



**Snapshot Obstetric National Anaesthetic Research Project – SONAR 1**

Case Record Form 1 – Intraoperative data from caesarean delivery			
To be completed by the anaesthetist clinically present for the case are requested to complete CRF 1 for <b>all</b> patients other than de novo General Anaesthesia. Please complete as much of the demographic, obstetric, and anaesthetic information at possible. If there are gaps, please ask the patient where possible.			
<b>Part 1 Patient demographics</b>			
1.1 DAY of caesarean (e.g. Monday)			
1.2.1 Hospital ID: (NOT TRANSFERRED TO RedCAP)		1.2.2 Date dd/mm/yyyy (NOT TRANSFERRED TO RedCAP)	
1.3 Age _____		1.4.1 Booking Weight _____ kg	
		1.4.2 Height _____ cm	
		1.4.3 BMI _____ kg/m <sup>2</sup>	
1.5 1st /preferred language:			
<input type="checkbox"/> English <input type="checkbox"/> Any other language			
1.5.1 If other please (Please state) _____			
1.6 ASA Grade (noting ASA 2 due to pregnancy)			
<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
1.7 Past Medical/Obstetric History (please tick all that apply)			
1.7.1 Cardiovascular		1.7.2 Obstetric	
<input type="checkbox"/> Idiopathic Hypertension <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Ischaemic heart disease <input type="checkbox"/> Congenital heart disease and/or valvular disease <input type="checkbox"/> Cardiac arrhythmia		<input type="checkbox"/> Previous caesarean delivery /myomectomy <input type="checkbox"/> Pre-eclampsia with severe features or eclampsia <input type="checkbox"/> PET/ Gestational hypertension <input type="checkbox"/> Multiple gestation <input type="checkbox"/> Intrauterine foetal demise <input type="checkbox"/> Placenta praevia/accreta/abruption <input type="checkbox"/> Diabetes mellitus on insulin	
1.7.3 Respiratory		1.7.4 Other	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Autoimmune disease/Lupus <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Bleeding disorder/ coagulopathy/anticoagulation <input type="checkbox"/> Epilepsy/Cerebrovascular disease/neuromuscular disorder <input type="checkbox"/> Chronic renal disease <input type="checkbox"/> Substance use disorder <input type="checkbox"/> Alcohol abuse	
1.8 Does the patient have a known documented previous history of		<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> PTSD	
1.9 Does the patient have a history of chronic pain?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Part 2 Obstetric Details</b>			
2.1 Gestational age (weeks + days) / 40 Weeks		2.2.1 Gravida	2.2.2 Parity
2.3 Labour category at caesarean delivery		2.4 Category of caesarean at delivery	
<input type="checkbox"/> Spontaneous <input type="checkbox"/> Induced <input type="checkbox"/> Not in labour		<input type="checkbox"/> Category 1 <input type="checkbox"/> Category 2 <input type="checkbox"/> Category 3 <input type="checkbox"/> Category 4	

Part 3 – Labour analgesia (Complete if applicable, otherwise leave blank. This excludes non-pharmacological methods)	
<b>3.1.1 Systemic opioids</b> <input type="checkbox"/> Pethidine <input type="checkbox"/> Morphine <input type="checkbox"/> Diamorphine <input type="checkbox"/> Other _____ (please specify)	<b>3.1.2 Patient controlled analgesia</b> <input type="checkbox"/> Remifentanyl <input type="checkbox"/> Other _____ (please specify)
<b>3.2.1. Neuraxial analgesia performed</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3.2.2. How long ago was the neuraxial inserted</b> <input type="checkbox"/> <1 hour <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-8 hours <input type="checkbox"/> 8+ hours
<b>3.3.1 State type of labour neuraxial analgesia</b> <input type="checkbox"/> Epidural <input type="checkbox"/> Combined Spinal Epidural <input type="checkbox"/> Dural Puncture Epidural <input type="checkbox"/> Intrathecal catheter <b>3.3.2 If Combined Spinal Epidural or intrathecal catheter</b> State drug _____ Dose _____	<b>3.4 Labour neuraxial analgesia:</b> <b>Please state the grade of inserting clinician:</b> <input type="checkbox"/> CT1-3 <input type="checkbox"/> ST4-5 <input type="checkbox"/> ST6-7 <input type="checkbox"/> SAS/Specialty doctor <input type="checkbox"/> Consultant
<b>3.5 Drug used for labour epidural analgesia</b> <input type="checkbox"/> Low Dose Mix (0.1% Levo + 2mcg/ml Fentanyl) <input type="checkbox"/> Other _____ (please specify)	<b>3.6 Dosing regime</b> <input type="checkbox"/> PCEA (ml bolus and lockout time) <input type="checkbox"/> PIEB (mls, interval time) <input type="checkbox"/> CL (ml/hr) <input type="checkbox"/> Other _____ (please specify) For combined PCEA+PIEB please complete both above
Part 4 – Intraoperative details	
<b>4.1.1 Time NEURAXIAL insertion or epidural top up (hh:mm) _____</b>  <b>4.1.2 Time of Baby DELIVERY (hh:mm) _____</b>  <b>4.1.3 Time of 'SIGN OUT' e.g. end of surgery (hh:mm) _____</b>	
<b>4.2 Indication for Caesarean (circle all that apply)</b> <input type="checkbox"/> Previous caesarean <input type="checkbox"/> PET <input type="checkbox"/> Abnormal placentation <input type="checkbox"/> Abnormal presentation <input type="checkbox"/> Pelvic/Other MSK indication <input type="checkbox"/> Maternal request <input type="checkbox"/> Failure to progress <input type="checkbox"/> Abnormal CTG <input type="checkbox"/> Neonatal medical indication <input type="checkbox"/> Maternal medical indication <input type="checkbox"/> Other (please state) _____	<b>4.3 Grade of most senior anaesthetist present during caesarean:</b> <input type="checkbox"/> CT1-3 <input type="checkbox"/> ST4-7 <input type="checkbox"/> SAS/Specialty doctor <input type="checkbox"/> Consultant
<b>4.4 What was the primary mode of anaesthesia for caesarean?</b> <input type="checkbox"/> Epidural top up <input type="checkbox"/> Spinal <input type="checkbox"/> CSE <input type="checkbox"/> DPE <input type="checkbox"/> Intrathecal catheter <input type="checkbox"/> Other (please state) _____	<b>4.5 Did you need to convert to a different type of anaesthetic before surgical incision? (i.e. failure of primary anaesthetic)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please select below</b> <input type="checkbox"/> Unplanned epidural/CSE catheter top up <input type="checkbox"/> Repeat neuraxial <input type="checkbox"/> Conversion to GA
Part 5 – Medication details. This refers to the medication used for the primary mode of anaesthesia for the caesarean Please give total doses for the procedure.	
<b>INTRATHECAL drugs/doses:</b>	
<b>5.1.1 Local anaesthetic drug/dose/ % conc</b> <input type="checkbox"/> Heavy Bupivacaine 0.5%. _____ (ml)	<b>5.1.2 Opioid drug/dose</b> <input type="checkbox"/> Morphine _____ (mcg)

<input type="checkbox"/> Plain bupivacaine (ml) 0.5% _____ (ml) <input type="checkbox"/> Levobupivacaine (ml) 0.5% _____ (ml) <input type="checkbox"/> Prilocaine (ml) 0.5% _____ (ml) Other (please state) _____	<input type="checkbox"/> Fentanyl _____ (mcg) <input type="checkbox"/> Diamorphine _____ (mcg) Other (please state) _____
<b>EPIDURAL drugs/doses:</b>	
<b>5.2.1. Local anaesthetic drug/doses</b> <input type="checkbox"/> Bupivacaine (_____% ) _____ (ml) <input type="checkbox"/> Levobupivacaine (_____% ) _____ (ml) <input type="checkbox"/> Ropivacaine (_____% ) _____ (ml) <input type="checkbox"/> Lidocaine (_____% ) _____ (ml) <input type="checkbox"/> Other (please state) _____	<b>Opioid drug/doses</b> <input type="checkbox"/> Fentanyl _____ (mcg) <input type="checkbox"/> Morphine _____ (mg) <input type="checkbox"/> Diamorphine _____ (mg) <input type="checkbox"/> Other (please state) _____

**Part 6 – Testing the block**

How was the block assessed?  
 See below  
 Not formally assessed  
 Other (please state) \_\_\_\_\_

**Document the upper dermatomal level. Please tick the table to indicate which modality was used to check the block. You may have used more than one.**

Dermatome	Left				Right			
	Cold	Light touch	Pinprick	Other	Cold	Light touch	Pinprick	Other
T2								
T3								
T4								
T5								
T6								
T7								
T8								
T9								
T10								
T11								
T12								

Other level LEFT \_\_\_\_\_ (please state)                      Other level RIGHT \_\_\_\_\_ (please state)

<b>Motor Block LEFT</b> <b>(Please Tick)</b>	<input type="checkbox"/> Unable to move feet or knees <input type="checkbox"/> Able to move feet only <input type="checkbox"/> Just able to move knees <input type="checkbox"/> Full flexion of knees and feet
<b>Motor Block RIGHT</b> <b>(Please Tick)</b>	<input type="checkbox"/> Unable to move feet or knees <input type="checkbox"/> Able to move feet only <input type="checkbox"/> Just able to move knees <input type="checkbox"/> Full flexion of knees and feet
<b>Did the patient have intraoperative pain?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If yes, complete Section 7</b>

**Part 7- Intraoperative record and pain**

**7.1 Please describe any UNPLANNED analgesia, if you had planned to give analgesia via the epidural at the end, for example, this should be documented in Part 5.**

Time patient reports intraoperative pain (hh:mm)	Stage of procedure. E.g. KTS, delivery gutters, closing	Analgesia / Anxiolytic administered?	If yes, what analgesia/ anxiolytic medications administered in response to this report of pain (please document drugs/ doses)	Resolution of pain	Reassurance given	GA offered?
		Yes/No		Yes/No	Yes/No	Yes/No
		Yes/No		Yes/No	Yes/No	Yes/No
		Yes/No		Yes/No	Yes/No	Yes/No
		Yes/No		Yes/No	Yes/No	Yes/No
		Yes/No		Yes/No	Yes/No	Yes/No

**7.2 Indication for supplemental analgesia (tick all that apply):**

- Inadequate block from start
- Initially adequate block but pain during procedure
- Inadequate duration of block - e.g. duration of surgery
- Failure of communication between patient and anaesthetist, including pre-operative communication
- Other (please specify) \_\_\_\_\_

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**7.3.1 Was the primary mode of anaesthesia converted to GA?**

- Yes
- No

**7.3.2 If yes, at what time was induction (hh:mm) \_\_\_\_\_**

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**7.3.3 If yes, what was the indication for conversion to GA (tick all that apply)**

- Pain
- Surgical requirement – e.g. massive haemorrhage, extended length of procedure
- Anaesthetic complication (e.g. total spinal)
- Other please state \_\_\_\_\_