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Banco Interamericano de Desarrollo

Salud Mesoamerica 2015 (SM2015)

Login page for the Health Facility Survey

ID:

Medical Record Review
Please note that all questions in this section refer to the measurements and procedures performed on the mother, unless otherwise specified

1. Today's Date:
(DD/MM/YYYY)

2. Interviewer ID 1:

3. Interviewer ID 2:

4. What type of medical unit is this?
(CHOOSE ONE):
- Health Clinic / Health Post / Mobile Unit
- Community Hospital
- Regional Hospital

5. District ID:
- Orange Walk
- Corozal District
- Cayo District
- Other

6. Facility ID:
- Orange Walk Town / Northern Regional Hospital
- Orange Walk Town / Orange Walk Health Center (Urban)
- San Jose Village / Zenobia Meggs Health Center
- San Felipe Village / San Felipe Health Center
- August Pine Ridge Village / August Pine Ridge Health Center
- Guinea Grass Village / Guinea Grass Health Center
- Santa Martha Village / Santa Martha Health Post
- Carmelita Village / Carmelita Health Post
- Lousiana Area, Orange Walk town / Lousiana Health Post (non functioning due to infrastructure)
- Fireburn Village / Fireburn Health Post (non functioning due to infrastructure)
- San Lazaro Village / Ignacia Moguel Health Post
- San Carlos Village / San Carlos Health Post
- Indian Church Village / Indian Church Health Post
- San Antonio Village / San Antonio Health Post
- San Roman Village / San Roman Health Post
- Orange Walk Town / Mobile Clinic
- Corozal Town / Corozal Community Hospital
- Corozal Town / Corozal Health Center (Urban)
- San Narciso Village / San Narciso Health Center
- Caledonia Village / Caledonia Health Center
- Libertad Village / Libertad Health Center
- Sarteneja Village / Sarteneja Health Center

- ○ Progresso Village / Progresso Health Center
- ○ Chunox Village / Chunox Health Post
- ○ Concepcion Village / Concepcion Health Post
- ○ San Joaquin Village / San Joaquin Health Post
- ○ Xaibe Village / Xiabe Health Post
- ○ Chan Chen Village / Chan Chen Health Post
- ○ Copper Bank Village / Copper Bank Health Post
- ○ San Victor Village / San Victor Health Post
- ○ Corozal Town / Mobile Clinic
- ○ Belmopan City / Western Regional Hospital
- ○ Belmopan City / Belmopan Health Center (Urban)
- ○ Valley of Peace Village / Valley of Peace
- ○ Cotton Tree Village / Cotton Tree Health Post
- ○ St Matthews Village / St Matthews Health Post
- ○ Franks Eddy Village / Franks Eddy Health Post
- ○ Santa Martha /St Margaret Village / Santa Martha Health Post (St Margaret)
- ○ Belmopan City / Mobile Clinic
- ○ San Ignacio / San Ignacio Community Hospital
- ○ San Ignacio / San Ignacio Health Center (Urban)
- ○ Benque Viejo Del Carmen / Mopan Clinic Health Center
- ○ Georgeville / Georgeville Health Center
- ○ San Antonio Village / San Antonio Health Post
- ○ San Ignacio / Mobile Clinic
- ○ Other (specify): _____

7. Please note if the following was recorded:
Date of admission
- ○ Yes: _____ (DD/MM/YYYY)
- ○ Not recorded

8. Please note if the following was recorded:
Hour of admission
- ○ Time: _____ (HH:MM)
- ○ Not recorded

9. Age:
- ○ Age: _____
- ○ Not observed

This file is ineligible. You indicated that the date of admission was . Please review records where the birth occurred between 01/05/2012 - 30/07/2014.

10. Education
- ○ None
- ○ Primary
- ○ Secondary
- ○ University
- ○ Not recorded

11. Marital status
- ○ Married
- ○ Common law wife
- ○ Single
- ○ Divorced
- ○ Widowed
- ○ Other (specify): _____
- ○ Not recorded

12. Gestational age
- ○ Age: _____ weeks
- ○ Not recorded

OBSTETRIC COMPLICATIONS
Maternal Complications

13. Did the woman have any of the following complications (Select ALL that apply)?
- ☐ Sepsis
- ☐ Hemorrhage
- ☐ Severe pre-eclampsia

- ☐ Eclampsia
- ☐ None

Please note if the following was done for the patient with sepsis.
Please record if the following checkups were done. Record the value, date and time of the first checkup.

14.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Diastolic BP			mmHg		
Systolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were performed and record results, date and time of the first test

15.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count		x10^3microlliter		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following medications were adminsitered and record dosage, date and time of first administration

16.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Amikacin		mg/kg		
Clindamicin		mg/kg		
Gentamicin		mg/kg		
Ampicillin		mg/kg		
Metronidazole		mg/kg		
Other antibiotics (specify)		mg/kg		
Other antibiotics (specify)		mg/kg		
Other antibiotics (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

17. Were any of the above medications administered at the same time during this hospitalization?

- ○ Yes
- ○ No
- ○ Not recorded

18. Disposition:
- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify): _____
- ○ Not recorded

19. Reason for referral:
- ☐ High temperature
- ☐ High leukocyte
- ☐ Bleeding
- ☐ Lochia
- ☐ Other _____
- ☐ Not recorded

20. Date of discharge/referral
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

21. Time of discharge/referral
- ○ Time: _____ (HH:MM)
- ○ Not recorded

22. Date of death
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

23. Time of death
- ○ Time: _____ (HH:MM)
- ○ Not recorded

Please record if the following checkups were done. Record the value, date and time of the first checkup.

24.

	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Systolic BP			mmHg		
Diastolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify) _____					
Other (specify) _____					
Other (specify) _____					

25.

	Recorded	Value		Date (DD/MM/AAAA)	Hour (HH:MM)
Leukocyte Count			x10^3/liter		
Other (specify) _____					

26. Please record cause of sepsis (select all that apply)

- ☐ Septic abortion, corioplacentarios remains infected
- ☐ Uterine perforation
- ☐ Chorioamnionitis
- ☐ Abscesses
- ☐ Infected ectopic pregnancies
- ☐ Pelviperitonitis
- ☐ Vaginal tears
- ☐ Episiotomy channel infected
- ☐ Other (specify)
- ☐ Not recorded

27. Result/procedure (select all that apply))

- ☐ MVA (Manual vacuum aspiration)
- ☐ Revision of uterine cavity
- ☐ Normal delivery
- ☐ Caesarean
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Surgical repair
- ☐ Other (specify)
- ☐ Not recorded

Please check if the following medications were adminsitered and record dosage, date and time of first administration

28.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Amikacin		mg/kg		
Clindamicin		mg/kg		
Gentamicin		mg/kg		
Ampicillin		mg/kg		
Metronidazole		mg/kg		
Other antibiotics (specify)		mg/kg		
Other antibiotics (specify)		mg/kg		
Other antibiotics (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		
Other medications (specify)		mg/kg		

29. Were any of the above medications administered at the same time during this hospitalization?

- ○ Yes
- ○ No
- ○ Not recorded

30. Disposition:

- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify):
- ○ Not recorded

31. Reason for referral:

- ☐ High temperature
- ☐ High leukocyte
- ☐ Bleeding
- ☐ Lochia
- ☐ Other
- ☐ Not recorded

32. Date of discharge/referral
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

33. Time of discharge/referral
- ○ Time: (HH:MM)
- ○ Not recorded

34. Date of death
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

35. Time of death
- ○ Time: (HH:MM)
- ○ Not recorded

Please note if the following was done for the patient with hemorrhage
Please record if the following checkups were done. Record the value, date and time of the first checkup.

36.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Pulse		per minute		
Diastolic BP		mmHg		
Systolic BP		mmHg		
Respiratory rate		per minute		
Temperature		°C		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following medications were adminsitered and record dosage, date and time of first administration

37.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Oxytocin		units		
Ringer lactate				
Gentamicin		mg/kg		
Other uterotonics (specify)		units		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

38. Were any of the above medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

39. Disposition:
- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after he finished his treatments
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify): _____
- ○ Not recorded

40. Reason for referral:
- ☐ Low blood pressure
- ☐ Low hemoglobin
- ☐ Bleeding
- ☐ Lochia
- ☐ Other _____
- ☐ Not recorded

41. Date of discharge/referral
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

42. Time of discharge/referral
- ○ Time: _____ (HH:MM)
- ○ Not recorded

43. Date of death
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

44. Time of death
- ○ Time: _____ (HH:MM)
- ○ Not recorded

Please record if the following checkups were done. Record the value, date and time of the first checkup.

45.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Diastolic BP			mmHg		
Systolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify) _____					
Other (specify) _____					
Other (specify) _____					

Please check if the following lab tests were performed and record results, date and time of the first test

46.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Protrombin time (PT)			second(s)		

PTT (Partial thromboplastin time)		second(s)		
Platelets		×10^9/L		
Hemoglobin		g/dL		
Hematocrit				
Other (specify)				
Other (specify)				
Other (specify)				

47. Please record cause of hemorrhage (select all that apply)

- ☐ Complicated abortion
- ☐ Retained placenta
- ☐ Placenta previa
- ☐ Placental abruption
- ☐ Uterine rupture
- ☐ Uterine atony
- ☐ Ectopic pregnancy
- ☐ Tears of the cervix
- ☐ Vaginal tears
- ☐ Other (specify)
- ☐ Not recorded

48. Result/procedure (select all that apply)

- ☐ MVA (Manual vacuum aspiration)
- ☐ Revision of uterine cavity
- ☐ Caesarean
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Surgical repair
- ☐ Normal Delivery
- ☐ Other (specify)
- ☐ Not recorded

Please check if the following medications were adminsitered and record dosage, date and time of first administration

49.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Oxytocin		units		
Ringer lactate				
Gentamicin		mg/kg		
Other uterotonics (specify)		units		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

50. Were any of the above medications administered at the same time during this hospitalization?

- ○ Yes
- ○ No
- ○ Not recorded

51. Disposition:

- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility

- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify): _____
- ○ Not recorded

52. Reason for referral:
- ☐ Low blood pressure
- ☐ Low hemoglobin
- ☐ Bleeding
- ☐ Lochia
- ☐ Other _____
- ☐ Not recorded

53. Date of discharge/referral
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

54. Time of discharge/referral
- ○ Time: _____ (HH:MM)
- ○ Not recorded

55. Date of death
- ○ Date: _____ (DD/MM/YYYY)
- ○ Not recorded

56. Time of death
- ○ Time: _____ (HH:MM)
- ○ Not recorded

Please note if the following was recorded for patients with pre-eclampsia.
Please record if the following checkups were done. Record the value, date and time of the first checkup.

57.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Diastolic BP			mmHg		
Systolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify) _____					
Other (specify) _____					
Other (specify) _____					

Please check if the following lab tests were performed and record results, date and time of the first test

58.	Recorded (yes/no)	Negative	Number of +	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Urine protein				g/day		
Other (specify) _____						
Other (specify) _____						
Other (specify) _____						

Please check if the following medications were adminsitered and record dosage, date and time of first administration

59.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)

Magnesium sulfate		gr		
Hidralazin		mg		
Nifedipine		mg		
Other antihypertensive (specify)		mg		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

60. Were any of the above medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

61. Disposition:
- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify):
- ○ Not recorded

62. Reason for referral:
- ☐ High blood pressure
- ☐ Urine protein
- ☐ Bleeding
- ☐ Lochia
- ☐ Seizures
- ☐ Other
- ☐ Not recorded

63. Date of discharge/referral
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

64. Time of discharge/referral
- ○ Time: (HH:MM)
- ○ Not recorded

65. Date of death
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

66. Time of death
- ○ Time: (HH:MM)
- ○ Not recorded

Please record if the following checkups were done. Record the value, date and time of the first checkup.

67.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Pulse		per minute		
Diastolic BP		mmHg		
Systolic BP		mmHg		

Respiratory rate		per minute		
Temperature		°C		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following checkups were done and the date and time of the first checkup

68.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Patellar reflex			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the patient had the following symptoms are recorded and note the date and time of the first symptom observed

69.	Symptom	Date (DD/MM/YYYY)	Time (HH:MM)
Seizures			
Oliguria			
Other (specify)			
Other (specify)			
Other (specify)			

Please check if the following lab tests were performed and record results, date and time of the first test

70.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Platelet count		x10^9/L		
Aspartate aminotransferase		U/liter		
Alanine aminotransferase		U/liter		
Lactate dehydrogenase		U/liter		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were performed and record results, date and time of the first test

71.	Recorded (yes/no)	Negative	Number of +	Value	Date ((DD/MM/YYYY)	Time (HH:MM)
Urine protein				g/day		
Other (specify)						
Other (specify)						
Other (specify)						

Please check if the following medications were adminsitered and record dosage, date and time of first administration

72.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Magnesium sulfate		gr		
Hidralazin		mg		

Nifedipine		mg		
Betamethasone		mg		
Dexamethasone		mg		
Other antihypertensive (specify)		mg		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

73. Were any of the above medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

74. Result/procedure (select all that apply)
- ☐ MVA (Manual vacuum aspiration)
- ☐ Revision of uterine cavity
- ☐ Normal delivery
- ☐ Caesarean
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Surgical repair
- ☐ Other (specify)
- ☐ Not recorded

75. Result of the pregnancy:
- ○ Caesarean
- ○ Normal vaginal
- ○ Other
- ○ Not recorded

76. Disposition:
- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatments
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify):
- ○ Not recorded

77. Reason for referral:
- ☐ High blood pressure
- ☐ Urine protein
- ☐ Bleeding
- ☐ Lochia
- ☐ Seizures
- ☐ Other
- ☐ Not recorded

78. Date of discharge/referral
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

79. Time of discharge/referral
- ○ Time: (HH:MM)
- ○ Not recorded

80. Date of death
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

81. Time of death
- ○ Time: (HH:MM)
- ○ Not recorded

Please note if the following was recorded for patients with eclampsia.
Please record if the following checkups were done. Record the value, date and time of the first checkup.

82.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Diastolic BP			mmHg		
Systolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following lab tests were performed and record results, date and time of the first test

83.	Recorded (yes/no)	Negative	Number of +	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Urine protein				g/day		
Other (specify)						
Other (specify)						
Other (specify)						

Please check if the following medications were administered and record dosage, date and time of first administration

84.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Magnesium sulfate		gr		
Hidralazin		mg		
Nifedipine		mg		
Other antihypertensive (specify)		mg		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

85. Were any of the above medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

86. Disposition:

- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify):
- ○ Not recorded

87. Reason for referral:

- ☐ High blood pressure
- ☐ Urine protein
- ☐ Bleeding
- ☐ Lochia
- ☐ Seizures
- ☐ Other
- ☐ Not recorded

88. Date of discharge/referral

- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

89. Time of discharge/referral

- ○ Time: (HH:MM)
- ○ Not recorded

90. Date of death

- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

91. Time of death

- ○ Time: (HH:MM)
- ○ Not recorded

Please record if the following checkups were done. Record the value, date and time of the first checkup.

92.	Recorded (yes/no)	Value		Date (DD/MM/YYYY)	Time (HH:MM)
Pulse			per minute		
Diastolic BP			mmHg		
Systolic BP			mmHg		
Respiratory rate			per minute		
Temperature			°C		
Other (specify)					
Other (specify)					
Other (specify)					

Please check if the following checkups were done and the date and time of the first checkup

93.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Patella reflex			
Other			

Please check if the patient had the following symptoms and note the date and time of the first observed symptom

94.	Symptom	Date (DD/MM/YYYY)	Time (HH:MM)
Seizures			
Oliguria			
Other (specify):			

Please check if the following lab tests were performed and record results, date and time of the first test

95.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Platelet count		x 10^9/L		
Aspartate aminotransferase		U/liter		
Alanine aminotransferase		U/liter		
Lactate dehydrogenase		U/liter		
Other (specify)				
Other (specify)				
Other (specify)				

Please check if the following lab tests were performed and record results, date and time of the first test

96.	Recorded (yes/no)	Negative	Number of +	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Urine protein				g/day		
Other (specify)						
Other (specify)						
Other (specify)						

Please check if the following medications were adminsitered and record dosage, date and time of first administration

97.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Magnesium sulfate		gr		
Hidralazin		mg		
Nifedipine		mg		
Betamethasone		mg		
Dexamethasone		mg		
Other antihypertensive (specify)		mg		
Other medications (specify)				
Other medications (specify)				
Other medications (specify)				

98. Result/procedure (select all that apply)

- ☐ MVA (Manual vacuum aspiration)
- ☐ Revision of uterine cavity
- ☐ Normal delivery
- ☐ Caesarean
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Surgical repair
- ☐ Other (specify)
- ☐ Not recorded

99. Were any of the above medications administered at the same time during this hospitalization?
- ○ Yes
- ○ No
- ○ Not recorded

100. Result of the pregnancy:
- ○ Caesarean
- ○ Normal vaginal
- ○ Other
- ○ Not recorded

101. Disposition:
- ○ Death in hospital
- ○ Discharged home
- ○ Discharged to a family member's house
- ○ Transferred to another facility
- ○ Left after finished treatment
- ○ Left against medical advice
- ○ Unknown
- ○ Other (specify):
- ○ Not recorded

102. Reason for referral:
- ☐ High blood pressure
- ☐ Urine protein
- ☐ Bleeding
- ☐ Lochia
- ☐ Seizures
- ☐ Other
- ☐ Not recorded

103. Date of discharge/referral
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

104. Time of discharge/referral
- ○ Time: (HH:MM)
- ○ Not recorded

105. Date of death
- ○ Date: (DD/MM/YYYY)
- ○ Not recorded

106. Time of death
- ○ Time: (HH:MM)
- ○ Not recorded

107. Please note if the child has any of the following complications (select all that apply)
- ☐ Sepsis
- ☐ Asphyxia
- ☐ Low birth weight
- ☐ Prematurity
- ☐ Other
- ☐ No complications

The records of maternal complications should only be reviewed in hospitals.
You indicated that the women did not have any complications. Please review only records of sepsis, haemorrhage, pre eclampsia and eclampsia.

You have reached the end of the survey.

Please click the button 'submit' to submit your responses and close the survey. You cannot modify any responses after the survey has been submitted.

If you believe that this page was reached in error, please click 'Previous' and revise your responses as necessary.

Thank you for your time today.

108. Enter relevant comments about this section