



2009 ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2009

1.

Network ID

Hospital No.

Please make a clean photocopy of this form and mail it to CPQCC. Keep the original on file at your center. Do not staple or fold the form.

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

A. 401-1500 grams

Yes (Go to Q.1), No (Go to Part B)

Yes No

B. GA range 22/0 -- 29/6 weeks

Yes (Go to Q.1), No (Go to Part C)

Yes No

C. If >1500 grams

Answer ALL entry criteria. To be eligible, **MUST** answer Yes to at least one

Yes No

Death

Yes No

Surgery

Yes No

Vent > 4 hrs

Yes No

Nasal S/IMV

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 NICU (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

3. Best Estimate of Gestational Age

 Unk

a) Weeks b) Days (0-6)

4. Birth Date

MM/DD

 / / 2009

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

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Delivery and Maternal History

9. Maternal Age

		<input type="checkbox"/> Unk <small>Years</small>
--	--	------------------------------------------------------

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*

<input type="checkbox"/> Black	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Other
<input type="checkbox"/> Native American	<input type="checkbox"/> 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)

	<input type="checkbox"/> N/A <input type="checkbox"/> Unk
Total	

c) Birth Order

	<input type="checkbox"/> N/A <input type="checkbox"/> 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/Previa
- Other Obstetrical
- Unk

If Other, specify:



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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="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table> <input type="checkbox"/> Unk			<table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table> <input type="checkbox"/> Unk			<table border="1" style="display: inline-table; 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

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

21. Surfactant Treatment

- | | |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| a) Surfactant given in Delivery Room | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| b) Surfactant given at Any Time
<i>Part b must be Yes if Part a is answered Yes</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |

c) If Yes, enter Age at First Dose

<table border="1" style="display: inline-table; width: 100px; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>					<table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table>			<input type="checkbox"/> N/A <input type="checkbox"/> Unk
Hours	Minutes (0-59)							

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="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> </table>			<table border="1" style="display: inline-table; 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*

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

24. Use of Nasal CPAP

- | | |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| a) Nasal CPAP | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| b) If Yes, was NCPAP used before ETT Ventilation? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> N/A |

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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, specify ventilation time: Unk N/A
- | | | | | |
|------|--|--|--------------|--|
| | | | | |
| Days | | | Hours (0-23) | |

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

31. ECMO

- Yes, Here Yes, Elsewhere Yes, Here and Elsewhere 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. Supplemental 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

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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, here Yes, elsewhere Yes, here and elsewhere No Unk

b) NEC Surgery

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

41. Focal GI Perforation

Yes, here Yes, elsewhere Yes, here and elsewhere 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 describe where indicated (Here, Elsewhere, or Here AND Elsewhere). 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) If peri-intraventricular was present, where was it first diagnosed?

First Here First Elsewhere N/A Unk

d) Shunt Placed for Bleed

Yes No Unk N/A

e) Other Intracranial Hemorrhage ON or Before Day 28

Yes No Unk N/A

If Yes, specify: _____

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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 Severe Moderate Mild 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.

Enter birth defect description for codes

100 150 200 300 400 504 601 605 800 900 : _____

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 NICU (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 /Not Done

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

Note that responses in this section will be ignored if you DO NOT answer item 54, initial disposition from your center

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



2009 TRANSPORT / POST-TRANS. FORM FOR INFANTS BORN IN 2009

Transfer Information

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

58. Reason for Transfer *Choose only one*

- | | |
|--------------------------------------------------------|------------------------------------|
| <input type="checkbox"/> ECMO | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Growth / Discharge Planning | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medical / Diagnostic Services | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Unk |
| <input type="checkbox"/> Chronic Care | |

59. Hospital the infant was transferred to:

Enter center's OSHPD Code

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- 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

--	--	--	--	--

Grams

- N/A
 Unk

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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

	/		/		200	
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Enter Comments or Notes Below

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