

# Case Report Form, OptiBreech 1



Name:
Hospital Number:
Date of birth:
NHS/CHI Number:

(or mother's sticker)

Referred by: obstetrician / midwife / self		Diagnosed prior to labour? Y / N
Parity:	Had an ECV? Y / N	Gestation at referral:
Baby's DOB:		Baby's NHS/CHI number:
Mode of birth		Elective CS / Emergency CS / Vaginal breech birth / Cephalic birth
If CS, why?		
FOR VAGINAL BREECH BIRTHS AND LABOURS	Was someone present who:	Had completed physiological breech birth training? Y / N
		Met all proficiency criteria? Y / N
	Maternal birth position: upright / supine / CS	Was maternal movement and effort encouraged prior to hands-on intervention? Y / N / none required
		< 5 minutes between birth of pelvis & birth of head? Y / N / CS
Admission to neonatal unit (directly following birth)? Y/N		
Perinatal mortality		None / Stillbirth / Neonatal death (prior to discharge from maternity care, within 28 days)
Total time someone spent on-call	Above and beyond normal work hours or already scheduled on-call hours. Do not include days/nights already counted on another case report form.	
	Days	Nights

**Please scan and return to research team along with Breech Birth Pro Forma.**

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