

Birth Defects Surveillance Programme

Case record ID: Date of report: (dd/mm/yyyy)	Name of health facility: City: Province/State/Territory:
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FETUS / NEONATE

PARENTS

Name, if available: Date of birth: Date of diagnosis of congenital anomaly: (dd/mm/yyyy) (dd/mm/yyyy) Sex: male female ambiguous missing/unknown Outcome at birth: live birth stillbirth elective termination of pregnancy with fetal anomaly Gestational age: (completed weeks) Best estimation: ultrasound: LMP: other: Weight: (grams) Length: (cm) Head circumference: (cm) Multiple birth: Yes No If yes, specify: Photographs taken: Yes No Did neonate die? Yes No If yes, specify date of death: (dd/mm/yyyy) Cause of death: Autopsy: Yes No If yes, specify details on back of this sheet.	Father's given name(s): Father's family name(s): Father's date of birth: Father's age: (dd/mm/yyyy) (completed years) Race/ethnicity: Mother's given name(s): Mother's family name(s) (including maiden name): Mother's date of birth: Mother's age: (dd/mm/yyyy) (completed years) Race/ethnicity: Primary address during 1st trimester of pregnancy: Town/city: Province: Current address (If different from above): Town/city: Province: Telephone number: Total number of previous: live births: stillbirths: spontaneous abortions: terminations of pregnancy:
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Are parents of fetus/neonate related? Yes No
 If yes, specify: first cousins second cousins aunt – nephew uncle – niece other (specify):

Congenital anomaly present	Full description of congenital anomaly (use back of form if needed)	ICD-10 code	C or P*
1.			C P
2.			C P
3.			C P
4.			C P
5.			C P
6.			C P
7.			C P
8.			C P
9.			C P
10.			C P

Diagnostic tests performed, pending results; notes and comments:

* C = Confirmed diagnosis
 P = Possible diagnosis

Name of professional completing the form: Contact information:
 physician nurse other (specify):

Additional information for autopsy:

Additional information for congenital anomaly: