce consumption of inhibitors.

- Iron fortification of commonly consumed food.
- Supplementation with iron rich medication.
- Treating any infections that may alter the absorption of iron and other nutrients (e.g. parasitic diseases).

Iron supplements have been suggested as a strategy to improve the mother's iron status, and consequently her health and survival and the size of the fetus, including the child's iron status and development during the neonatal and post-neonatal period.
Unless otherwise indicated by national standards, all pregnant women should be supplemented with 60 mg of elementary iron per day, from the moment pregnancy is suspected to the period following delivery. The total supplementation time should not be less than 6 months, and in those places where the prevalence of anemia during pregnancy exceeds 40%, it is advisable to keep iron supplementation up to 3 months after delivery.

Mark ***(NO)*** in the circle if no iron supplementation was prescribed, and check the blank circle ***(YES)*** when it was.

Folate deficit is the second leading cause of nutritional anemia during pregnancy and it also accounts for defects in the closure of the neural tube (anencephalus, bifid spine, myelomeningocele and encephalocele), cleft lip, cleft palate and other defects.
Women should receive 0.4 mg/day of folic acid about three months before getting pregnant (at least 4 weeks earlier) to prevent anemia and neural tube defects.
Check the circle ***(NO)*** if no folic acid supplementation was prescribed and mark the blank circle ***(YES)*** if it was.

SYPHILIS - DIAGNOSIS & TREATMENT

In spite of the progress with congenital syphilis in the region, the disease continues to be a relevant public health problem. Upon the request of the ministers of health of the member countries, PAHO has implemented the "Plan for the elimination of congenital syphilis in the Americas", which is complemented with the strategy called "an HIV- and congenital syphilis-free generation of children".

The detection and treatment of syphilis in pregnancy has been defined as one of the key strategies to eliminate congenital syphilis. This

strategy includes screening at the first prenatal visit, promotion of an early prenatal control and reduction of the risk of re-infection by treating the sexual partners and advising on the use of condoms.
Tests to detect syphilis are recommended at the time of delivery in all those women with no prenatal control (to diagnose it and to treat both the woman and her newborn) and in the women who had an abortion or stillbirth. The most widely used detection tests are Non treponemic tests (VDRL or RPR)., and it is suggested they should be conducted twice; once at the time the woman is seen at her first antenatal visit (before Week 20 of pregnancy) and then in the third trimester. In case of abortion it should not be filled alter 20 weeks.
If local conditions apply rapid treponemic tests may be used for diagnosis. These tests may be false positive for active syphilis, because they may remain positive in cured patients.
In these women if a non treponemic test is not immediately available treatment may be justified.

Women with reactive tests should receive counseling and information about their disease, its risks and the need to treat their sexual partners and the child after birth. Negative women should be provided information about how to prevent sexually transmitted infections.

Gestational age (in weeks) of confirmed or negative syphilis diagnosis shall be registered in the rectangular boxes. In the circles check (treponemic, non treponemic or both), considering the test performed to do the diagnosis of maternal syphilis.
In the others circles check ***(-)*** if syphilis diagnosis were negative and ***(+)*** if positive and ***(n/a)*** if Unknown. If treatment was administered check the next box. Remember that penicillin is the only valid treatment for congenital syphilis.
Due to frequent reinfection after treatment and before delivery, a reminder has been included in the form to consider testing and eventually treating sexual partners of the pregnant woman.
Write ***NO*** when needed treatment was not administered, ***YES*** when given and **N/A** (not applicable) when was not needed.
If treatment was administered check the next box.
Remember that penicillin is the only valid treatment for congenital syphilis.
Due to frequent reinfection after treatment and before delivery, a reminder has been included in the form to consider testing and eventually treating sexual partners of the pregnant woman.
Write ***NO*** when needed treatment was not administered, ***YES*** when given and ***N/A*** (not applicable) when was not needed.

CHAGAS' DISEASE

Chagas' disease (infection by tripanosoma cruzi) is found exclusively in the American continent. It is considered endemic in 21 countries. The activities considered essential for the control of this disease include controlling the vector and screening serum tests for T. cruzi at blood banks. In the countries where the vector's transmission has been eliminated, vertical transmission is the only way the disease can be maintained. So much so, that for some countries pregnancy Chagas has become a sentinel disease.

Record the result of Chagas Test (Negative/Positive/Not done) as appropriate.

PALUDISM / MALARIA

CLAP/SMR has included the variable paludism due to the prevalence of this disease in 21 of the 37 countries of the Region.

If malaria is endemic in your country, you should review your national standards to check measures for detection, treatment and prevention, as well as the degree of endemicity of transmission in your area. The PCR includes the term Malaria or Paludism. If paludism testing is performed in your country, record the result of the diagnostic test performed (regardless of the technique employed): check it as negative if paludism was not detected, positive (yellow circle) if the disease is confirmed, and not done, if the test was not performed.

BACTERIURIA

Asymptomatic bacteriuria refers to symptom-free bacterial colonization of the urinary tract.

In places where the urine culture is not an option, the urine dipstick may be an alternative during prenatal monitoring.

Mark "Bacteriuria: Normal", when the urine culture is negative (less than 100,000 colony forming units/ml), or the dipstick is negative; Abnormal, if the urine culture or dipstick yield positive results. If no urine culture or dipstick are performed during pregnancy monitoring, check the circle indicating the service was not provided. In cases of abortion should not be filled alter 20 weeks.

FASTING BLOOD SUGAR

Record the blood sugar value obtained, according to the gestation week in milligrams per deciliter in the appropriate box. If baseline blood

sugar is equal to or greater than 105 mg/dl, mark the yellow circle, too. Since the use of blood sugar level and its replacement by PTOG is controversial in obstetric routine, refer to Scientific Publication CLAP/ SMR 1562. In case of abortion do not check alter 30 weeks.

B STREPTOCOCCUS 35 - 37 weeks

In case of abortion this variable does not apply.

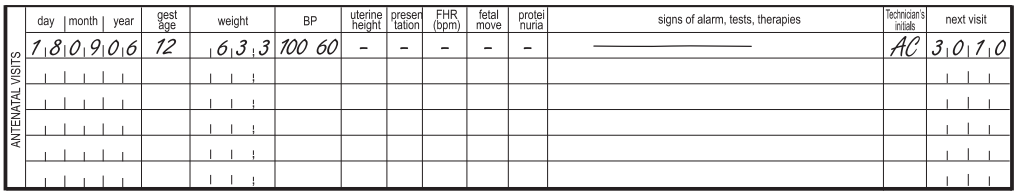
PREPARING FOR DELIVERY

In case of abortion this variable does not apply.

BREASTFEEDIING COUNSELING

In case of abortion this variable does not apply.

ANTENATAL VISITS



ANTENATAL VISITS	day | month | year	gest age	weight	BP	uterine height	presentation	FHR (bpm)	fetal move	proteinuria	signs of alarm, tests, therapies	Technician's initials	next visit
	18|09|06	12	63.3	100 60	–	–	–	–	–	———	AC	30|10|10

In case of abortion with no previous antenatal visits this section does not apply

For those women with pre-abortion antenatal visits the PCR has space for 6 prenatal visits; if additional space is required for new visits, attach the “PCR complementary visit chart”.

The data to be recorded are:

- Day, month and year of the visit
- Gestational age at the time of visit, in completed weeks.
- Weight, in kilograms.
- Blood pressure (BP), in mm of Hg.
- Uterine height, in centimeters.
- Presentation, cephalic (cep), breech (bre), including shoulder or transversal (tra).
- Fetal heart rate in beats per minute (FHR bpm)
- Fetal movements, positive or negative; the absence of data is interpreted as a service not provided
- Proteinuria: record as positive if albumin or proteins are present in urine; if it does not contain any, write Negative. Leaving the box blank will be interpreted as (not performed).

- Signs of alarm, tests and therapies, write only positive and relevant signs.
- Technician's initials.
- Date of the next appointment, day and month.

In those situations where these procedures do not apply because of gestational age (for example, fetal presentations before week 28), write NA (not appropriate)

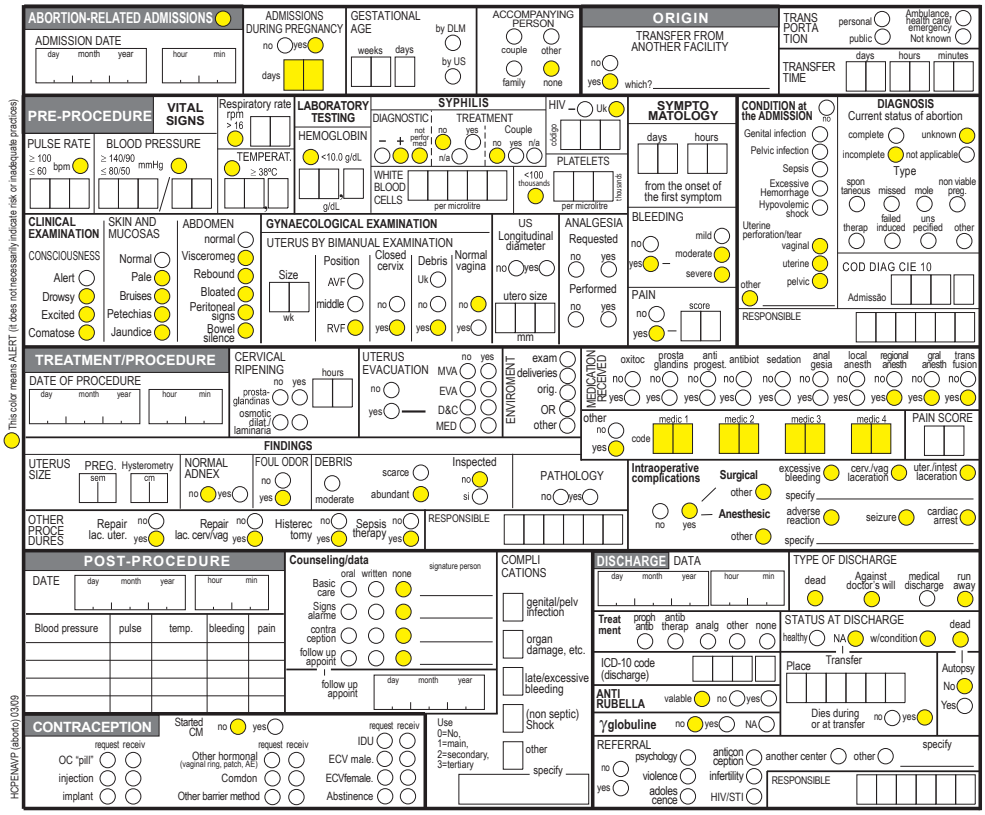
Section: ABORTION

As a result of their technical cooperation agreement, CLAP/SRM and Ipas developed a form that complements the Perinatal Clinical Record, to be used in the case of women undergoing abortion.

Ipas is an international organization (www.ipas.org) that works globally to empower women so they can exert their sexual and reproductive rights and to reduce the death rates and the number of abortion-related injuries. It has a 10-year experience designing recording systems for women undergoing abortion. The process started with the development of InfoAPA and reached its fullest development with COMPAC (Comprehensive Post Abortion Care). The COMPAC system combines clinical forms in hard copy and software that permits an on-going storage and evaluation of the quality of care, seeking to improve the delivery of woman-focused services. It was in this context, in the framework of the CLAP/SRM and Ipas cooperation, and tapping on the strengths of the two institutions, that a form was developed to complement the Perinatal Clinical Record, meant to be applied to women undergoing abortion.

The section on Abortion was designed to record the data relevant to women undergoing abortion. The variables considered were exhaustively tested during the development, and they were carefully selected following the CLAP health care systems monitoring standards; their Perinatal Electronic System additions ensure its integrated and complementary approach.

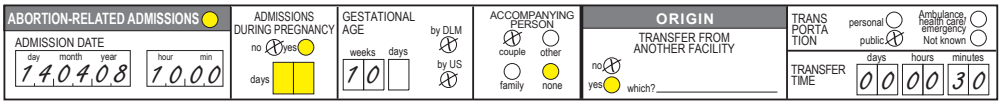
In the case of women undergoing abortion, the PCR *sections on childbirth, maternal diseases, newborn, puerperium, newborn's discharge, maternal discharge and contraception* shall be replaced by the complementary abortion form attached as a sticker.



The Abortion Section addresses the following stages of care sequentially:

- Origin/transfer
- Admission
- Pre-procedure
- Procedure
- Contraception
- Discharge

Section: ABORTION-RELATED ADMISSIONS



ADMISSION DATE

This is the date of the pregnant woman's admission to the hospital. The date is recorded as date-month-year and time is recorded in hour-minutes.

ADMISSIONS DURING PREGNANCY

This refers to hospitalizations occurring for different reasons. If the woman was admitted in the course of this pregnancy, check the yellow circle that says Yes; in that case the total stay in days must also be recorded in the yellow squares (of the only single admission or the sum of days of all the admissions).

GESTATIONAL AGE ON ADMISSION

Record the gestational age on admission, in complete weeks and days, and state whether the calculation was based on the date of the last menstrual period (PLM) and/or in the ultrasound (US).

ACCOMPANYING PERSON (CONTINUOUS SUPPORT THROUGHOUT THE CLINICAL COURSE, PROCEDURE AND SUBSEQUENT PERIOD)

The PCR has incorporated this variable based on patient's right to be accompanied by the person they want wants and on the scientific evidence that shows better clinical outcomes in women that are accompanied during health care process.

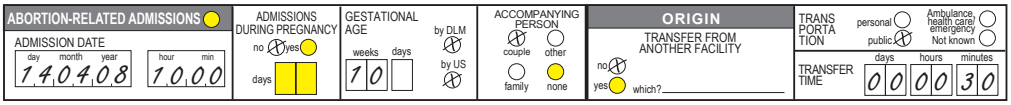
This addition for abortion records the presence of a person that could be the couple, the family or another (friend or health care professionals) that offers continuous and individualized emotional support, information, encouragement and comfort to the woman undergoing abortion, during hospitalization.

The choices are:

couple, family, other (including health care staff) and none.

The term 'accompanying person' does not include the health care professionals present only for the purpose of evaluating the patient or administering therapy.

Section: ORIGIN



TRANSFER FROM ANOTHER FACILITY

Check Yes or No as appropriate, if the patient was transferred from another health unit, medical center or hospital, either private or public.

If you checked Yes, state which institution is referring the patient, its name and/or code. According to national standards.

TRANSPORTATION

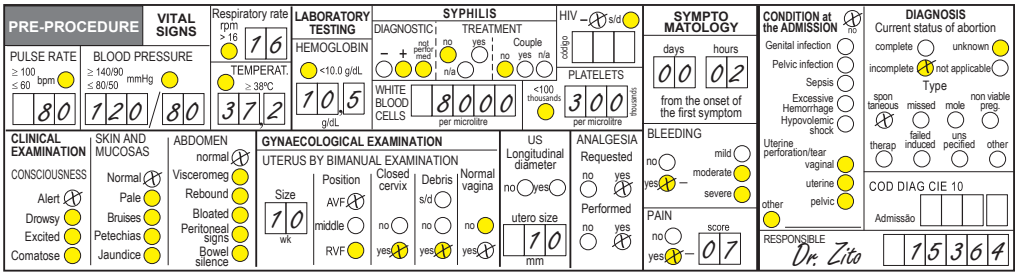
This refers to the type of transportation used to get to the health care center. The choices are:

- **Personal**, when the woman went to the center by her own means of transportation or a friend's or a relative's. Examples of such means of transportation could be a car, cart, bicycle, horse, etc.
- **Public**, the woman took a bus, taxi-cab, mini-bus or any other shared means of transportation typically used by the public.
- **Ambulance, health care center/emergency**: The woman was brought in a public or private ambulance or she was brought by firefighters, public law-enforcing agents or police as an emergency.
- **No reply**, information is not known or is not available, or the woman or her family fails to provide it.

TRANSFER TIME

Record the time required for the patient's transfer from her home, work or another institution, to the health care center, expressing it in days, hours and minutes.

Section: PRE-PROCEDURE



VITAL SIGNS

This section records all the data related with the vital signs before the procedure:

- **PULSE RATE,** in beats per minute (bpm). If it is greater or equal to 100 bpm or lower or equal to 60 bpm, check the yellow circle.
- **BLOOD PRESSURE,** systolic and diastolic in millimeters of mercury (mmHg). Whenever possible, the BP must be measured with the woman sitting, placing the sphygmomanometer cuff on her right forearm and auscultating the ulnar artery. If the BP is greater or equal to 140/90 mmHg or lower than 80/50 mmHg, check the yellow circle. Do not leave any number box empty. If values are less than 100 mmHg fill first box to the left with 0. (i.e.: 90 mmHg, write 090).
- **Respiratory rate (RR),** in respirations per minute (rpm). Rates exceeding 16 rpm are considered tachypnea, and the yellow circle should be marked.
- **Axillary Temperature (TEMPERAT),** it is recorded in degrees centigrade to the decimal. Put the thermometer in the axilla for at least a minute. The presence of fever may be a sign of severe infection. If the temperature is greater or equal to 38 ºC, record it in the yellow circle.

LABORATORY TESTING

Blood testing includes measurement of hemoglobin, white blood cells, platelets, HIV and VDRL/RPR.

- **HEMOGLOBIN,** is measured in grams/deciliter (gr/dL) of blood. It is expressed in the corresponding units and one decimal. If the value is under 10.0 g/dl the patient has anemia; that fact will be recorded as a warning sign in the yellow circle. Do not leave any number box empty. If values are less than 10 g/dL fill first box to the left with 0. (i.e.: 8.0 g/dL write 08,0).

- **SYPHILIS,** is a Sexually Transmitted Infection (STI) produced by a spirochette called Treponema pallidum. It may be asymptomatic, or

there may be evidence of the earliest sign (chancre) that appears in the site of inoculation. If untreated, the disease goes through its typical stages. This infection affects 330,000 pregnant women in Latin America and the Caribbean. It is estimated that unless it is treated, one third of the fetuses will be aborted. The application of preventive measures through counseling on the use of condoms, the sexual partner's testing and treatment and the capture of sexual contacts and their treatment will reduce the risk of re-infection and the risk of acquiring new syphilis infections. Refer to the Scientific Publication CLAP/SMR # 1562.

- **DIAGNOSIS OF SYPHILIS (SYPHILIS DIAGNOSTIC)** If the diagnosis was done by serological tests it shall be registered in the specific circles. According to local availability different tests can be used (non treponemic VDRL or RPR, rapid treponemic tests or rapid combined treponemic and non treponemic) tests. Regardless the available test, write the results in the circles: ***(-)*** if not confirmed, ***(+)*** if confirmed, or ***(not performed)***. If the test was reactive, the treatment shall be registered in the box below. The only effective treatment to the pregnant woman to avoid congenital syphilis is penicillin.

- **TREATMENT OF SYPHILIS (SYPHILIS TREATMENT)** The therapy of syphilis will be done following the national standard or using penicillin G benzathine 2.400.000 U intramuscular; one single dose in case of primary syphilis. If the woman is allergic to penicillin, in the case of abortion - and differing from the management of the infection during pregnancy- other effective antibiotics may be used.
  Check the yellow circle that says ***(No)*** when the woman failed to receive the therapy she needed. Check ***(Yes)*** if she received therapy, and if therapy was not required, check where it says it was not applicable ***(n/a)***. When Syphilis is not confirmed after treponemic confirmatory tests were done treatment is not needed. Follow national standards that request confirmation before treatment. When those tests are not immediately available benefits of treating unconfirmed cases may outweigh risks of treatment delay.

- **COUPLE TREATMENT (SYPHILIS TREATMENT COUPLE)** A major cause of failure in reducing congenital syphilis is the lack of identification and treatment of the pregnant sexual partner. This record includes a reminder for health care personnel to search, diagnose and treat sexual partners if necessary as well as to give advice for safe sex practice. Write ***(No)*** if treatment was needed but NOT DONE, ***(Yes)*** if needed and done and ***(n/a)*** if NOT NEEDED.

- **HIV,** the timely detection and therapy of the HIV infection are key activities to reduce the impact of this disease and to reduce its transmission, while they give an opportunity to apply preventive measures. HIV screening tests (rapid tests on blood and saliva samples, or ELISA) are conducted. Positive tests must be confirmed with the Western blot technique or through immunofluorescence.

Check (-) if the result of the HIV is negative; check the yellow circle Uknown (UK) when test was not done or lab result unknown.If POSITIVE write code "76" in the box corresponding to DISEASES DURING PREGNANCY according to CODE LIST in the reverse of the PCR

- **WHITE BLOOD CELLS,** expressed in units per microliter. Report the total white blood cells (WBC) count per microliter. 5 numeric boxes are available, if WBC count is LESS than 10000 (i.e.: 9000 per microlitre write 09000).

- **PLATELETS,** expressed in thousands per microliter. Fill the three appropriate boxes with numbers. For example, if the result is 450,000, report it as 450, since the word thousand is already written in letters. The yellow space must be checked when the value is lower than 100 thousand platelets. If than number is 45000 then write 045.

- Blood group and Rh factor (Rh Group), if this was not recorded during the prenatal testing it must be done now and recorded in the section Current Gestation, as explained above. A box to register the administration of Anti D Gammaglobin is available under the Blood Group and Rh box. In case of abortion this data will be recorded in a specific box in the Discharge Section.

SYMPTOMATOLOGY

Indicate the total duration of symptoms in days and hours, from the onset of the first symptom.

BLEEDING

If the woman presents no bleeding, record ***(No)***. If she presents bleeding, check the yellow circle that says ***(Yes)***; this allows you to identify the volume of bleeding, checking the proper circle, as appropriate, stating whether bleeding was mild, moderate or severe. The latter two (in yellow) are considered alert signs, so caution must be taken to prevent hypovolemic shock.

PAIN

Record the existence of abdominal and/or pelvic pain: Yes or No as appropriate. Ask the woman to use the Pain Analog Visual Scale (PAVS); this scale was developed at Ipas as a simple way to quantify a subjective element such as the intensity of pain (see annex A). To indicate the intensity of pain, write the appropriate score expressed in units with one decimal (for instance, a 4.8 pain score). The patient is asked to evaluate the maximum pain she has experienced since the onset of the clinical episode that led her to seek care. If there is no PAVS available, she will be asked to rank her pain in a 0 to 10 scale, being 0 the absence of pain and 10 the maximum pain she has experienced. In this case, only entire numbers will be used, without decimals.

CLINICAL EXAMINATION

Indicate the signs found in the clinical examination in the appropriate entries.

CONSCIOUSNESS

Consciousness is recorded by checking ONE of the four options:

- **Alert,** if the woman is well aware of time and space, she can maintain a coherent dialog.
- **Drowsy,** the woman is in a persisting state of drowsiness.
- **Excited,** hyperkinesia, predominantly of upper and lower limbs. The movements are involuntary, un-coordinated and unconscious
- **Comatose,** the woman is unconscious, has lost sensitivity and voluntary motor skill. The depth of coma is defined by planes (1 to 4). Being 1 the mildest and 4 the deepest coma.

SKIN AND MUCOSAS

Record the appearance of skin and mucosa in the correlative entries; the variables accept more than one option (e.g. pale and petechias):

- **Normal,** when there are no visible changes in the color of skin, taking the typical skin of the woman's ethnic group as a reference.
- **Pale,** Significantly lighter color of mucosa and skin as compared to the color typical for the woman's ethnic group.
- **Bruises,** subdermal or submucosal spots, purple blue or yellowish purple, depending on their stage. If there is no history of trauma, they may suggest the presence of coagulation disorders.
- **Petechias,** small spots that appear as red dots on the skin, which do not disappear when finger-pressed. They may suggest the presence of coagulation disorders.
- **Jaundice,** yellowish coloring of the skin and mucosa that may suggest liver failure.

The three last options are signs of alert that require great attention, so they are in yellow.

ABDOMEN

State the status and appearance of the abdomen through static and dynamic observation and palpation of the abdomen.

- **Normal,** no evidence of any changes and it excludes other options.
- **Visceromegalies,** enlargement and/or dilation of the inner organs. The presence of liver or spleen enlargement indicates a greater organic and/or functional involvement. The cause must be investigated, as it may be part of a severe infectious syndrome, among other causes.
- **Rebound,** onda líquida o del témpano. this sign is pathognomonic of ascitis (excessive accumulation of fluid in the abdominal cavity).
- **Bloating,** the abdomen is enlarged and palpation shows an increased tension from the surface to the muscular plane.
- **Peritoneal signs,** pain upon decompression of the abdominal wall occurs due to inflammation of the peritoneum. This sign is present in cases of perforation of the uterus and other abdominal and/or pelvic viscera. It can be related to abortive procedures or to complicated ectopic pregnancies.
- **Abdominal silence,** the abdominal auscultation indicates the absence of abdominal noises, which indicates a loss of the bowel peristalsis, suggesting a detention of intestinal transit. The circles of the last five options are in yellow due to their potential severity.

GYNAECOLOGICAL EXAMINATION

The gynecological bimanual examination is intended to determine the size and the clinical characteristics and contents of the uterus, as well as the status of the cervix, the existence of debris and the exploration of the vaginal canal.

BIMANUAL EXAMINATION OF THE UTERUS

Record:

- **Size of uterus (size),** in weeks of gestation (wk), as determined by the bimanual examination performed by trained staff.
- **Position,** check whether the uterus is in anteversion flexion (AVF), (middle) or in retroversion flexion (RVF) in the yellow circle.
- **Closed cervix,** this is a warning sign when evacuating the uterine contents; record Yes (yellow circle) or No, as appropriate.
- **Ovular debris,** if there are ovum debris, check Yes (yellow circle) or No, depending on the findings of the gynecological examination.
- **Normal vagina,** check Yes or No, as appropriate.

ULTRASOUND

The diagnosis of abortion is mainly clinical. Performance of laboratory testing does not preclude the beginning of therapy. The ultrasound should be performed whenever available when the diagnosis is highly complex or when the woman or her family are worried and there is a need to speed up the diagnostic steps (e.g. in anembryonic ova).
In case of abortion, the ultrasound may show the uterus occupied by the gestational sac or by the ovular debris and/or clots. The uterus will not be empty until the abortion is completed. This test may be very useful for ruling out differential diagnoses- refer to the Scientific Publication CLAP/ SMR # 1562.
Check Yes if the ultrasound was performed, or No, as appropriate. If it was performed, state the **uterus size** in weeks of gestation. If fundal height is 70 mm write 070.

ANALGESIA

Record Yes or No in the item “Requested”, depending on whether the woman has requested medication to relieve her pain or not. Record Yes or No in the variable “Performed” to express whether she received any medication or not.

CONDITION AT THE ADMISSION

Write any adverse health condition previous to any diagnostic or therapeutic intervention in the health care facility where the woman was admitted. If there is no disease impairing maternal health status at admission check circle ***NO***. If a disease is present check all corresponding options.
The most significant complications of Incomplete Abortion are hemorrhage with acute anemia and infection; women that underwent instrumental procedures may be at a higher risk of perforation.
The most frequent complications of spontaneous abortion occur due to the migration of germs from the lower genital tract. Likewise, the uterus can get infected if the material used is contaminated. The severity of the condition covers a broad range, from endomyometritis to sepsis.

Check the option(s) below:

- **Genital infection,** when there are signs and symptoms compatible with an infection: fever, chills, foul vaginal discharges, abdominal or pelvic pain of spontaneous onset and/or when the uterus is mobilized, prolonged hemorrhage and elevated white blood cells.

- **Pelvic infection,** the most frequent findings are abdominal or pelvic pain, peritoneal signs evidenced by abdominal – pelvic decompression, pain upon mobilization of the uterus, fever equal

or greater than 38ºC and mucopurulent and/or foul leukorrhea, and elevated white blood cell count.

- **Sepsis,** is a severe condition with great impairment of the general status; it may affect consciousness and it is accompanied by fever and multi-parenchymal involvement (jaundice, anuria or oligoanuria, hypotension, respiratory disorders, coagulation disorders, etc.). It is a complication frequently associated with abortion or performed under dubious safety conditions, by unqualified personnel and/or in poor conditions of asepsia.

- **Excessive Hemorrhage:** abundant and continuous metrorrhage, over 500 ml. It is frequently present when there is uterine atonia, (increasingly common as gestational age progresses), but it can also be secondary to ovular debris retention or injuries (perforations) during the evacuation process.

- **Hypovolemic shock:** It is produced by an excessive hemorrhage and rapid course, secondary to a complication. It is accompanied with significant impairment of consciousness and of the general status, and it usually has a severe hemodynamic impact.

- **Uterine perforation/tear,** the perforation is a relatively frequent complication in the uterine evacuation process, especially following curettage. It may be caused by a minor perforation, usually asymptomatic, and resolves spontaneously or after administering oxytocic agents. Large perforations can cause a peritoneal irritation syndrome and/or hemodynamic shock, and may require an exploration laparotomy. See CLAP/SMR Scientific Publication #1562.

  Other times there may be tears. In any of these events, the site of the injury must be identified: vaginal, uterine and/or pelvic. Describe the site of the tear and/or perforation (vagina or uterus). Pelvic is any lesion in a pelvic organ like rectum, bladder or pelvic vessels. OTHER applies to abdominal organ injuries.

DIAGNOSIS
Current status of abortion

Abortion: it is defined as the expulsion or extraction of the product of conception with a weight equal to or under 500 grams outside the mother's womb or when the interruption of pregnancy occurs before the 22nd weeks.

- Current status of abortion, check the diagnosis found by the examiner. The choices in the version of the Perinatal Clinical Report for Women Undergoing Abortion are those reported more frequently, i.e., complete abortion, incomplete abortion and other alternatives such as “unknown” or “not applicable”.
- Complete abortion consists of the total expulsion or extraction of the ovum from the uterine cavity in a complete stage. Once it occurs, uterine contractions cease, the pain disappears, the size of the uterus is reduced and so is genital bleeding, and the cervix shows involution.
- Incomplete abortion, expulsion or extraction of the ovum is partial and there is retention of the placenta and/or the ovum membranes. There is persistence of painful uterine contractions and genital bleeding; the uterus is soft and the cervix continues to be dilated.

In the entries corresponding to the other options presented, record:

- **Unknown**, when the health care provider does not know what the clinical situation is and/or no gynecological examination was performed.
- **Not applicable**, this option is checked in the case of therapeutic abortions (e.g. evacuation of an unembryonic sac, interruption due to risk to mother’s life, etc.).

Type of abortion

Check the Type of abortion in the appropriate circle, as appropriate:

- **Spontaneous Abortion (Spont)**: it occurs without the intervention of any circumstances artificially interfering in the course of pregnancy; 25% of spontaneous abortions have evident symptoms. They can occur as threatened abortion and resolve with therapy, or they may be part of dynamic clinical conditions that evolve in several stages: Threatened abortion, imminent abortion and completed abortion. Please, refer to Scientific Publication CLAP/ SMR # 1562.

- **Missed abortion (missed)**: the embryo or fetus die before week 22, and the fetus is retained (there are no spontaneous uterine contractions or cervix dilation yet). It is diagnosed through the ultrasound, and is also known as blighted and retained ovum.

- **Mola**: el aborto se debe a una degeneración hidrópico vacuolar del trofoblasto. Clínicamente se sospecha por la presencia de vesículas que remedan racimos de uva.

- **Non viable pregnancy (non viable preg.)**: the fetus or the embryo has been determined to present a condition that makes it incompatible with extrauterine life. This applies to those countries with a legal framework contemplating this situation.

- **Therapeutic Abortion (therap)**: when the interruption of pregnancy is done for therapeutic purposes, due to diseases in which pregnancy jeopardizes the mother's life. This applies to the countries where there is a legal framework that contemplates this situation.

- **Failed induced abortion (failed induced)**: the procedures and/or the medication used were inadequate or ineffective for the purpose. If the failure is confirmed or if there is an incomplete abortion, a complementary surgical method will be required to evacuate the uterus: vacuum aspiration or dilation and curettage for pregnancies in the second trimester.

- **Unspecified (unspecif):** Check this option when the interruption of pregnancy is deliberate.

- **Other:** when none of the options above apply.

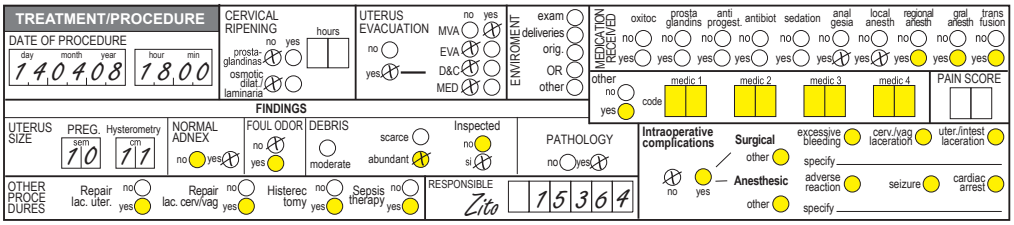
ICD 10 DIAG. CODE: in this box record the code of the diagnosis when the woman was admitted to the health care center. The diagnosis of the current status of abortion and the type will be done based on the ICD – E10 criteria (ANNEX 1); refer to Scientific Publication CLAP/SMR # 1562.

If abortion is spontaneous and complete, the PROCEDURE module will be deactivated automatically in the electronic version of the Clinical Record of Women Undergoing Abortion.

RESPONSIBLE

The health care professional shall write down and/or stamp his/her name and identification number, and will sign as the person responsible for the woman's clinical care and diagnosis upon admission.

Section: THERAPY/PROCEDURE



DATE OF PROCEDURE

Record the day, month and year, hour and minutes the procedure is started. Use one number per box only. It is very important to provide precise data, since the time written will be used to calculate the overall duration of the procedure.

CERVICAL MATURATION

There are different clinical conditions (blighted ovum and anembryonic ovum, etc) where the cervix is formed and closed and the uterine cervix requires being prepped or needs maturation. Proceed as indicated by each country's standards for each specific case. The use of medical methods such as the osmotic dilators, or pharmacological management, or laminarias facilitates the procedure and reduces the incidence of complications, especially after the ninth week of gestation.

The pharmacological therapy majorly used consists in the use of prostaglandins. Misoprostol (prostaglandin E1 analog), is indicated as follows:

- **prostaglandins,** check Yes or No, indicating whether prostaglandins were administered or not.
- **Osmotic dilators/laminarias,** record Yes or No, depending on whether these elements were used to dilate the cervix or not.
- **Hours,** check the total duration of the dilation procedure in hours.

UTERINE EVACUATION

If the uterine evacuation was performed, check Yes or No, as appropriate. If Yes, it is possible to specify the technique(s) used and not used, marking Yes or No in the correlative circles, as appropriate.

The uterus can be evacuated with several techniques. Before each procedure, the woman must receive analgesia and/or local anesthesia (paracervical lidocaine) or general anesthesia, according to the needs and availability of each case in particular.

Vacuum aspiration, either manual or electrical, is the safest and fastest surgical method (from 3 to 10 minutes) and can be done on an outpatient basis. It is the method of choice for the evacuation of pregnancies until twelve complete weeks. It consists of a plastic or metal cannula that is attached to a vacuum source. Before inserting the cannula, the cervix must be dilated using osmotic or mechanic dilators - alone or with prostaglandins - or else cervix maturation.

- **MVA**: manual vacuum aspiration, the vacuum is created using a plastic aspirator or 60-ml syringe sustained and activated manually using sterile, disposable cannulas, with diameters ranging from 4 to 12-mm.
- **EVA**: electrical vacuum aspiration, the vacuum pump source is electrical.
- **D&C**: dilation and curettage, is a surgical procedure used for evacuation through dilation (metal dilators) and curettage of the uterus. This method is not as safe and it has a higher complication rate (perforations). It can be used in pregnancies under 12 weeks, when vacuum aspiration methods are not available; in pregnancies greater than 12 weeks, if there are no medical methods available for the dilation and expulsion of the fetus, and also when the fetal expulsion has occurred and there are no vacuum aspiration methods available for evacuation of the uterus.
- **Medications (MED)**, The use of misoprostol (prostaglandin analog) is very effective, safe and acceptable for the interruption of pregnancy during the first trimester. However this scheme poses some difficulties.

In any of the cases above, if the evacuation of the uterus is not completed, it is completed with an aspiration method or IUC, as available..

ENVIRONMENT

Indicate the environment where the procedure was conducted, checking the circle of the appropriate option: **Examining room (Exam), Delivery room (Delivery), Procedures room (Proced), Operating room (OR) and in (Other)** any other space not included in the options above.

MEDICATION RECEIVED

In all cases, record whether the medicines listed were used or not, indicating Yes or No in each case. The medical record permits to specify any other medication used, indicating Yes in Other and using the coded entries for medic 1, medic 2, medic 3 and medic 4. Medication codes will be provided in accordance with the usual classification used at the center. If no additional medication was used, check No in Other.

PAIN SCORE

Indicate the patient's perception of the pain she suffered, using the Pain Analog Visual Scale (PAVS). Continuous monitoring of the perception of pain, applying evidenced-based techniques. The pain is a clinically relevant sign that appears early in the case of complications and the effective management of pain is an essential element to assess the quality of care. The use of the PAVS also helps to evaluate efficacy and to compare the results of the different therapies.
If there is no PAVS available, the woman will be asked to rank her pain in a 0 to 10 scale. Number are filled in the appropriate space, with no decimals. This evaluation must be done immediately after the procedure, to obtain more reliable data. (ANNEX 2)

FINDINGS

In the entries provided, indicate the clinical findings obtained during the therapy/procedure.

- **Uterine size**, check the size of the uterus in weeks of pregnancy, as measured with the bimanual examination conducted before the procedure.
- **Hysterometry**, Record the size of the uterus in cm, as measured with the hysterometer or with a perforated Easy Grip type cannula (or similar).

NORMAL ADNEXES

Check Yes or No as appropriate.

FOULNESS

Check Yes or No to indicate whether the uterine contents and/or the discharges have a foul odor.

DEBRIS
Record the existence of ovular debris in the appropriate circles, stating if they were **(Scarce)**, **(Moderate)** or **(Abundant)**. Also check if the debris were inspected or not, indicating Yes or No, as appropriate.

PATHOLOGY
Mark Yes or No depending on whether the uterus was sent for pathology examination or not.

INTRAOPERATIVE COMPLICATIONS
Write No if there were no intraoperative complications; and check Yes if there were any. This option will differentiate the type of complications in:

- **Surgical complications,** check the appropriate circles for the different choices, as appropriate: **Excessive bleeding, Cervico-vaginal laceration (cerv./ vag.laceration), utero – intestinal laceration (uter./intest.laceration).** The choice Other will permit to expand the data specifying the surgical complication.

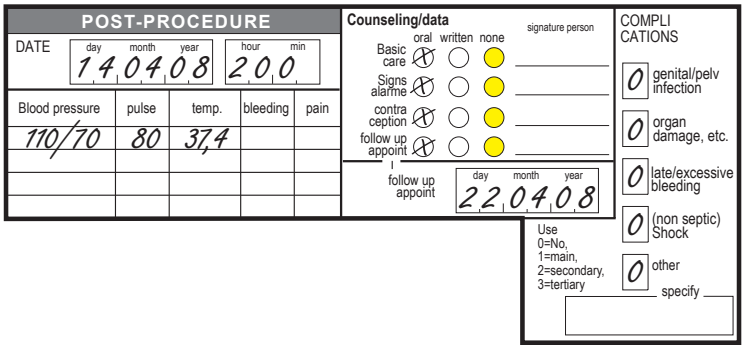
- **Complications of anesthesia,** check the circles with the different options, as appropriate: **Adverse reaction, Seizure, Cardiac arrest.** The choice Other will permit to expand the data specifying the anesthetic complication.

OTHER PROCEDURES

In all cases check Yes or No in the appropriate circle for the following variables:
Repair of uterine laceration (repair uterine laceration), Repair of cervico- vaginal laceration (repair cerv./ vag. lacer.), (hysterectomy) Treatment of sepsis (treat. sepsis).
Implica el empleo de otros procedimientos quirúrgicos específicos

RESPONSIBLE
Record and/or use a stamp with the health professional's name, Id. Number. The professional will sign as responsible for the clinical care, diagnosis and the procedure and therapy applied.

Section: POST-PROCEDURE



DATE, in the entries corresponding to day, month and year, indicate the date the post-procedure care was started and record the hour and minutes the procedure was completed and the post-procedure care was started. This will permit to calculate the overall duration of the procedure.

In the controls box record the blood pressure, pulse, temperature, bleeding and pain. Record vital signs and pain hourly the first four hours after the procedure. In the fifth row record the controls the last hour before the patient is discharged.

- **Blood pressure (BP),** Record the systolic and diastolic BP, in millimeters of mercury (mmHg).
- **Pulse,** in beats per minute (bpm)
- Temperature (temp.) check axillary temperature in degrees centigrade (ºC).
- **Bleeding (bleeding),** record the level of genital bleeding as mild (Mi), moderate (Mo) or severe (Se).
- **Pain, (see annex 2),** the woman will be asked to evaluate her pain, using the Pain Analog Visual Scale (PAVS). Record it in numbers, using up to one decimal, using evidence-based technique. If there is no PAVS available, she will be asked to rank her pain in a 0 to 10 scale, using only entire numbers, without decimals, and recording it in the appropriate space. Any increase in the pain values perceived may be a sign of complications.

COUNSELING/DATA

Check the appropriate circles and indicate if the woman received counseling or information on **Basic care, Alarm Signs and/or Contraception** and a follow-up or monitoring visit was scheduled. State whether counseling

or the information was Oral or Written, or check **None** if no oral or written counseling was provided on these issues. In the column "signature of the person responsible" write down the name and/or initials of the professional in charge. If a follow-up appointment was scheduled, record the day, month and year in the appropriate box in **Follow-up visit.**

Basic care, after discharge, the first days; the home controls will include:

- temperature, color, amount and odor of vaginal discharges, persistence of pain and bowel movement disorders. The presence of some or several changes of these parameters or other signs of concern will permit an early detection of complications; the woman should be instructed to seek care immediately.
- Sexual activity may be resumed as soon as the genital discharges cease.
- Schedule a control visit from 7 to 10 days after the abortion, evaluate the woman's course and complete any actions pending since discharge.

• **Alarm signs**: the woman must be instructed to recognize these signs and to seek care immediately if pain persists, if bleeding worsens, if fever goes ≥38 ºC, if there are changes in the amount, color, odor and appearance of the discharges, presence of foul genital secretions, lochia with ovum debris, skin - mucosa pallor, dizziness, lightheadedness, loss of consciousness.

Severity of any adverse outcome will be registered with the following options:

- Genital and or pelvic infection (genital / pelvic infection)
- Pelvic organ or other injured
- Late or excessive bleeding
- Non septic shock
- Other, specify any other complication up to 3 complications occurring during this admission. Write them in order of severity starting by the most severe.
  Write 0 if no complications occurred.

• **Other,** record other type of complications not specified in the previous options.

POSTABORTION ANTIRUBELLA

This refers to whether it is necessary to administer the vaccine in the postabortion period in women without previous immunization. This preventive measure seeks to protect the woman and will also be beneficial for her in her next pregnancy.

Check **"not applicable"** if she had a valid vaccine and therefore she did not require immunization. Check Yes when the woman had to receive the vaccine and she was immunized at discharge and check **No** when the woman that had to be immunized is discharged without receiving the vaccine.

RESPONSIBILITY

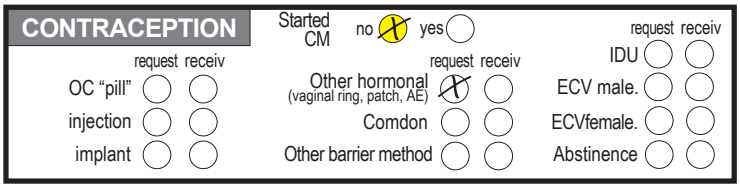
The professional in charge must write down his/her name, sign and/or stamp the professional license number. The professional is clinically and legally responsible for the care and therapy delivered by the woman.

POST ABORTION GAMMAGLOBIN

Hyperimmune Anti D Gammaglobin should be administered at discharge to every Rh negative woman not yet immunized.

Check YES if given, NO if needed and not given, and N/A if NOT NEEDED.

Section: CONTRACEPTION

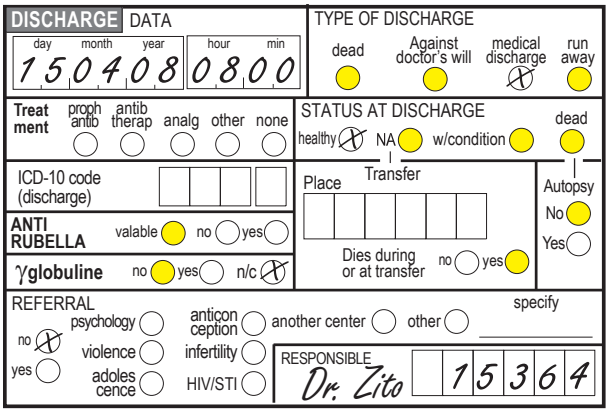


Has the woman started using any contraception methods? Write down Yes or No depending on whether the woman started a contraceptive method before leaving the center or not (for example, she took the first OC pill, she had an IDU implanted, she received an injection or put on a patch). If the answer is Yes, indicate which of the methods below she **Requested and/or Received** in the appropriate circles:

- Oral contraceptives, (OC or "pill")
- Injection
- Implant
- Another hormonal contraceptive method (Another hormonal, vaginal ring, patch, (EC) Emergency contraceptives).
- Condom (male or female).
- Other barrier methods (spermicides, diaphragm, etc.)
- Intrauterine Device (IUD)
- Male voluntary surgical sterilization, (Male VSS)
- Female voluntary surgical sterilization, (Female VSS)
- Abstinence (periodical abstinence with baseline temperature monitoring, Billings' method, etc.).

Check REQUEST if the woman selects this method.
Check RECEIV if the method is provided to the woman.
In case of ABSTINENCE check RECEIV even it is conditioned to a later behavior.

Section: DISCHARGE



Record the date (day, month and year) and the time and minutes of discharge in the appropriate entries as explained in the situations above.

TREATMENT

Indicate if the woman was discharged home on any drug therapy. Check the choices below in each circle as appropriate:

- **Prophylactic antibiotics**
- **Therapeutic antibiotics**
- **Analgesics**
- **Others,** other than the options above
- **None,** if she received no therapy or prescription at discharge

.

TYPE OF DISCHARGE

Indicate the type of discharge by checking the appropriate circle:

- **Dead,** if the woman died in the center where she received care, check the circle 'dead' and then include the moment, date and time of death in TYPE OF DISCHARGE.
- **Against doctor's advice,** when the woman leaves the center without the doctor's consent but the staff is aware of her decision.
- **Medical discharge:** The doctor or some other health care provider signed the discharge.
- **Run away,** the woman leaves the center without an authorization and without the staff's knowledge.

STATUS AT DISCHARGE

In the appropriate circle, indicate if upon discharge the woman was:

- **Healthy,** in good health.
- **Not applicable (NA),** when the woman has been transferred to another center to continue with her care.
- **With some condition (w/condition)**, either general and/or related with the reason for admission and therapy or procedure performed during her hospitalization.
- **Dead,** the woman dies at some stage of the process.
  - **Autopsy**
    In case of death mark YES or NO if AUTOPSY was done.

ICD- 10 DIAGNOSTIC CODE (DISCHARGE)

The ICD- 10 Code will be used to define the final diagnosis in the space available in three adjacent boxes and one separate box. E.g.:
The code for Incomplete Abortion is O03 and the code for Incomplete Abortion without complications is .4. Hence, the Incomplete Abortion with no complications will be recorded as: O03.4.

REFERRAL

Some women undergoing abortion may require care from various specialists that may or may not be at the same hospital or health care center. Systematic referral to the nearest center; if the woman was transferred, specify the type of center she was referred to.
Check Yes or No to indicate whether the woman was referred to one of the departments below:

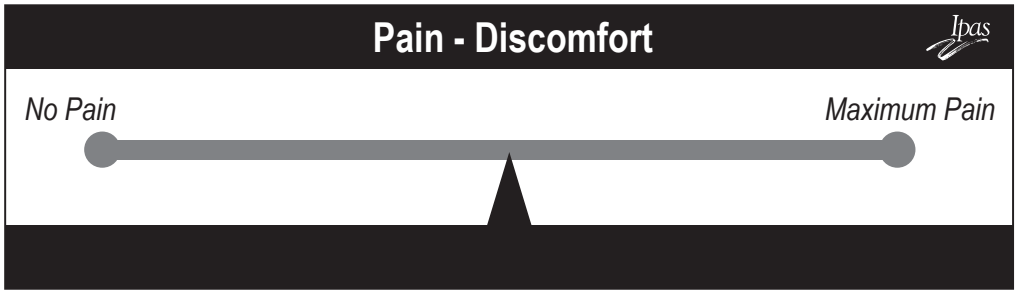
- Psychology
- Violence
- Adolescence
- Contraception
- Infertility
- HIV/STI
- Another center (another cent.)
- Other

If any of the last two options are checked, the name and/or code of the center must be filled in the appropriate space.

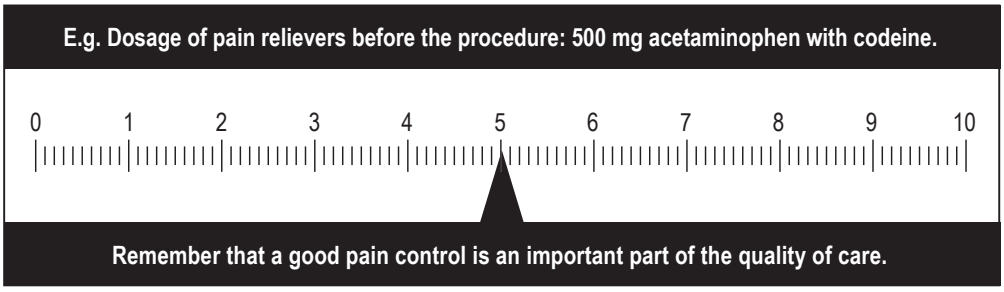
ANNEX A

ANALOG VISUAL SCALE (PAVS)

Ipas has designed a tool that facilitates the quantification of the patient's subjective rating of her pain.
Using the side of the scale labeled as "Pain - Discomfort", ask the woman to slide the paper tab into the plastic sleeve until the blue arrow points at the right place between the two extremes "No pain" and "Maximum pain



Later, turn round the scale and write the number in¬dicated by the blue arrow in the number scale, expressed to the decimal. Note that the values increase from right to left, and not the other way round.



ANNEX B

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) RELATED WITH PREGNANCIES WITH ABORTIVE OUTCOME

Pregnancy with abortive outcome (000-008)

Excludes: continuing pregnancy in multiple gestation after abortion of one fetus or more (031.1)

O00 Ectopic pregnancy
Includes: ruptured ectopic pregnancy
Use additional code from category O08.-, if desired, to identify any associated complication.

O00.0 Abdominal Pregnancy
Excludes: delivery of viable fetus in abdominal pregnancy (O83.3) maternal care for viable fetus in abdominal pregnancy (O36.7)

O00.1 Tubal Pregnancy
Fallopian pregnancy
Rupture of (Fallopian) tube due to pregnancy
Tubal abortion

O00.2 Ovarian Pregnancy

O00.8 Other ectopic pregnancies
Pregnancy: cervical
cornual
intraligarnentous
mural

O00.9 Unspecified ectopic pregnancy

O01 Hydatidiform mole
Use additional code from category O08.-, if desired, to identify any associated complication.
Excludes: malignant hydatidiform mole (D39.2)

O01.0 Classical hydatidiform mole
Complete hydatidiform mole

O01.1 Incomplete and partial hydatidiform mole

O01.9 Hydatidiform mole, unspecified
Trophoblastic disease NOS
Vesicular mole NOS

O02 Other abnormal products of conception
Use additional code from category O08.-, if desired, to identify any associated compli¬cation.
Excludes: papyraceous fetus (O31.0)

O002.0 Blighted ovum and nonhydatidiform mole
Mole: carneous
fleshy
intrauterine NOS
Pathological ovum

O02.1 Missed abortion
Early fetal death with retention of dead fetus
Excludes: Missed abortion with: - blighted ovum (O02.0)
- mole: • hydatiform (O01.-)
• nonhydatidiform (O02.0)

O02.8 Other specified abnormal products of conception
Excludes: those with: - blighted ovum (O02.0)
- mole: • hydatidiform (O01.-)
• nonhydatidiform (O02.0)

O02.9 Abnormal product of conception, unspecified
The following fourth-character subdivisions are for use with categories 003-006:
Note: Incomplete abortion includes retained products of conception following abortion.

.0 Incomplete, complicated by genital tract and pelvic infection
With conditions in O08.0

.1 Incomplete, complicated by delayed or excessive haemorrhage
With conditions in O08.1

.2 Incomplete, complicated by embolism
With conditions in O08.2

.3 Incomplete, with other and unspecified complications
With conditions **in O08.3-O08.9**

.4 Incomplete, without complication

.5 Complete or unspecified, complicated by genital tract and pelvic infection
With conditions in O08.0

.6 Complete or unspecified, complicated by delayed or excessive haemorrhage
With conditions in O08.1

.7 Complete or unspecified, complicated by embolism
With conditions in O08.2

.8 Complete or unspecified, with other and unspecified complications
With conditions in O08.3-O08.9

.9 Complete or unspecified, without complication

O03 Spontaneous abortion
[See before O03 for subdivisions]
Includes: miscarriage

O04 Medical abortion
[See before O03 for subdivisions]
Includes: termination of pregnancy:
- legal
- therapeutic
therapeutic abortion

O05 Other abortion
[See before O03 for subdivisions]

O06 Unspecified abortion
[See before O03 for subdivisions]
Includes: induced abortion NOS

O07 Failed attempted abortion
Includes: failure of attempted induction of abortion
Excludes: incomplete abortion (O03-O06)

O07.0 Failed medical abortion, complicated by genital tract and pelvic infection
With conditions in O08.0

O07.1 Failed medical abortion, complicated by delayed or excessive haemorrhage
With conditions in O08.1

O07.2 Failed medical abortion, complicated by embolism
With conditions in O08.2

O07.3 Failed medical abortion, with other and unspecified complications
With conditions in O08.3-O08.9

O07.4 Failed medical abortion, without complication
Failed medical abortion NOS

O07.5 Other and unspecified failed attempted abortion, complicated by genital tract and pelvic infection
With conditions in O08.0

O07.6 Other and unspecified failed attempted abortion, complicated by delayed or excessive haemorrhage
With conditions in O08.1

O07.7 Other and unspecified failed attempted abortion, complicated by embolism
With conditions in O08.2

O07.8 Other and unspecified failed attempted abortion, with other and unspecified complications
With conditions in O08.3-O08.9

O07.9 Other and unspecified failed attempted abortion, without complication
Failed attempted abortion NOS

O08 Complications following abortion and ectopic and molar pregnancy

Note: This code is provided primarily for morbidity coding. For use of this category reference should be made to the morbidity coding rules and guidelines in the 2006 Version of ICD - Volume 2.

O08.0 Genital tract and pelvic infection following abortion and ectopic and molar pregnancy
Endometritis
Oophoritis
Parametritis
Pelvic peritonitis — following conditions
Salpingitis — classifiable to O00-O07
Salpingo-oophoritis
Sepsis
Septic shock
Septicaemia

Excludes: septic or septicopyaemic embolism (O08.2)
urinary tract infection (O08.8)

O08.1 Delayed or excessive haemorrhage following abortion and ectopic and molar pregnancy
Afibrinogenaemia — following conditions
Defibrination syndrome — classifiable to O00-O07
Intravascular coagulation

O08.2 Embolism following abortion and ectopic and molar pregnancy
Embolism:
NOS
air
- amniotic fluid
- blood-clot — following conditions
pulmonary — classifiable to O00-O07
pyaemic
septic or septicopyaemic
soap

O08.3 Shock following abortion and ectopic and molar pregnancy

Circulatory collapse following conditions
Shock (postoperative) classifiable to O00-O07

Excludes: septic shock (O08.0)

O08.4 Renal failure following abortion and ectopic and molar pregnancy

Oliguria
Renal:
- failure (acute)
- shutdown following conditions
- tubular necrosis classifiable to O00-O07

Uraemia

O08.5 Metabolic disorders following abortion and ectopic and molar pregnancy

Electrolyte imbalance following conditions classifiable to O00-O07

O08.6 Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy

Laceração, perfuração, ruptura ou lesão química de:
- bladder
- bowel following conditions
- broad ligament classifiable to O00-O07
- cervix
- periurethral tissue
- uterus

O08.7 Other venous complications following abortion and ectopic and molar pregnancy

O08.8 Other complications following abortion and ectopic and molar pregnancy

Cardiac arrest following conditions
Urinary tract infection a classifiable to O00-O07

O08.9 Complication following abortion and ectopic and molar pregnancy, unspecified

Unspecified complication following conditions classifiable to O00-O07

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