



# 2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

1.

Network ID  
[ ][ ][ ][ ][ ][ ]

Hospital No.  
[ ][ ][ ][ ][ ]

**Selection Criteria** To be eligible, **MUST** answer Yes to at least one of the possible criteria (A-C)

**A. 401-1500 grams**  Yes  No  
Yes (Go to Q. 1), No (Go to Part B)

**B. GA range 22/0 -- 29/6 weeks**  Yes  No  
Yes (Go to Q. 1), No (Go to Part C)

**C. If >1500 grams**  Yes  No  
Answer ALL entry criteria. To be eligible, **MUST** answer Yes to at least one

Death  Yes  No  
Surgery  Yes  No  
Vent > 4 hrs  Yes  No  
Hyperbilirubinemia  Yes  No

Acute Trans. In  Yes  No  
Acute Trans.Out  Yes  No  
Early Bacterial Sepsis  Yes  No

**NOTE : ANY infant that was previously discharged home and readmitted to your Hospital (on or before Day 28) for Total Serum Bilirubin => 25 mg/dL (427 Micromols/Liter) and/or exchange transfusion.**

## Identification and Demographics

**1. Birth weight**

[ ][ ][ ][ ][ ] Grams

**2. Head Circumference at Birth**

[ ][ ] . [ ]  Unk  
cm

**3. Best Estimate of Gestational Age**

[ ][ ]  Unk  
a) Weeks b) Days (0-6)

**4. Birth Date**  
MM/DD

[ ][ ] / [ ][ ] / 2008

**5. Infant Sex**

Male  Female  Unk

**6. Died in Delivery Room**

If Yes, use Delivery Room Death Form.

Yes  No

**7. a) Location of Birth**

If >1500 grams or Outborn, complete 7b

Inborn  Outborn

**b) Age in Days at Admission to your NICU**

[ ][ ] Date of Birth is Day 1  
Days (1-28)

**c) Hospital of Birth**

[ ][ ][ ][ ][ ][ ]  N/A

If Outborn, enter Code for Birth Hospital

Name of Facility: \_\_\_\_\_

**8. Admission History**

Answer only for Outborn infants. Answer Parts a and b

**a)**  Never home after birth (Skip Part b)  
 Was home after birth (Answer Part b)  
 N/A

**b)**  First Admission to this NICU  
 Readmission to this NICU  
 N/A

Sections of this form include data elements and definitions developed by Vermont Oxford Network

**This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.**



# 2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

**Network ID**

**Hospital No.**

**Delivery and Maternal History**

**9. Maternal Age**

Unk  
 Years

**10. Maternal Race / Ethnicity** *Answer both Parts a and b*

**a) Is Mother of Hispanic Origin?**

Yes  No  Unk

**b) Maternal Race** *Choose only one*

Black  Asian or Pacific Islander  
 White  Other  
 Native American  Unk

**11. Prenatal Care**

Yes  No  Unk

**12. Group B Strep Positive**

Yes  No  Unk  
 Not Done

**13. Antenatal Steroids**

Yes  No  Unk

**14. Spontaneous Labor**

Yes  No  Unk

**15. a) Multiple Births**

Yes  No  Unk

**b) If Yes, total number of infants delivered. (Count live born and stillborn infants)**

N/A  
 Total  Unk

**c) Birth Order**

N/A  
 Unk

**16. Mode of Delivery** *Choose only one*

Spont. vag.  Op. vag.  Cesarean  Unk

**17. Antenatal Conditions (Mandatory for ALL CPQCC eligible infants)**

*Select all conditions occurring in this pregnancy.  
 If **None**, select checkbox for "None" in each column.*

**Maternal**

- None
- Hypertension
- Chorioamnionitis
- Other Infection
- Diabetes
- Prev. Cesarean
- Other Maternal
- Unk

*If **Other**, specify:*

**Fetal**

- None
- IUGR
- Distress
- Anomaly
- Other Fetal
- Unk

*If **Other**, specify:*

**Obstetrical**

- None
- Premature ROM
- Prolonged ROM(>18hr)
- Malpresent./Breech
- Bleed/Abrupt/Placenta
- Other Obstetrical
- Unk

*If **Other**, specify:*

---

*Sections of this form include data elements and definitions developed by Vermont Oxford Network*

**This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.**



# 2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

**Network ID**

--	--	--	--	--

**Hospital No.**

--	--	--	--

**Delivery and Maternal History (continued)**

**18. Indications for Cesarean Section  
(Mandatory for ALL CPQCC eligible infants)**

*Select at least one*

- |  |  |
|--|--|
| <input type="checkbox"/> Not Applicable (No C/S) | <input type="checkbox"/> Elective                    |
| <input type="checkbox"/> Malpresentation/Breech  | <input type="checkbox"/> Dystocia/Failed to progress |
| <input type="checkbox"/> Multiple gestation      | <input type="checkbox"/> Placental Problems          |
| <input type="checkbox"/> Fetal distress          | <input type="checkbox"/> Hypertension                |
| <input type="checkbox"/> Other (specify)         | <input type="checkbox"/> Unk                         |

*If Other, specify:* \_\_\_\_\_

**19. Apgar Scores**

<table border="1" style="width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table> <input type="checkbox"/> Unk			<table border="1" style="width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table> <input type="checkbox"/> Unk			<table border="1" style="width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table> <input type="checkbox"/> Not Done <input type="checkbox"/> Unk		
1 min	5 min	10 min						

**20. Delivery Room Resuscitation**

- |   |   |
|---|---|
| <b>a) Oxygen:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk   | <b>d) Endotracheal tube/vent:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| <b>b) CPAP:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk     | <b>e) Epinephrine:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk            |
| <b>c) Bag/Mask:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | <b>f) Cardiac compression:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk    |

**21. Surfactant Treatment**

- a) Surfactant given in Delivery Room**     Yes    No    Unk
- b) Surfactant given at Any Time**     Yes    No    Unk  
*Part b must be Yes if Part a is answered Yes*
- c) If Yes, enter Age at First Dose**
- |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| <table border="1" style="width: 100px; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table><br>Hours |  |  |  |  | <table border="1" style="width: 60px; height: 20px;"> <tr><td> </td><td> </td></tr> </table><br>Minutes (0-59) |  |  | <input type="checkbox"/> N/A<br><input type="checkbox"/> Unk |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**Post-Delivery Diagnoses and Interventions--Respiratory**

**22. a) Temperature Measured Within 1 Hour of NICU Admission**

- Yes    No    Unk

**b) If Yes, enter temperature**

<table border="1" style="width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table>			-	<table border="1" style="width: 20px; height: 20px;"> <tr><td> </td></tr> </table>		<input type="checkbox"/> N/A <input type="checkbox"/> Unk
Degrees C						

**23. Respiratory Support** *After leaving DR*

- |   |   |
|---|---|
| <b>a) Oxygen</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk            | <b>d) High Flow Nasal Cannula</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| <b>b) Conventional Vent</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | <b>e) Nasal IMV or SIMV</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk       |
| <b>c) HIFI Vent</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk         |   |

**24. Use of Nasal CPAP**

- a) Nasal CPAP**     Yes    No    Unk
- b) If Yes, was NCPAP used before ETT Ventilation?**     Yes    No    Unk    N/A

*Sections of this form include data elements and definitions developed by Vermont Oxford Network*

**This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.**



# 2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

**Network ID**

--	--	--	--	--

**Hospital No.**

--	--	--	--

### Post-Delivery Diagnoses and Interventions--Respiratory (continued)

#### 25. Use of Assisted Ventilation

a) Length of Ventilation

None     <= 4hrs     > 4hrs     Unk

b) If Vent > 4 hrs, fill in Days and Hours below:

								<input type="checkbox"/> N/A
Days				Hours (0-23)				<input type="checkbox"/> Unk

26. Infant Death Within 12 Hours of Admission to the NICU

Yes     No     Unk

27. Respiratory Distress Syndrome

Yes     No     Unk

28. Pneumothorax

Yes, Here     Yes, Elsewhere     Yes, Here and Elsewhere     No     Unk

29. Meconium Aspiration Syndrome

Yes     No     Unk

30. Inhaled Nitric Oxide

Yes     No     Unk

31. ECMO

Yes     No     Unk

32. a) Postnatal Steroids (Were postnatal steroids given?)

Yes     No     Unk

b) If postnatal steroids were used, check all reasons that applied

CLD (check location):     Given here     Given elsewhere     Given here and elsewhere  
 Extubation     Blood Pressure     Other     Unk     N/A

33. Supplemental Oxygen on Day 28

Continuous     Intermittent     None     Unk     N/A

34. Oxygen at 36 Weeks Adjusted GA

Continuous     Intermittent     None     Unk     N/A

35. Respiratory Support at Discharge

a) Apnea/Cardio-Respiratory Monitor

Yes     No     Unk

b) Oxygen

Yes     No     Unk

c) Mechanical Ventilation

Yes     No     Unk

d) Other (specify)

Yes     No     Unk

For **Other**, specify: \_\_\_\_\_

### Post-Delivery Diagnoses and Interventions--Infections

36. Early Bacterial Sepsis and/or Meningitis On or before Day 3

GBS     e.Coli     Other     No     Unk

For **Other**, specify

Organism: \_\_\_\_\_

37. Late Sepsis and/ or Meningitis after Day 3

N/A if infant not in your hospital after Day 3

a) Bacterial Pathogen

GBS     e.Coli     Other     No     N/A     Unk

If GBS, e.Coli, or Other, check location of occurrence:

Here     Elsewhere     Here and Elsewhere

For **Other**, specify

Organism: \_\_\_\_\_

b) Coagulase Negative Staphylococci

Yes, here     Yes, elsewhere     Yes, here and elsewhere     No     N/A     Unk

c) Fungal

Yes, here     Yes, elsewhere     Yes, here and elsewhere     No     N/A     Unk

Sections of this form include data elements and definitions developed by Vermont Oxford Network

This form is for internal use ONLY. Please **DO NOT** submit this form to the CPQCC Data Center.



2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

Network ID [ ][ ][ ][ ][ ]

Hospital No. [ ][ ][ ][ ]

Post-Delivery Diagnoses and Interventions--Infections (continued)

38. Congenital Viral Infection

[ ] Yes [ ] No [ ] Unk

If Yes, specify pathogen: \_\_\_\_\_

Post-Delivery Diagnoses and Interventions--Other diagnoses, surgeries, and surgical complications

39. a) Patent Ductus Arteriosus

[ ] Yes [ ] No [ ] Unk

b) Indomethacin

[ ] Yes [ ] No [ ] Unk

c) Ibuprofen

[ ] Yes [ ] No [ ] Unk

d) PDA Ligation

[ ] Yes, here [ ] Yes, elsewhere [ ] Yes, here and elsewhere [ ] No [ ] N/A [ ] Unk

40. a) Necrotizing Enterocolitis

[ ] Yes [ ] No [ ] Unk

b) NEC Surgery

[ ] Yes, here [ ] Yes, elsewhere [ ] Yes, here and elsewhere [ ] No [ ] N/A [ ] Unk

41. Focal GI Perforation

[ ] Yes [ ] No [ ] Unk

42. Retinopathy of Prematurity

a) Was a Retinal Exam Performed

[ ] Yes [ ] No [ ] Unk

b) If Yes to a), enter Worst Stage (0 - 5)

[ ] Unk [ ] N/A Stage

c) ROP Surgery

[ ] Yes, here [ ] Yes, elsewhere [ ] Yes, here and elsewhere [ ] No [ ] N/A [ ] Unk

43. a) Other Surgery

[ ] Yes [ ] No [ ] Unk

b) If Yes, enter up to 10 Surgery Codes and specify the location of the surgery as either Here (H), Elsewhere (E) or Both (B). For example: S100 H. See Manual for Codes.

\_\_\_\_\_

If necessary, enter surgery description: \_\_\_\_\_

44. Surgical Complications Choose only one. If Yes is chosen, describe complications below. See Manual for list of complications.

[ ] Yes (Surgery complications occurred) [ ] No (Surgery done, but no complications) [ ] N/A [ ] Unk

Post-Delivery Diagnoses and Interventions--Neurological

45. Intracranial Hemorrhage

a) Neural Imaging Done on or before Day 28

[ ] Yes [ ] No [ ] Unk

b) If Yes to a), enter Worst Grade (0 - 4)

[ ] N/A [ ] Unk Grade

c) Shunt Placed for Bleed

[ ] Yes [ ] No [ ] Unk [ ] N/A

d) Other Intracranial Hemorrhage on or before day 28

[ ] Yes [ ] No [ ] Unk [ ] N/A

If Yes, specify: \_\_\_\_\_

Sections of this form include data elements and definitions developed by Vermont Oxford Network

This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.



## 2008 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2008

6.

**Network ID**

--	--	--	--	--	--

**Hospital No.**

--	--	--	--	--

**Post-Delivery Diagnoses and Interventions -- Neurological (continued)**

**46. Cystic Periventricular Leukomalacia (CPVL)**

a) Neural Imaging Performed

Yes    No    Unk

b) If Yes, evidence of CPVL

Yes    No    N/A    Unk

**47. Seizures, EEG or Clinical**

Yes    No    Unk

**48. Hypoxic-Ischemic Encephalopathy**

None    Mild    Moderate    Severe    N/A    Unk

*Must check N/A if LESS THAN 36 weeks GA at birth*

**Post-Delivery Diagnoses and Interventions -- Congenital Malformations**

**49. a) Congenital Anomalies**

Yes    No    Unk

b) If Yes, enter up to 5 Birth Defect Codes. See Manual for Codes. \_\_\_\_\_

**Post-Delivery Diagnoses and Interventions--Hyperbilirubinemia**

*NOTE: The following items 50 - 52 pertain to ANY infant that was previously discharged home and readmitted to your Hospital (on or before Day 28) for Total Serum Bilirubin =>25 mg/dL (427 Micromols/Liter) and/or exchange transfusion.*

**50. Maximum Level of Bilirubin (mg/dL) Found On THIS Re-Admission**

< 25    25 - <30    >=30    N/A    Unk

**51. Exchange Transfusion On THIS Re-Admission**

Yes    No    N/A    Unk

**52. Hospital that Discharged Infant Home Prior to THIS Admission**

--	--	--	--	--	--

Unk  
 N/A

*Note: Enter OSHPD Code*

Name of Facility: \_\_\_\_\_

**Initial Disposition**

**53. Enteral Feeding at Discharge**

None    Human Milk Only    Formula Only    Human Milk in Combination with Fortifier or Formula    Unk

**54. Initial Disposition from Your Center**

*Choose only one*

Home    Transferred to Another Hospital    Died    Still Hospitalized as of 1st Birthday    Unk

**55. Weight at Initial Disposition**

--	--	--	--	--	--

Unk  
Grams

**56. Head circumference at Initial Disposition**

--	--	--	--	--

Unk  
cm

**57. Initial Discharge Date**

--	--	--	--	--	--	--	--	--	--	--	--

/ 200

*Sections of this form include data elements and definitions developed by Vermont Oxford Network*

**This form is for internal use ONLY. Please DO NOT submit this form to the CPQCC Data Center.**



2008 TRANSPORT / POST-TRANS. FORM  
FOR INFANTS BORN IN 2008

Transfer Information

**Complete items 58-60 for infants who were transferred to another hospital.**

**58. Reason for Transfer** Choose only one

- Growth / Discharge Planning       Insurance
- Medical / Diagnostic Services       Other
- Surgery       N/A
- Chronic Care       Unk

**59. Hospital the infant was transferred to:**

Enter center's  
OSHPD Code

--	--	--	--	--	--	--	--

 Unk  
 N/A

**60. Post Transfer Disposition**

- Home -- Skip to Question 64
- Transferred Again to Another Hospital -- Skip to Question 63
- Died -- Skip to Question 64
- Readmitted to Your Hospital -- Skip to Question 61
- Still Hospitalized as of First Birthday -- Skip to Question 64
- N/A
- Unk

**Complete items 61-62 for infants who were initially transferred from your center and then transferred back to your center without ever going home. For these infants, it is necessary to update items 21, 23-25, 27-53 with information that should be obtained from the episode of care at the hospital the infant was transferred to and the care upon re-admission at your center.**

**61. Weight at Initial Disposition after readmission**

--	--	--	--	--	--

 N/A  
 Unk  

Grams

**Network ID**

--	--	--	--	--	--

**Hospital No.**

--	--	--	--	--

**62. Disposition After Readmission**

- Home -- Skip to Question 64
- Transferred Again to Another Hospital
- Died -- Skip to Question 64
- Still Hospitalized as of First Birthday -- Skip to Question 61
- N/A
- Unk

**Complete item 63 for infants who were initially transferred from your center and then a) either transferred again to another hospital, or b) re-admitted to your center and then transferred from your hospital to another hospital.**

**63. Ultimate Disposition**

- Home
- Died
- Still Hospitalized as of 1st Birthday
- N/A
- Unk

**64. Last Discharge Date**

--	--	--	--	--	--	--	--	--	--	--	--

Enter Comments or Notes Below

Sections of this form include data elements and definitions developed by Vermont Oxford Network

This form is for internal use ONLY. Please **DO NOT** submit this form to the CPQCC Data Center.