Instructions: Please use this Data Collection Form (DCF) to abstract data from the medical record for each eligible patient. Enter all data into REDCap via the following link: https://redcap.hitchcock.org/redcap/surveys/?s=AYTYKCK3MT. Please complete this form no later than 8-12 weeks from the expected delivery date. Thank you! ☺

Patient Information ***For internal site use only. Please keep secure.***	
Patient Name:	_____
DOB:	_____/_____/_____
MRN:	_____
Expected delivery date:	_____/_____/_____
Expected delivery hospital:	_____
Study ID #:	_____
REDCap return code:	_____

Data Collection Form **REDCap link:**	
Site:	
Patient Study ID: *Please assign each patient a unique study ID. The Patient Study ID should consist of **your site's two-letter identifier** followed by a 3-digit number (e.g. 'DH001').*	**Patient Study ID**: _____ _____
Is this PRE- or POST- implementation?	○ **PRE**-implementation ○ **POST**-implementation
Expected delivery date (month/year):	_____ / _____ (month) (year)

Demographics:	
Age in years at time of delivery:	_____years
Number of living children (not including this delivery):	_____
Race: *Please check all that apply.*	☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown (check all that apply)

Ethnicity:	○ Hispanic or Latino origin ○ Not Hispanic or Latino origin ○ Other/Unknown
Tobacco/nicotine use during pregnancy: *Please check all that apply.*	☐ Non-smoker ☐ Former smoker ☐ Smoked during pregnancy ☐ Quit during pregnancy ☐ Vaped during pregnancy ☐ Smokeless tobacco use ☐ Nicotine replacement therapy (NRT) → ☐ Unknown (check all that apply)
If NRT used, please specify type: *Please check all that apply.*	☐ Patch ☐ Gum ☐ Lozenges ☐ Other (check all that apply)
Transportation status: *Please check all that apply.*	☐ Has own transportation ☐ Medicaid ride service ☐ Bus/public transportation ☐ Unknown (check all that apply)
Housing status: *Please check all that apply.*	☐ Rents/owns ☐ Staying with others ☐ At risk for losing housing ☐ Incarcerated ☐ Unknown (check all that apply)
Comments on patient demographics (optional):	

Treatment History:	
Did patient transfer care from another prenatal practice?	○ Yes → ○ No
<u>If transfer</u>, how many visits did patient have at previous provider?	○ 1 visit ○ More than 1 visit ○ Unknown
<u>If transfer</u>, gestational age at first OB visit at previous care site (in weeks):	_____weeks

Is treatment for OUD co-located (provided within the same institution)?	○ Yes ○ No ○ Not receiving MAT
Treatment for opioid use disorder during pregnancy: *Please check all that apply.*	☐ Methadone ☐ Buprenorphine/Subutex/Suboxone → ☐ None ☐ Unknown (check all that apply)
Buprenorphine type (if applicable):	○ Buprenorphine (Subutex) ○ Buprenorphine/Naloxone (Suboxone)
Is psychiatric diagnosis included on the problem list?	○ Yes → ○ No ○ Unknown
If yes, specify psychiatric diagnosis: *Please check all that apply.*	☐ Depression ☐ Anxiety ☐ PTSD ☐ Other psychiatric diagnosis:_____ (check all that apply)
Is patient being treated with a psychiatric medication?	○ Yes ○ No ○ Unknown
Total number of prenatal visits at your site:	_____visits
Gestational age at first prenatal visit at your site (in weeks):	_____weeks
Treatment history comments (optional):	

Process Measures:

Is a substance use diagnosis included on the problem list?	○ Yes ○ No ○ Unknown
Is the checklist present in the record?	○ Yes ○ No ○ Unknown
Was information about the risk of non-prescribed drugs and alcohol given?	○ Yes ○ No ○ Unknown

Was smoking cessation education and/or treatment given?	○ Yes ○ No ○ Unknown
Was marijuana use discussed?	○ Yes ○ No ○ Unknown
Was breastfeeding education given?	○ Yes ○ No ○ Unknown
Was Naloxone (Narcan) discussed and Rx offered?	○ Yes ○ No ○ Unknown
Was Plan of Safe Care discussed?	○ Yes → ○ No ○ Unknown
If yes, was a plan <u>initiated</u>?	○ Yes ○ No ○ Unknown
Did domestic violence screening take place using a validated screener?	○ Yes ○ No ○ Unknown
Checklist process comments (optional):	

Outcome Measures:	
Hepatitis C antibody:	○ Positive → ○ Negative ○ Not tested or results not available
Hepatitis C viral load (if HCV antibody positive):	○ Positive ○ Negative ○ Not tested or results not available
HIV status:	○ Positive ○ Negative ○ Not tested or results not available
Third trimester drug screening results for non-prescribed drugs:	○ Positive → ○ Negative ○ Not tested or results not available
If positive, please specify type(s) of drugs used: *Please check all that apply.*	☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Other: _____ ☐ Unknown (check all that apply)
Was patient admitted during pregnancy for any reason other than for delivery?	○ Yes → ○ No
If yes, please specify reason for admission:	

Delivery Outcomes:	
Was discharge summary received?	○ Yes ○ No
Gestational age at delivery (weeks and days):	_____ weeks _____ days
If <38 weeks, please specify reason for early delivery:	
Birthweight in grams:	_____ grams
Was this a multiple or twin birth?	○ Yes ○ No

Maternal length of stay during delivery hospitalization: *Elapsed time from delivery to maternal discharge.*	_____ days
If >3 days, please specify reason for prolonged stay:	○ Normal OB management ○ Complications →
If complications, please specify type:	○ Prenatal ○ Delivery-related ○ Postpartum ○ Other
Admission drug screening results for non-prescribed drugs:	○ Positive → ○ Negative ○ Not tested or results not available
If positive drug test result, specify type(s) of drugs used: *Please check all that apply.*	☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ ***Other:*** _____ ☐ Unknown (check all that apply)
What type of feeding was infant receiving at discharge?	○ Breast milk only ○ Breast milk and formula ○ Formula only ○ Unknown
Did baby require NICU care?	○ Yes ○ No ○ Unknown
APGAR Scores available?	○ Yes → ○ No
APGAR Scores (1, 5, and 10-minute, as available):	▪ *1-minute:* _____ ▪ *5-minute:* _____ ▪ *10-minute:* _____
Outcomes comments (optional):	

Postpartum Visit:	
Did postpartum visit occur within 8 weeks after delivery?	○ Yes → ○ No →
If yes, please check all that apply:	☐ Visit within 2 weeks ☐ Visit within 4 weeks ☐ Visit within 6 weeks ☐ Visit within 8 weeks (check all that apply)
If no postpartum visit, please specify reason:	
What type of feeding was infant receiving at postpartum visit?	○ Breast milk only ○ Breast milk and formula ○ Formula only ○ Unknown
Tobacco/nicotine use at postpartum visit: *Please check all that apply.*	☐ Non-smoker ☐ Former smoker ☐ Smoking ☐ Quit during pregnancy ☐ Vaping ☐ Using smokeless tobacco ☐ Nicotine replacement therapy (NRT) → ☐ Unknown (check all that apply)
If NRT used, please specify type: *Please check all that apply.*	☐ Patch ☐ Gum ☐ Lozenges ☐ Other (check all that apply)
Was patient continuing substance use treatment at time of postpartum visit?	○ Yes ○ No ○ Unknown
Postpartum visit comments (optional):	