



ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2023

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID:

HOSPITAL ID:

Do not use this form if this infant qualifies as a delivery room death (DRD). If this infant is a DRD please fill out the DRD form.

- The “**Identification and Demographics**”, “**Maternal History**” and “**Delivery Room and First Hour After Birth**” sections **must** be filled out when an eligible infant is admitted to your NICU.
- The “**Post-Delivery Diagnoses and Interventions-Respiratory**” (respiratory, infections, other diagnoses, surgeries, and surgical complications, neurological, and congenital malformations) and the “**Initial Disposition**” sections must be filled out when the baby is discharged for the first time from your center.
- The “**Transport Information**” section only needs to be filed out if the infant was transported after its initial stay.

SELECTION CRITERIA

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

A. **≤ 1500 grams** Yes (If Yes go to item #1) No (If No go to Part B)

B. **GA ≤ 31 6/7 weeks** Yes (If Yes go to item #1) No (If No go to Part C)

C. **If > 1500 grams** Yes (If Yes select criteria below) No

MUST check at least one to be eligible.

NOTE: Any infant that was previously discharged home and re-admitted to any location in our hospital (On or before Day 28) for Total Serum Bilirubin=>25mg/dl (427 Micromols/Liter) and/or exchange transfusion is CPQCC NICU eligible.

- | | |
|---|---|
| <input type="checkbox"/> Death | <input type="checkbox"/> Acute Transport-In |
| <input type="checkbox"/> Major Surgery with general anesthesia or equivalent | <input type="checkbox"/> Acute Transport-Out |
| <input type="checkbox"/> Intubated Vent > 4hrs | <input type="checkbox"/> Early Bacterial Sepsis |
| <input type="checkbox"/> Non-Intubated Vent > 4hrs | <input type="checkbox"/> Hyperbilirubinemia |
| <input type="checkbox"/> Suspected Encephalopathy or Suspected Perinatal Asphyxia | <input type="checkbox"/> Active Therapeutic Hypothermia |
| | <input type="checkbox"/> Seizures |

IDENTIFICATION AND DEMOGRAPHICS

1. **Birth Weight:** _____ grams

2. **Head Circumference at Birth:** _____ cm Unknown Not Done

3. **Best Estimate of Gestational Age:** _____ a) Weeks (15-46) _____ b) Days (0-6) Unknown

4. **a. Birth Date:** (MM-DD) _____ - _____ -2023

b. Birth Time: (00:00) _____ : _____ (use 24-hour clock)

5. **Infant Sex:** Male Female Undetermined Unknown

6. **Died in Delivery Room:** Yes (If Yes, Use DRD Form) No

7. **a. Location of Birth:** Inborn Outborn Born at Co-Located Hospital (Satellite NICUs Only)

NOTE: For infants who were previously home, always check Outborn, even if the infant was born at your hospital or at a Co-Located Hospital (for Satellite NICUs only.)

b. Age in Days at Admission to your NICU: _____ Date of Birth is Day 1

c. Hospital of Birth for Outborn Infants: _____ (Enter HCAI Code (Formerly OSHPD) Unknown NA

d. Reason for Transport – In (If Location of Birth is “Outborn”, select only one response indicating the primary reason for transport in):

- | | | |
|--|--|---|
| <input type="checkbox"/> ECMO | <input type="checkbox"/> Growth/Discharge Planning | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hypothermic Therapy | <input type="checkbox"/> Chronic Care | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Insurance | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other Medical/Diagnostic Services | | |

8. **Hospital Admission History** (answer parts a. and b. only for Outborn infants)

NOTE: The Hyperbilirubinemia items 53 to 55 are activated ONLY if the infant was home after birth (item 8a). A home birth does NOT qualify for checking “Was Previously Discharged Home form a Hospital after Birth.”

a. Discharged Home after Birth:

- Never Discharged Home from a Hospital after Birth Was Previously Discharged Home after Birth NA



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b. NICU Re-Admission Status after PDH:

First Admission to this NICU
 Readmission to this NICU
 NA

MATERNAL HISTORY

9. **a. Maternal Date of Birth:** (MM/DD/YY) ____/____/____ **b. Maternal Age:** years Unknown

10. **Maternal Race/Ethnicity:** (answer both parts a. and b.)

a. Is the Mother of Hispanic Origin? Yes No Unknown

b. Maternal Race (check only one) Black Native Hawaiian/Pacific Islander White Other
 Asian American Indian/Alaska Native Unknown

11. **Prenatal Care:** Yes No Unknown

12. **Group B Strep Positive:** Yes No Not Done Unknown

13. **a. Is there documentation that Antenatal Steroids therapy was initiated before delivery?** Yes No Unknown

b. Is there documentation in the medical record of reason for NOT initiating antenatal steroid therapy before delivery? (This item is only applicable and optional for inborn infants who are <34 weeks GA) Yes No Unknown

c. If Yes, what was the documented reason for NOT administering antenatal steroids? (This item is only applicable and optional for inborn infants who are <34 weeks GA)

<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> History of adverse reaction to corticosteroids
<input type="checkbox"/> Other active infection	<input type="checkbox"/> Comfort Care
<input type="checkbox"/> Immediate delivery	<input type="checkbox"/> Other
<input type="checkbox"/> Fetus has anomalies incompatible with life	<input type="checkbox"/> Unknown

14. **Spontaneous Labor** Yes No Unknown

15. **a. Multiple Gestation** Yes No Unknown

b. If Yes, to multiple gestation enter number of infants delivered including stillborn ____ Unknown NA

c. Birth Order: ____ Unknown NA

16. **Delivery Mode** (check only one) Spontaneous Vaginal Operative Vaginal Cesarean Unknown

17. **Antenatal Conditions** (select ALL conditions occurring in this pregnancy)

a. Maternal Antenatal Conditions	<input type="checkbox"/> None <input type="checkbox"/> Other Infection	<input type="checkbox"/> Antenatal Magnesium Sulfate
	<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (describe): _____
	<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Prev. Cesarean	<input type="checkbox"/> Unknown
b. Fetal Antenatal Conditions	<input type="checkbox"/> None <input type="checkbox"/> Non-Reassuring Fetal Status	<input type="checkbox"/> Other Fetal (describe): _____
	<input type="checkbox"/> IUGR <input type="checkbox"/> Anomaly	<input type="checkbox"/> Unknown
c. Obstetrical Conditions	<input type="checkbox"/> None	<input type="checkbox"/> Prolonged ROM (>18hrs)
	<input type="checkbox"/> Preterm (<37 wks) Labor	<input type="checkbox"/> Malpresentation/Breech
	<input type="checkbox"/> Preterm (<37 wks) Premature ROM before onset of labor	<input type="checkbox"/> Bleeding/Abruption/Previa
	<input type="checkbox"/> Term Premature ROM (≥37 wks) before onset of labor, not premature gestation)	<input type="checkbox"/> Other Obstetrical (describe): _____

18. **Indications for Cesarean Section** (select at least one)

<input type="checkbox"/> Not Applicable (No C/S)	<input type="checkbox"/> Multiple Gestation	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Elective	<input type="checkbox"/> Placental Problems	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Malpresentation/Breech	<input type="checkbox"/> Non-Reassuring Fetal Status	<input type="checkbox"/> Unknown
<input type="checkbox"/> Dystocia/Failed to Progress		



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DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

19. Delayed Cord Clamping

NOTE: For outborn babies it is acceptable that these variables are 'unknown', if this information is unavailable)

- a. Was delayed umbilical cord clamping performed? Yes No Unknown
- b. How long was umbilical cord clamping delayed? 30-60 secs 61-120 secs >120 secs NA Unknown
- c. If DCC was not done, reason why (optional)? Maternal Bleeding Neonatal Causes Other (specify) _____
- d. Was umbilical cord milking performed? Yes No Unknown
- e. Did breathing begin before umbilical cord clamping? Yes No Unknown

20. Apgar Scores: 1min Unknown Not Done 5min Unknown Not Done 10min Unknown Not Done

21. Perinatal Asphyxia

NOTE: that items 21a – 21e apply only to infants >1,500 grams AND items 21b – 21e apply if infant meets at least one of the following criteria:

1. Admitted with suspected encephalopathy or suspected perinatal asphyxia [Yes to item 21a]
2. 5-min Apgar \leq 3 or 10-min Apgar \leq 4 [item 20]
3. Received active hypothermia [Selective or Whole Body to item 24d]
4. Diagnosis with HIE [Mild/Moderate or Severe to item 51]

- a. Suspected Encephalopathy of Suspected Perinatal Asphyxia Low 5-min and/or 10-min Apgar Score? Yes No Unknown NA
- b. In there an umbilical cord blood gas or a baby blood gas in the first hour of life available? Yes No Unknown NA
- c. Source of blood gas: Cord Umbilical Arterial (UA) Cord Umbilical Venous (UV) Arterial Baby Gas Venous Baby Gas Capillary Baby Gas Unknown NA
- d. pH within one hour of life: ____ . ____ Unknown NA
- e. Base deficit: ____ . ____ Unknown NA Too Low to Register

22. Delivery Room Resuscitation

- a. Supplemental Oxygen: Yes No Unknown
- b. Nasal CPAP: Yes No Unknown
- c. PPV via Bag/Mask: Yes No Unknown
- d. ETT Ventilation Yes No Unknown
- e. Epinephrine: Yes No Unknown
- f. Cardiac Compressions: Yes No Unknown
- g. Noninvasive Ventilation Yes No Unknown
- h. Laryngeal Mask Airway (LMA) Yes No Unknown

23. Surfactant Treatment

- a. Was Surfactant given in the Delivery Room? Yes No Unknown
- b. Was Surfactant given at any time? Yes No Unknown
- c. Enter age at first dose: ____ hours ____ mins Unknown NA
or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM)
_____ - _____ - _____ : _____



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POST-DELIVERY DIAGNOSES AND INTERVENTIONS - RESPIRATORY

24. Temperature and Cooling for HIE

a. Was the temperature measured within one hour of the NICU admission? Yes No Unknown

b. Enter first temperature either in Centigrade or Fahrenheit Degrees: _____ °C _____ °F Too Low Unknown

NOTE: The temperature has to be entered even if the infant continued cooling in your NICU or started cooling in your NICU prior to the first temperature.

c. Infant cooling status during stay at your NICU No Cooling Cooling Started Cooling Continued Unknown

d. Last Cooling Method Used for HIE Passive Whole Body Other Unknown

25. Respiratory Support after Initial Resuscitation

a. Supplemental Oxygen Yes No Unknown

b. Intubated Conventional Ventilation Yes No Unknown

c. Intubated HIFI Ventilation Yes No Unknown

d. Nasal Cannula Yes, flow rate >2l/min Yes, flow rate ≤ 2l/min Yes, flow rate unknown No Unknown

e. Noninvasive Ventilation (or any other form of non-intubated assisted ventilation) ≤4 hours >4 hours No Unknown

f. Nasal CPAP Yes (Always if 25e. is "Yes") No Unknown

27. Use of Intubated Assisted Ventilation

a. Length of Intubated Assisted Ventilation ≤ 4 hours > 4 hours No Unknown

b. If Intubated Ventilation > 4 hours, specify ventilation time in days: days Unknown

c. If > 1 Episode of Intubated Assisted Ventilation, Total Duration of Intubated Assisted Ventilation (optional) _____

28. Infant Death within 12 Hours of NICU Admission Yes No Unknown

29. Respiratory Distress Syndrome Yes No Unknown

30. Pneumothorax Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown

31. Meconium Aspiration Syndrome Yes No Unknown

32. Caffeine for any Reason Yes No Unknown

33. Intramuscular Vitamin A for any Reason Yes No Unknown

34. Inhaled Nitric Oxide > 4 hours Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown

35. ECMO Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown

36. Postnatal Steroids

a. Were postnatal steroids used? Yes No Unknown

b. If postnatal steroids were used, select all reasons that applied

Chronic Lung Disease: Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown

Extubation: Yes No Unknown

Hypotension/Blood Pressure: Yes No Unknown

Other Reason: Yes No Unknown

37. Supplemental Oxygen on Day 28 Continuous Intermittent None Unknown NA

38. Respiratory Support at 36 weeks

a. Supplemental Oxygen: Continuous Intermittent None Unknown NA

b. Intubated Conventional Ventilation Yes No Unknown NA

c. Intubated High Frequency Ventilation Yes No Unknown NA

d. Nasal Cannula Yes, flow rate >2l/min Yes, flow rate ≤ 2l/min Yes, flow rate unknown No Unknown

e. Noninvasive Ventilation Yes No Unknown NA

f. Nasal CPAP Yes No Unknown NA



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POST-DELIVERY DIAGNOSES AND INTERVENTIONS – RESPIRATORY (continue)

39. Respiratory Monitoring and Support Devices at Discharge

NOTE: Responses to this item will be ignored if you do not answer item 57, Initial disposition from your Center!

If the infant had a tracheostomy in place at discharge, make sure to enter the surgery code S101 as a major surgery under item 47b.

- a. Apnea/Cardio-Respiratory Monitor Yes No Unknown
- b. Supplemental Oxygen: Yes No Unknown
- c. Intubated Conventional Ventilation Yes No Unknown
- d. Intubated High Frequency Ventilation Yes No Unknown
- e. Nasal Cannula Yes, flow rate >2l/min Yes, flow rate ≤ 2l/min Yes, flow rate unknown
 No Unknown
- f. Noninvasive Ventilation Yes No Unknown
- g. Nasal CPAP Yes No Unknown

POST-DELIVERY DIAGNOSES AND INTERVENTIONS - INFECTIONS

40. Early Bacterial Sepsis and/or Meningitis on or before Day 3 Yes No Unknown

NOTE: Please refer to Appendix B for the Bacterial Infection Pathogen codes

If Yes, specify up to 3 pathogen codes: 1. _____ 2. _____ 3. _____

Enter a description for pathogen code 8888 (other): _____

41. Late Infection after Day 3:

NOTE: Please refer to Appendix B for the Bacterial Infection Pathogen codes

- a. Late Bacterial Sepsis and/or Meningitis Yes, here Yes, here and elsewhere NA
 Yes, elsewhere No Unknown

If Yes, select up to 3 pathogens: 1. _____ 2. _____ 3. _____

Enter a description for pathogen code 8888 (other): _____

- b. Coagulase Negative Staphylococci Yes, here Yes, here and elsewhere NA
 Yes, elsewhere No Unknown

- c. Fungal Yes, here Yes, here and elsewhere NA
 Yes, elsewhere No Unknown

42. Congenital Infection Yes No Unknown

If Yes, select up to 3 pathogens: 1. _____ 2. _____ 3. _____

Enter a description for pathogen code 8888 (other): _____

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES

- 43. a. Patent Ductus Arteriosus PDA meeting revised 2011 VON definition No
 PDA Diagnosis based on echo and/or clinical evidence or was treated for PDA, but not meeting all 2011 VON criteria. Unknown

- b. Indomethacin for any Reason Yes No Unknown

- c. Ibuprofen for Prevention and Treatment of PDA Yes No Unknown

- d. Acetaminophen (Paracetamol) for Prevention and Treatment for PDA Yes No Unknown

- e. Infant received prostaglandin medication to maintain ductal patency Yes (Applicable only if PDA is diagnosed) No Unknown
 NA (If infant is not diagnosed with PDA)

- f. PDA Ligation or PDA Closure by Catheterization Yes NA (If infant is not diagnosed with PDA)
 No Unknown

- g. Was PDA Surgery done in conjunction with Repair or Palliation of Congenital Heart Disease (S504) Yes (Applicable only if 43f. is Yes) No Unknown
 NA If no PDA Ligation or Closure by Catheterization



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- 44. **a. Probiotics** Yes No Unknown
- b. Necrotizing Enterocolitis** Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown
- c. NEC Surgery** Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown NA

- 45. **Focal Intestinal Perforation**
 - a. Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:**
 - Yes, here Yes, elsewhere Yes, here and elsewhere No Unknown
 - b. Surgically Confirmed or Clinically Diagnosed**
 - Surgically Confirmed Clinically Diagnosed NA Unknown



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POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES (continue)

46. Retinopathy of Prematurity **NOTE: This section is only applicable to infants \leq 1,500 grams or \leq 31 completed weeks GA unless your NICU participates in the VON expanded data collection.**

- a. Was a retinal exam performed? Yes No Unknown NA
- b. If retinal exam was performed, enter worst stage of ROP 0, No ROP 1 2 3 4 5 Unknown NA
- c. Treatment of ROP with Anti-VEGF Drug Yes No Unknown NA
- d. ROP Surgery (for infants with ROP stage 1 or higher) Yes, here Yes, here and elsewhere Unknown
 Yes, elsewhere No NA

47. a. Major Surgery (Not NEC, ROP, PDA) Yes No Unknown

b. If Yes, Enter up to 10 surgery codes:

Specify the location of the surgery, and – for surgeries that were performed at your hospital only (never elsewhere) – whether or not a surgical site infection (SSI) occurred at your hospital.

- | | | | | | |
|----------------|-----------|-------------------------------|------------------------------------|-------------------------------|-----------------------------------|
| Code 1. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 2. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 3. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 4. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 5. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 6. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 7. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 8. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 9. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |
| Code 10. _____ | Location: | <input type="checkbox"/> Here | <input type="checkbox"/> Elsewhere | <input type="checkbox"/> Both | <input type="checkbox"/> SSI Here |

NOTE: If infant had NEC surgery, one of the following surgeries should be listed: S302, S303, S308, S309 or S333

NOTE: If infant had a PDA Ligation or a PDA Closure by Catheterization, one of the following surgeries should be listed: S515, S516 or S605

Provide description for surgery codes S100, S200, S300, S500, S600, S700, S800, S900 AND S1000:

Blank area for providing descriptions for surgery codes.



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POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES

48. Intracranial Hemorrhage

a. Neural Imaging done on or before Day 28 Yes No Unknown

b. If neural imaging was done on or before Day 28, enter worst grade of peri-intraventricular hemorrhage: 0, No Hemorrhage 1 2 3 4 Unknown NA

c. If peri-intraventricular hemorrhage was present, where was it first diagnosed? Here Elsewhere Unknown NA

d. If peri-intraventricular hemorrhage was present, was shunt placed for bleed? Yes No Unknown

e. If neural imaging was done on or before Day 28, was any other intracranial hemorrhage found? Yes No Unknown

Describe Other: _____

49. Cystic Periventricular Leukomalacia (CPVL) & Cerebellar Hemorrhage

a. Was a neural image done? Yes No Unknown

b. If neural image done, evidence of Cystic PVL? Yes No Unknown

c. Cerebellar Hemorrhage Yes No Unknown

50. Seizures, EEG or Clinical Yes No Unknown

51. Hypoxic-Ischemic Encephalopathy Mild Moderate Severe None Unknown NA

CONGENITAL MALFORMATIONS / HYPERBILIRUBINEMIA

52. a. Congenital Anomalies Yes No Unknown

b. If Yes, enter up to 5 congenital anomaly codes:
Code 1. _____ Code 2. _____ Code 3. _____ Code 4. _____ Code 5. _____

Enter a congenital anomaly description for codes 100, 150, 200, 300, 400, 504, 601, 605, 800 and 900:

53. **NOTE: The following items 53-55 pertain to ANY infant that was previously discharged home and re-admitted before day 28.** < 25 mg/dl ≥ 30 mg/dl
 25 - < 30 mg/dl Unknown/Not Done NA

a. Maximum Level of Bilirubin (mg/dl) found On THIS Re Admission

b. Exchange Transfusion on THIS Re-Admission Yes No Unknown

c. Hospital that Discharged Infant Home Prior to THIS Admission: _____

54. Primary Caregiver's Preferred Language: Please select the primary caregiver's preferred language.

<input type="checkbox"/> Arabic	<input type="checkbox"/> Hmong/Miao	<input type="checkbox"/> Spanish
<input type="checkbox"/> Armenian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Cambodian/Khmer	<input type="checkbox"/> Korean	<input type="checkbox"/> Thai
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> English	<input type="checkbox"/> Mixteco	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Farsi/Persian	<input type="checkbox"/> Punjabi	<input type="checkbox"/> Other, Describe: _____
<input type="checkbox"/> Hindi	<input type="checkbox"/> Russian	<input type="checkbox"/> Unknown

55. Did the primary caregiver require interpreter services (either in-person or remote) during this hospitalization? Yes No Not Applicable (If primary language is English) Unknown



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INITIAL DISPOSITION

56. Enteral Feeding at Discharge None Human Milk with Fortifier or Formula Unknown
 Human Milk Only Formula Only
57. Initial Disposition from your Center Home Transported Unknown
 Died Still Hospitalized as of 1st Birthday
58. Weight at Initial Disposition _____ grams Unknown
59. Head Circumference at Initial Disposition _____ . _____ cm Unknown Not Done
60. Initial Discharge Date: (MM-DD-YYYY) _____ - _____ - _____ Unknown

POST-TRANSPORT STATUS

NOTE: If infant was transported to another hospital, complete items 61 – 63.

61. Reason for Transport ECMO Growth/Discharge Planning Unknown
 Hypothermic Therapy Chronic Care Other Reason
 Surgery Insurance Not Applicable
 Other Medical/Diagnostic Services

62. Hospital the infant was transported to: _____

63. Post-Transport Disposition Home (skip to item 67) Re-Admitted to your hospital (continue with item 64)
 Transport again to another hospital (skip to item 66) Still Hospitalized as of 1st Birthday (skip to item 67)
 Died (skip to item 67) Unknown

NOTE: Complete items 64 – 65 for infants who were initially transported from or center and then transported back to your center without every going home. For these infants, it is necessary to update items 23, 25 – 27, and 29 – 56 with information that should be obtained from the episode of care at the hospital the infant was transported to and the care upon re-admission at your center. The intention is to capture the cumulative interventions received by the infant while the infant was in your NICU before and after transport and while the infant was at the transport-out NICU.

NOTE: That these items do not need to be tracked for subsequent transports and re-admissions.

64. Weight after Re-Admission _____ grams Unknown
65. Disposition after Re-Admission Home (skip to item 67) Still Hospitalized as of 1st Birthday (skip to item 67)
 Transport again to another hospital Unknown
 Died (skip to item 67)

NOTE: Complete item 66 for infants who were initially transported from your center and then a) either transported again to another hospital, or b) re-admitted to your center and then transported from your hospital to another hospital.

66. Ultimate Disposition Home Died Still Hospitalized as of 1st Birthday Unknown
67. Final Discharged Date: (MM-DD-YYYY) _____ - _____ - _____