Study ID Number

CADDRE

NEONATAL MEDICAL RECORD

ABSTRACTION FORM

(11/15/05)

Study ID Number

A. IDENTIFYING INFORMATION

1. Name (Last, First, Middle, Suffix) (Name of identified child for study)			
2. AKA	5. Date of birth _ _/_ _/_ _ _ _	6. Time of Birth _ _ : _ _	
7. Mother's Name (Last, First, Middle)	8. Mother's Maiden Name	9. Mother's SSN	
10. Street Address	11. City	12. State	13. Zip Code
14. Birth Hospital Name	15. Baby's Medical Record #	16. Mother's Medical Record #	
17. Hospital Address	18. City	19. State	20. Zip code
21. Father's Name (Last, First, Middle)			

22. Time @ 4-hour Age Date _ _/_ _/_ _ _ _ Time _ _:_ _	23. Time @ 12-hour Age Date _ _/_ _/_ _ _ _ Time _ _ : _ _	24. Time @ 24-hour Age Date _ _/_ _/_ _ _ _ Time _ _:_ _	25. Time @ 48-hour Age Date _ _/_ _/_ _ _ _ Time _ _ : _ _

25. Date Abstracted __ __/__ __/__ __ __ __	26. Abstractor
27. Start Time __ __ : __ __	28. Stop Time __ __ : __ __
29. Start Time __ __ : __ __	30. Stop Time __ __ : __ __
31. Start Time __ __ : __ __	32. Stop Time __ __ : __ __
33. Start Time __ __ : __ __	34. Stop Time __ __ : __ __
Comments	

Study ID Number ☐

A. INFANT TRANSPORT ☐ NO INFO

FIRST INFANT TRANSPORT

1. Name of Receiving Hospital	2. Baby's MR# (receiving hospital)	3. Date Arrived _ _/_ _/_ _	4. Date Departed _ _/_ _/_ _	5. Reason for Transport 6. Transport Service

SECOND INFANT TRANSPORT

1. Name of Receiving Hospital	2. Baby's MR# (receiving hospital)	3. Date Arrived _ _/_ _/_ _	4. Date Departed _ _/_ _/_ _	5. Reason for Transport 6. Transport Service

THIRD INFANT TRANSPORT

1. Name of Receiving Hospital	2. Baby's MR# (receiving hospital)	3. Date Arrived _ _/_ _/_ _	4. Date Departed _ _/_ _/_ _	5. Reason for Transport 6. Transport Service

7. Comments:

B. TEMPERATURES ☐ NO INFO

1. Initial temp (nursery admit) _____.____ 1☐ ºF 2☐ ºC 9 ☐ Unknown **Mode:** 1☐ Skin, 2 ☐ Axillary, 3 ☐ Rectal, 9 ☐ Unknown	2. Initial temp date __ __/__ __/__ __ __ __	3. Initial temp time __ __ : __ __ 9 ☐ Unknown
4. *Lowest* temp **in first 48 hrs** _____.____ 1☐ ºF 2☐ ºC 9 ☐ Unknown **Mode:** 1☐ Skin, 2 ☐ Axillary, 3 ☐ Rectal, 9 ☐ Unknown	5. *Highest* temp **in first 48 hrs** _____.____ 1☐ ºF 2☐ ºC 9 ☐ Unknown **Mode:** 1☐ Skin, 2 ☐ Axillary, 3 ☐ Rectal, 9 ☐ Unknown	
6. Comments		

Study ID Number

D. FIRST BABY GASES *(within first 2 hours after birth)* ☐ NO INFO

	Time drawn	pH	BE/BD
1.	:		
2.	:		
3.	:		
4.	:		

Comments:

E. RESPIRATORY SUPPORT ☐ NO INFO

Mode of respiratory support:

1 = IMV, 2 = (N)CPAP, 3 = Oxy hood, 4 = NC, 5 = HFV, 6 = Nitric Oxide, 8 = Other (specify), 9 = Unknown

(WITHIN FIRST 2 HOURS AFTER BIRTH)

	Mode	Start Date	End Date	Comments
1.		__ __/__ __/__ __	__ __/__ __/__ __	
2.		__ __/__ __/__ __	__ __/__ __/__ __	
3.		__ __/__ __/__ __	__ __/__ __/__ __	
4.		__ __/__ __/__ __	__ __/__ __/__ __	

Comments:

Study ID Number

C. GLUCOSE STABILITY				☐ NO INFO
Bedside screens	**Date drawn**	**Time drawn**	**Value (mg/dL)**	**Comments**
1. First glucose screen	__ __/__ __/__ __	:		
2. If ABNL, first WNL	__ __/__ __/__ __	:		
3. Highest glucose in first 24 hrs	__ __/__ __/__ __	:		
4. Lowest glucose in first 24 hrs	__ __/__ __/__ __	:		
5. Comments:				

D. BILIRUBIN				☐ NO INFO
Total Bilirubin	**Date drawn**	**Time drawn**	**Value (mg/dL)**	**Comments**
1. Highest bilirubin	_ _/_ _/_ _ _ _	:		

Study ID Number _____

E. SCORE FOR NEONATAL ACUTE PHYSIOLOGY (SNAP)

1☐ Transferred to a well baby setting (e.g. home, MIR, maternal room, foster care, etc.) ?
2☐ Transported-in or re-admit to NICU greater than 4 hours after birth?

If one of the above boxes is checked then, DO NOT collect this information and check here ☐ NA
Otherwise please complete this table (Section H).

SNAP period begins with physical entry into the NICU, even if the baby first spent time in the Well Baby Nursery
(for < 4 hours). Only indicate values for first 24 hours after birth

Time of Entry into NICU ____:____

1. Lowest Mean Arterial Pressure	Time ___ :___	(*Do not include blood pressures in the delivery room)* Systolic _____ Diastolic _____ MAP = _____
2. Lowest Temperature	Time ___ : ___	(*Do not record temps obtained by probe only)* °F_____ °C_____ 9 ☐ Unknown 1 ☐ Axillary 2 ☐ Rectal 9 ☐ Unknown
3. Highest Mean Airway Pressure	Time ___ : ___	*If baby was not on a ventilator during this period, score as "not done."* ____ ____ ____ mm Hg
4. Lowest PaO_2	Time ___ : ___	*If baby was not on supplemental O_2 during this period, count as "not done."* ____ ____ ____ mm Hg
5. Highest FiO_2	Time ___ : ___	*You may need to obtain this value from the Respiratory Therapy or Nursing Notes.* ____ ____ ____ mm Hg
6. Lowest Serum pH (free)	Time ___ : ___	(*This may be obtained by arterial, venous, or capillary blood gas)* _____
7. Seizures		1 ☐ None 2 ☐ Single 3 ☐ Multiple
8. Urine Output		(*Add up the total for the 24 hour period)* _____ cc/24 hours
9. Comments		

Study ID Number ☐

F. NURSERY ADMISSION ☐ NO INFO

1. GA By Exam (Wks) (wks) (days)	2. Dubowitz Gestational Age Assessment _____ (wks) _____ (days)	3. Estimated GA 9 ☐ Not Stated 1☐ AGA 3 ☐ LGA
4. HC _____ (cm)	5. Height/ Length _____ (cm)	6. Weight _____ (gm)
7. Toxicology Screen 9 ☐ Not Stated		

8. Blood Type

9. Hepatitis B Vaccine Given:	10. Surfactant Given

☑ 11. Birth Trauma Noted ☐ NO INFO		☑ 12. Problems/Impressions ☐ NO INFO			
	Bruising		Sepsis		Hypotension
	Laceration		PFC/PPHN		Hypoglycemia
	Brachial Plexus Injury (E.G., Erb's Palsy)		RDS/HMD		Hypothermia
	Fractured Clavicle		MAS (Meconium Aspiration Syn.)		PDA (Patent Ductus Arteriosus)
	DIC (Disseminated Intravascular Coagulation)		Birth Asphyxia		Pneumothorax
	TTN (Transient Tachypnea of Newborn)		Other *(specify)* _____		Other *(specify)* _____
	Other *(specify)* _____		Other *(specify)* _____		Other *(specify)* _____

13. Resuscitation in delivery room ☑ ☐ NO INFO	14. Nutrition 1☐ Breast Only 2☐ Formula Only 3☐ Combination 9☐ Unknown
Bag & Mask: 1☐ < 2 min 2☐ > 2 min	
Medications	
Chest compressions, duration ____ min.	15. Formula given at any time in the nursery? 1☐ Yes 2☐ No 9 ☐ Unknown
Intubation & ET suction for meconium	If yes, how often? _____ 9 ☐ Unknown Type of Formula 1 ☐ Soy 2 ☐ Cow's milk 3 ☐ Elemental Formula 9 ☐ Unknown Name of formula ? _____

Study ID Number

	Intubation & positive pressure ventilation	16. NG or OG feeds? 1☐ Yes 2☐ No 9 ☐ Unknown If yes, how often? _____ 9 ☐ Unknown
	Describe Intubation: 1☐ Routine 2 ☐ Difficult 9 ☐ Unknown	17. Was a referral made to a lactation consultant? 1☐ Yes 2☐ No 3☐ NA 9 ☐ Unknown
Comments		

J. MEDICAL HISTORY ☐ NO INFO

Includes the Discharge Diagnoses

Med Hx Codes: Refer to Appendix A for list of codes.

Precision Codes: 1= Possible, 2= Probable, 3= R/O, 4= Definite, 9= Unknown

*** If 'yes' is checked for Medications, then complete Section N.**

No.	Med Hx Code	Precision Code	Date Diagnosed	Date Resolved	Medications Given*
1.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
2.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
3.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
4.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
5.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
6.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
7.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Study ID Number

8.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
9.			_ _/_ _/_ _ _ _ 9 ☐ Unknown	__ __/__ __/__ __ __ __ 1 ☐ Ongoing 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Comments					

Study ID Number

K. INFECTIONS ☐ NO INFO

Infection Code: Refer to Appendix A for list of codes.

Temperature: Record temperature if range is < 36.5°C (97.7°F) or ≥ 38.0°C (100.4°F). Also complete Section N.

If 'yes' is checked for Cultures, then complete Section L.
If 'yes' is checked for Medications, then complete Section P.

No.	Infection Code	Date Diagnosed	Certainty of Dx	Duration	Temperature	Cultures	Medication
1.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
2.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
3.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
4.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
5.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
6.		_ _/_ _/_ _ _ _ 9 ☐ Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	__ __ __ days 9 ☐ Unknown	°C_____ °F_____ 1. • No temp 999. • Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Comments:

L. CULTURES RELATED TO INFECTION ☐ NO INFO

Study ID Number ☐

M. CSF ABNORMALITIES ☐ NO INFO

1. Date __ __/__ __/__ __ __ __	2. Date __ __/__ __/__ __ __ __	3. Date __ __/__ __/__ __ __ __	4. Date __ __/__ __/__ __ __ __
☑ **Findings**	☑ **Findings**	☑ **Findings**	☑ **Findings**
☐ ↑ WBC	☐ ↑ WBC	☐ ↑ WBC	☐ ↑ WBC
☐ ↑ Protein	☐ ↑ Protein	☐ ↑ Protein	☐ ↑ Protein
☐ ↓ Glucose	☐ ↓ Glucose	☐ ↓ Glucose	☐ ↓ Glucose
☐ ⊕ Gram stain	☐ ⊕ Gram stain	☐ ⊕ Gram stain	☐ ⊕ Gram stain
☐ Other *(specify):* _____	☐ Other *(specify):* _____	☐ Other *(specify):* _____	☐ Other *(specify):* _____

N. Temperature ☐ NO INFO

Record temperatures < 36.5°C (97.7°F) or ≥ 38.0°C (100.4°F).

*** If 'yes' is checked for Medications, then complete Section P.**

No.	Date Started	Duration	Temp	Mode	Conditions	Action Taken	Medication Given*
1.	__ __/__ __/__ __ __	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ °C 2 ☐ °F	1 ☐ Skin 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Warmer 2 ☐ Isolette 9 ☐ Unknown	1 ☐ Bundled 2 ☐ Moved to warmer 3 ☐ Moved to isolette 4 ☐ Other *(specify)* _____ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
2.	__ __/__ __/__ __ __	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ °C 2 ☐ °F	1 ☐ Skin 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Warmer 2 ☐ Isolette 9 ☐ Unknown	1 ☐ Bundled 2 ☐ Moved to warmer 3 ☐ Moved to isolette 4 ☐ Other *(specify)* _____ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
3.	__ __/__ __/__ __ __	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ °C 2 ☐ °F	1 ☐ Skin 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Warmer 2 ☐ Isolette 9 ☐ Unknown	1 ☐ Bundled 2 ☐ Moved to warmer 3 ☐ Moved to isolette 4 ☐ Other *(specify)* _____ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown
4.	__ __/__ __/__ __ __	_____ hours _____ days 9 ☐ Unk	_____ 1 ☐ °C 2 ☐ °F	1 ☐ Skin 2 ☐ Axillary 3 ☐ Rectal 9 ☐ Unknown	1 ☐ Warmer 2 ☐ Isolette 9 ☐ Unknown	1 ☐ Bundled 2 ☐ Moved to warmer 3 ☐ Moved to isolette 4 ☐ Other *(specify)* _____ 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Study ID Number

O. SURGICAL HISTORY ☐ NO INFO

*** If 'yes' is checked for Medications or Anesthesia, then complete Section P.**

**** If temperature is < 36.5°C (97.7°F) or ≥ 38.0°C (100.4°F), then complete Section N.**

Circumcision 1 ☐ Yes 2 ☐ No 3 ☐ NA (female) 9 ☐ Unknown Date __ __/__ __/__ __ __ __		Anesthesia* 1 ☐ Conscious Sedation 2 ☐ Local 3 ☐ Epidural 4 ☐ General 9 ☐ Unknown	Medications Given* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Fever** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments (e.g. type of injury)
Proc 1	CPT Code 9 ☐ Unknown Date __ __/__ __/__ __ __ __ Name of Procedure	Anesthesia 1 ☐ Conscious Sedation 2 ☐ Local 3 ☐ Epidural 4 ☐ General 9 ☐ Unknown	Medications Given 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Fever	Comments (e.g. type of injury)
Proc 2	CPT Code 9 ☐ Unknown Date __ __/__ __/__ __ __ __ Name of Procedure	Anesthesia 1 ☐ Conscious Sedation 2 ☐ Local 3 ☐ Epidural 4 ☐ General 9 ☐ Unknown	Medications Given 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Fever 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments (e.g. type of injury)
Proc 3	CPT Code 9 ☐ Unknown Date __ __/__ __/__ __ __ __ Name of Procedure	Anesthesia 1 ☐ Conscious Sedation 2 ☐ Local 3 ☐ Epidural 4 ☐ General 9 ☐ Unknown	Medications Given 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Fever 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments (e.g. type of injury)

Study ID Number ☐

P. MEDICATIONS ☐ NO INFO

Refer No.: Please indicate the event number from the appropriate section for Refer No., otherwise enter the reason from medical chart.

Drug codes: 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention,88= other (specify), 99= unknown

Reason: Specify

	Refer No.	Code	Drug Name	Reason	Start Date/Time	Duration (in days)	Dose	Unit	Frequency
1					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
2					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number

P. MEDICATIONS								☐ NO INFO	
3					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
4					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
5					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number ☐

P. MEDICATIONS									☐ NO INFO
6					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
7					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info
8					_ _ /_ _ /_ _ _ _ 9 ☐ Unknown	_____	_____ ☐ Variable	1 ☐ gm 2 ☐ mg 3 ☐ mcg 4 ☐ mU 5 ☐ cc/ml 8 ☐ other	1 ☐ QD 2 ☐ BID 3 ☐ TID 4 ☐ QID 5 ☐ PRN 6 Every ___ hrs 7 ☐ Per week 8 ☐ Total Dose 9 ☐ No Info

Study ID Number | |

Q. BLOOD PRODUCT TRANSFUSIONS ☐ NO INFO

Exclude normal saline partial exchange transfusion for polycythemia and albumin infusions for hypotension

1. Total #

1☐ None 2 ☐ One 3 ☐ More than one

☑ 2. Reasons for transfusions

	Iatrogenic anemia		Thrombocytopenia		Hyperbilirubinemia
	Anemia of prematurity		DIC		Other *(specify):* _____
	Other anemia *(specify):* _____		Other clotting factor deficiency		

3. Comments

R. NEUROLOGY CONSULTS ☐ NO INFO

Neurology Codes: 1 = Birth asphyxia 2 = Brachial plexus injury 3 = Seizures 8 = Other *(specify in comments)*

Refer No.: Please indicate the event number from the appropriate section (e.g. D2 – for Section D, #2), otherwise enter the reason for consult.

*** If 'yes' is indicated for Medications Given, then please complete Section P.**

1		Date: __ __/__ __/__ __ __ __	Refer No. or Reason	Neurology Code	Medication Given* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments
2		Date: __ __/__ __/__ __ __ __	Refer No. or Reason	Neurology Code	Medication Given* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments
3		Date: __ __/__ __/__ __ __ __	Refer No. or Reason	Neurology Code	Medication Given* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments
4		Date: __ __/__ __/__ __ __ __	Refer No. or Reason	Neurology Code	Medication Given* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Comments

Study ID Number

S. SEIZURES ☐ NO INFO

Proximate cause:
1 = Cranial bleed, 2 = Cranial trauma, 3 = Drug withdrawal, 4 = HIE, 5 = Immunization, 6 = Medication, 7 = Meningitis, 8 = Metabolic encephalopathy, 88 = Other *(specify in comments)*, 9 = Unknown

1. Date __ __/__ __/__ __ __ __	Time ____ : ___	☑ Describe episode	☑ Witnessed by
		☐ Clonic/convulsive	☐ RN
Proximate cause$_1$		☐ Tonic/posturing	☐ MD
Proximate cause$_2$		☐ Myoclonic	☐ Parent
Meds given (specify in Section P) 1☐ Yes 2☐ No 9☐ Unknown		☐ Subtle	☐ Other *(specify):* _____
		☐ Other *(specify):* _____	
Comments			

2. Date __ __/__ __/__ __ __ __	Time ____ : ___	☑ Describe episode	☑ Witnessed by
		☐ Clonic/convulsive	☐ RN
Proximate cause$_1$		☐ Tonic/posturing	☐ MD
Proximate cause$_2$		☐ Myoclonic	☐ Parent
Meds given (specify in Section P) 1☐ Yes 2☐ No 9☐ Unknown		☐ Subtle	☐ Other *(specify):* _____
		☐ Other *(specify):* _____	
Comments			

3. Date __ __/__ __/__ __ __ __	Time ____ : ___	☑ Describe episode	☑ Witnessed by
		☐ Clonic/convulsive	☐ RN
Proximate cause$_1$		☐ Tonic/posturing	☐ MD
Proximate cause$_2$		☐ Myoclonic	☐ Parent
Meds given (specify in Section P) 1☐ Yes 2☐ No 9☐ Unknown		☐ Subtle	☐ Other *(specify):* _____
		☐ Other *(specify):* _____	
Comments			

Study ID Number | |

T. CRANIAL ULTRASOUNDS ☐ NO INFO

Please record <u>all</u> ultrasounds.

1. Date __ __/__ __/__ __ __ __	Results 1☐ Normal 2☐ Abnormal 3☐ Equivocal	***Hemisphere:*** *1 = Right, 2 = Left, 3 = Bilateral, 9 = Unknown* ***Location:*** *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = Unknown* ***Size:*** *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = Unknown*

	Findings *(1= No, 2= Definite, 3=Suspect)*	H	L	S	Description/Comments
	Ventriculomegaly				
	Echodensity/echogenicity				
	Echolucency				
	IVH grade _____				
	Germinal matrix bleed (Grade I IVH)				
	Other bleed				
	PVL/cavitation/white matter necrosis				
	Malformation				
	Subarachnoid hemorrhage/blood				
	Other findings (specify)				

2. Date __ __/__ __/__ __ __ __	Results 1☐ Normal 2☐ Abnormal 3☐ Equivocal	***Hemisphere:*** *1 = Right, 2 = Left, 3 = Bilateral, 9 = Unknown* ***Location:*** *1 = Anterior/Frontal, 2 = Posterior/Occipital, 3 = Parietal, 4 = Temporal, 9 = Unknown* ***Size:*** *1 = Small/Mild, 2 = Medium/Moderate, 3 = Large/Severe, 9 = Unknown*

	Findings *(1= No, 2= Definite, 3=Suspect)*	H	L	S	Description/Comments
	Ventriculomegaly				
	Echodensity/echogenicity				
	Echolucency				
	IVH grade _____				
	Germinal matrix bleed (Grade I IVH)				
	Other bleed				
	PVL/cavitation/white matter necrosis				
	Malformation				
	Subarachnoid hemorrhage/blood				
	Other findings (specify)				

Study ID Number

U. CRANIAL STUDIES (EEG, MRI AND CT SCAN) ☐ NO INFO

Please abstract all ultrasounds.

Code: 1 = EEG, 2 = Cranial MRI, 3 = CT scan, 8 = Other *(specify in comments)*

1. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments
2. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments
3. Date __ __/__ __/__ __ __ __	Code	Results 1☐ Normal 3☐ Equivocal 2☐ Abnormal 9☐ Unknown	Final Impression	Comments

V. OTHER PROCEDURE OR STUDY (ECG, CHEST X-RAY, GENETIC STUDY, ETC.) ☐ NO INFO

Refer No.: Please indicate the event number from the appropriate section (e.g. D2 – for Section D, #2), otherwise enter the reason from the chart.

		Refer No./ Reason	Type of Procedure	Date	Outcome
1.				_ _/_ _/_ _ _ _	
2.				_ _/_ _/_ _ _ _	
3.				_ _/_ _/_ _ _ _	
4.				_ _/_ _/_ _ _ _	
5.				_ _/_ _/_ _ _ _	

Study ID Number | |

W. DISPOSITION AT FINAL DISCHARGE ☐ NO INFO

1. Date of DC	2. HC	3. Height/ Length	4. Weight	5. Discharged to:
__ __/__ __/__ __ __ ___	_____ (cm) _____ (in)	_____ (cm) _____ (in)	_____ (gm) _____ (lbs)	1☐ Home with biological parent(s) 2☐ Foster care 3☐ Adopted 4☐ Custodial care 8☐ Other *(specify)* _____
6. Medications at Discharge 1☐ Yes *(Fill out Section P)* 2 ☐ No				

☑ 7. Referrals ☐ No Info

	Routine pediatrician appointment		Home health nurse home visit(s)		Ophthalmology follow-up
	Audiology follow-up		High-risk infant follow-up clinic		Public health home visit(s)
	Nutritional support 1☐ Bottle 2☐ Breast 3☐ Breast and Bottle 4☐ Tube 8☐ Other *(specify)* _____		Respiratory support 1☐ Oxygen 2☐ Respiratory support 3☐ Apnea monitor 8☐ Other *(specify)* _____		Other *(specify)* _____

8. Seizure status at time of discharge	9. Comments
1☐ No history of seizures 2☐ Controlled with meds 3☐ Resolved, not under treatment 4☐ Unresolved, still under treatment 9☐ Unknown	