



ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2019

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

NETWORK ID:

HOSPITAL ID:

Any eligible inborn infant who dies in the delivery room or at any other location in your hospital within 12 hours after birth and prior to admission to the NICU is defined as a "Delivery Room Death." These locations may include the mother's room, resuscitation rooms, or any location other than the NICU in your hospital. Outborn infants and infants who are admitted to the NICU should not be classified as Delivery Room Deaths.

- 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. 401 – 1500 grams Yes (If Yes go to item #1) No (If No go to Part B)

B. GA range 22 0/7 – 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"/> Surgery Requiring Anesthesia | <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) --2019

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

5. Infant Sex: Male Female 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 OSHPD Facility Code) Unknown NA

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

b. NICU Re-Admission Status after PDH:

First Admission to this NICU Readmission to this NICU NA

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MATERNAL HISTORY

9.	a. Maternal Date of Birth: (MM/DD/YY) <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	b. Maternal Age: <input type="text"/> <input type="text"/> years <input type="checkbox"/> Unknown
10.	Maternal Race/Ethnicity: (answer both parts a. and b.)	
	a. Is the Mother of Hispanic Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	b. Maternal Race (check only one) <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown	
11.	Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
12.	Group B Strep Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown	
13.	a. Is there documentation that Antenatal Steroids therapy was initiated before delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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"/> Other active infection <input type="checkbox"/> Immediate delivery <input type="checkbox"/> Fetus has anomalies incompatible with life	<input type="checkbox"/> History of adverse reaction to corticosteroids <input type="checkbox"/> Comfort Care <input type="checkbox"/> Other <input type="checkbox"/> Unknown
14.	Spontaneous Labor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
15.	a. Multiple Gestation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	b. If Yes, to multiple gestation enter number of infants delivered including stillborn _____ <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
	c. Birth Order: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
16.	Delivery Mode (check only one) <input type="checkbox"/> Spontaneous Vaginal <input type="checkbox"/> Operative Vaginal <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown	
17.	Antenatal Conditions (select ALL conditions occurring in this pregnancy)	
	a. Maternal Antenatal Conditions	
	<input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Other Infection <input type="checkbox"/> Diabetes <input type="checkbox"/> Prev. Cesarean <input type="checkbox"/> Antenatal Magnesium Sulfate <input type="checkbox"/> Other (describe): _____ <input type="checkbox"/> Unknown
	b. Fetal Antenatal Conditions	
	<input type="checkbox"/> None <input type="checkbox"/> IUGR	<input type="checkbox"/> Non-Reassuring Fetal Status <input type="checkbox"/> Anomaly <input type="checkbox"/> Other Fetal (describe): _____ <input type="checkbox"/> Unknown
	c. Obstetrical Conditions	
	<input type="checkbox"/> None <input type="checkbox"/> Preterm (<37 wks) Labor <input type="checkbox"/> Preterm (<37 wks) Premature ROM before onset of labor <input type="checkbox"/> Term Premature ROM (≥37 wks) before onset of labor, not premature gestation)	<input type="checkbox"/> Prolonged ROM (>18hrs) <input type="checkbox"/> Malpresentation/Breech <input type="checkbox"/> Bleeding/Abruption/Placenta Previa <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"/> 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"/> Non-Reassuring Fetal Status <input type="checkbox"/> Hypertension <input type="checkbox"/> Other (describe): _____ <input type="checkbox"/> Unknown



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DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

19. Delayed Cord Clamping

- 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 Venus (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. CPAP: Yes No Unknown
- c. Bag/Mask: Yes No Unknown
- d. ETT Ventilation Yes No Unknown
- e. Epinephrine: Yes No Unknown
- f. Cardiac Compressions: Yes No Unknown
- g. Nasal Intermittent Positive Pressure (NIPPV) 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 Selective Head 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. High Flow Nasal Cannula Yes No Unknown

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

26. Use of Nasal CPAP

a. Nasal CPAP Yes No Unknown

b. If "Yes" to either 22b or 26a, was NCPAP or Nasal IMV or Nasal SIMV first used before and ETT Ventilation? Yes No Unknown
NOTE: if ETT ventilation was never used, check "Yes"

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

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. High Flow Nasal Cannula Yes No Unknown NA

e. Nasal IMV or SIMV 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. High Flow Nasal Cannula Yes No Unknown
- f. Nasal IMV or SIMV 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. PDA Ligation or PDA Closure by Catheterization Yes, here No
 Yes, elsewhere Unknown
 Yes, here and elsewhere NA

- 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 Yes, here Yes, elsewhere Yes, here and elsewhere No 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 401 -1,500 grams or 22 – 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:



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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

49. Cystic Periventricular Leukomalacia (CPVL)

- a. Was a neural image done? Yes No Unknown
- b. If neural image done, evidence of Cystic PVL? 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.**

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

- < 25 mg/dl ≥ 30 mg/dl
- 25 - < 30 mg/dl Unknown/Not Done NA

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

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



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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 Surgery Other Reason
 Growth/Discharge Planning Chronic Care Unknown
 Medical/Diagnostic Services Insurance

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) - -