

Please follow the instructions below in filling out the California's Confidential Case Report of Rh Hemolytic Disease of the Newborn.

REPORTING SOURCE

1. Enter the name of your hospital.
2. Enter the hospital street address.
3. Enter the hospital city.
4. Enter the hospital state.
5. Enter the hospital zip code.
6. Enter the name of person filling out this report form.
7. Enter the title of person filling out this report form.
8. Enter the date form was completed.
9. Enter the telephone number, including area code, of the person preparing the report.
10. Enter the telephone extension number.

INFANT

11. Enter infant's last name.
12. Enter infant's first name.
13. Enter infant's name other than the one mentioned in #11 or #12.
14. Enter infant's birthweight in grams.
15. Enter infant's gestational age, in weeks, at birth.
16. Enter infant's date of birth (e.g., 02/19/2008).
17. Enter infant's medical record number.
18. Enter infant's gender: **Male** or **Female**.
19. Indicate infant's race/ethnicity. Check all that apply: **White, Hispanic, Black, Native American, Middle Eastern, Asian Indian** (e.g., Indian, Pakistani, Bangladeshi, and Nepalese), **Vietnamese, Cambodian, Laotian** (from Laos), **Other Southeast Asian** (e.g., Thai, Indonesian, and Malaysian), **Chinese, Japanese, Korean, Filipino, Samoan, Hawaiian, Guamanian, Other** (not listed on the form), **Unknown**.
20. Indicate infant's Rh blood type: **D+**, **D-**, **D weak (Du)**.
21. Indicate infant's ABO blood group: **A, B, AB, O**.
22. Indicate the ICD-9-CM (International Classification of Diseases-Ninth Revision-Clinical Modification) code(s), **773.0** and/or **656.1**, for infant's Rh hemolytic disease. ICD-9-CM code 773.0 is for infant and 656.1 is for mother affecting the management of her pregnancy.
23. Indicate the anti-D or direct Coombs test result for infant: **Positive/weakly positive, Negative**.
24. Indicate whether infant had anemia at birth: **None, Mild** (hemoglobin [HGB] level of 9.5-10 g/dl), **Moderate** (hemoglobin level of 8-9.4 g/dl), **Severe** (hemoglobin level of 6.5-7.9 g/dl), **Life threatening** (hemoglobin level less than 6.5 g/dl).
25. Enter the 'total' bilirubin values and age of infant at testing for bilirubin in hours. Please enter up to four values including the highest value.
26. Indicate any treatments for Rh hemolytic disease received by infant or fetus. Check all that apply: **Exchange transfusion** (requires that the infant's blood can be removed and replaced), **Phototherapy** (the process of using light to eliminate bilirubin in the blood), **None, Intrauterine Fetal Transfusion** (provides blood to an RhD positive fetus in utero to replace the lysed fetal RBCs), **Other** treatments (*specify* the treatments).

27. Indicate whether there was an elevated bilirubin due to Rh hemolytic disease recorded by a health care provider in infant's medical records: **Yes, No, Unknown**.
28. Indicate whether Rh hemolytic disease was recorded by a health care provider in infant's medical records: **Yes, No**. If it is *unknown*, please make notation on the form.
29. Indicate the discharge status of infant: **Alive, Deceased, Stillborn/fetal demise**.
30. Indicate whether infant was transferred from the birth hospital to another hospital: **Yes, No, Unknown**; *If yes*, provide the birth hospital name.
31. Indicate the name of hospital that infant was transferred to.

MOTHER

32. Enter mother's last name.
33. Enter mother's first name.
34. Enter mother's maiden name or any names used other than the one mentioned in #32 or #33.
35. Enter mother's birthdate in numeric month, day, and year (e.g., 07/19/2008).
36. Enter mother's medical record number.
37. Indicate mother's race/ethnicity, check all that apply: **White, Hispanic, Black, Native American, Middle Eastern, Asian Indian** (e.g., Indian, Pakistani, Bangladeshi, and Nepalese), **Vietnamese, Cambodian, Laotian** (from Laos), **Other Southeast Asian** (e.g., Thai, Indonesian, and Malaysian), **Chinese, Japanese, Korean, Filipino, Samoan, Hawaiian, Guamanian, Other** (not listed on the form), **Unknown**.
38. Indicate country of mother's birth: **United States, Other Country**. *Specify* the name of country if other than U.S.
39. Indicate mother's Rh blood type: **D+, D-, D weak (Du)**.
40. Indicate mother's ABO blood group: **A, B, AB, O**.
41. Indicate whether anti-D prophylaxis or RhoGAM was administered to mother: **Yes, No**. *If yes*, provide date(s).
42. Enter the anti-D antibody titer level(s) or the indirect Coombs test result(s) as a ratio (e.g., 1:16) and the date for each titer in numeric month, day, and year (e.g., 09/19/2008). If titer was not done or titer level was unknown, check the appropriate circle.
43. Mother's Natal History: enter the total number of previous pregnancies and the total number of previous livebirths.
44. Indicate whether mother had an amniocentesis for this pregnancy: **Yes, No**. If it is *unknown*, please make notation on the form. Indicate whether mother had an amniocentesis for a previous pregnancy: **Yes, No**. If it is *unknown*, please make notation on the form.