

Study ID
Number

CADDRE
NEONATAL MEDICAL RECORD
ABSTRACTION FORM
(11/15/05)

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 __:__	
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A. INFANT TRANSPORT					<input type="checkbox"/> 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			<input type="checkbox"/> NO INFO
1. Initial temp (nursery admit) ____.____ 1 <input type="checkbox"/> °F 2 <input type="checkbox"/> °C 9 <input type="checkbox"/> Unknown Mode: 1 <input type="checkbox"/> Skin, 2 <input type="checkbox"/> Axillary, 3 <input type="checkbox"/> Rectal, 9 <input type="checkbox"/> Unknown	2. Initial temp date --/ /--	3. Initial temp time __ : __ 9 <input type="checkbox"/> Unknown	
4. <i>Lowest</i> temp in first 48 hrs ____.____ 1 <input type="checkbox"/> °F 2 <input type="checkbox"/> °C 9 <input type="checkbox"/> Unknown Mode: 1 <input type="checkbox"/> Skin, 2 <input type="checkbox"/> Axillary, 3 <input type="checkbox"/> Rectal, 9 <input type="checkbox"/> Unknown	5. <i>Highest</i> temp in first 48 hrs ____.____ 1 <input type="checkbox"/> °F 2 <input type="checkbox"/> °C 9 <input type="checkbox"/> Unknown Mode: 1 <input type="checkbox"/> Skin, 2 <input type="checkbox"/> Axillary, 3 <input type="checkbox"/> Rectal, 9 <input type="checkbox"/> Unknown		
6. Comments			

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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.		__/__/__	__/__/__	

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C. GLUCOSE STABILITY				<input type="checkbox"/> 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				<input type="checkbox"/> NO INFO
Total Bilirubin	Date drawn	Time drawn	Value (mg/dL)	Comments
1. Highest bilirubin	__/__/__	:		

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F. NURSERY ADMISSION			<input type="checkbox"/> NO INFO
1. GA By Exam (Wks) (wks) (days)	2. Dubowitz Gestational Age Assessment _____ (wks) _____ (days)	3. Estimated GA 1 <input type="checkbox"/> AGA 3 <input type="checkbox"/> LGA	9 <input type="checkbox"/> Not Stated
4. HC _____ (cm)	5. Height/ Length _____ (cm)	6. Weight _____ (gm)	7. Toxicology Screen 9 <input type="checkbox"/> Not Stated
8. Blood Type			
9. Hepatitis B Vaccine Given:		10. Surfactant Given	
<input checked="" type="checkbox"/> 11. Birth Trauma Noted <input type="checkbox"/> NO INFO		<input checked="" type="checkbox"/> 12. Problems/Impressions INFO <input type="checkbox"/> NO	
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 <input checked="" type="checkbox"/> <input type="checkbox"/> NO INFO		14. Nutrition	
Bag & Mask: 1 <input type="checkbox"/> < 2 min 2 <input type="checkbox"/> > 2 min		1 <input type="checkbox"/> Breast Only 2 <input type="checkbox"/> Formula Only 3 <input type="checkbox"/> Combination 9 <input type="checkbox"/> Unknown	
Medications			
Chest compressions, duration _____ min.		15. Formula given at any time in the nursery?	
Intubation & ET suction for meconium		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	
		If yes, how often? _____ 9 <input type="checkbox"/> Unknown	
		Type of Formula	
		1 <input type="checkbox"/> Soy 2 <input type="checkbox"/> Cow's milk 3 <input type="checkbox"/> Elemental Formula 9 <input type="checkbox"/> Unknown	
		Name of formula ? _____	

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Intubation & positive pressure ventilation

16. NG or OG feeds?

1 Yes 2 No 9 Unknown

If yes, how often? _____ 9 Unknown

Describe Intubation:

17. Was a referral made to a lactation consultant?

1 Routine 2 Difficult 9 Unknown

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 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
2.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
3.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
4.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
5.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
6.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
7.			___/___/___ 9 <input type="checkbox"/> Unknown	___/___/___ 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown

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8.			-- / / -- 9 <input type="checkbox"/> Unknown	-- / / -- 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
9.			-- / / -- 9 <input type="checkbox"/> Unknown	-- / / -- 1 <input type="checkbox"/> Ongoing 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
Comments					

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 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
2.		__/__/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
3.		__/__/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
4.		__/__/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
5.		__/__/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
6.		__/__/____ 9 <input type="checkbox"/> Unknown	1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	____ days 9 <input type="checkbox"/> Unknown	°C ____ °F ____ 1. • No temp 999. • Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown

Comments:

L. CULTURES RELATED TO INFECTION NO INFO

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M. CSF ABNORMALITIES				<input type="checkbox"/> NO INFO
1. Date ____/____/____	2. Date ____/____/____	3. Date ____/____/____	4. Date ____/____/____	
<input checked="" type="checkbox"/> Findings	<input checked="" type="checkbox"/> Findings	<input checked="" type="checkbox"/> Findings	<input checked="" type="checkbox"/> Findings	
<input type="checkbox"/> ↑ WBC	<input type="checkbox"/> ↑ WBC	<input type="checkbox"/> ↑ WBC	<input type="checkbox"/> ↑ WBC	
<input type="checkbox"/> ↑ Protein	<input type="checkbox"/> ↑ Protein	<input type="checkbox"/> ↑ Protein	<input type="checkbox"/> ↑ Protein	
<input type="checkbox"/> ↓ Glucose	<input type="checkbox"/> ↓ Glucose	<input type="checkbox"/> ↓ Glucose	<input type="checkbox"/> ↓ Glucose	
<input type="checkbox"/> ⊕ Gram stain	<input type="checkbox"/> ⊕ Gram stain	<input type="checkbox"/> ⊕ Gram stain	<input type="checkbox"/> ⊕ Gram stain	
Other (specify): _____	Other (specify): _____	Other (specify): _____	Other (specify): _____	

N. Temperature							<input type="checkbox"/> 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 <input type="checkbox"/> Unk	____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	1 <input type="checkbox"/> Skin 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Warmer 2 <input type="checkbox"/> Isolette 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Bundled 2 <input type="checkbox"/> Moved to warmer 3 <input type="checkbox"/> Moved to isolette 4 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
2.	____/____/____	____ hours ____ days 9 <input type="checkbox"/> Unk	____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	1 <input type="checkbox"/> Skin 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Warmer 2 <input type="checkbox"/> Isolette 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Bundled 2 <input type="checkbox"/> Moved to warmer 3 <input type="checkbox"/> Moved to isolette 4 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
3.	____/____/____	____ hours ____ days 9 <input type="checkbox"/> Unk	____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	1 <input type="checkbox"/> Skin 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Warmer 2 <input type="checkbox"/> Isolette 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Bundled 2 <input type="checkbox"/> Moved to warmer 3 <input type="checkbox"/> Moved to isolette 4 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
4.	____/____/____	____ hours ____ days 9 <input type="checkbox"/> Unk	____ 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	1 <input type="checkbox"/> Skin 2 <input type="checkbox"/> Axillary 3 <input type="checkbox"/> Rectal 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Warmer 2 <input type="checkbox"/> Isolette 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Bundled 2 <input type="checkbox"/> Moved to warmer 3 <input type="checkbox"/> Moved to isolette 4 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown

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.

<p>Circumcision</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> NA 9 <input type="checkbox"/> Unknown (female)</p>	<p>Anesthesia*</p> <p>1 <input type="checkbox"/> Conscious Sedation 2 <input type="checkbox"/> Local 3 <input type="checkbox"/> Epidural 4 <input type="checkbox"/> General 9 <input type="checkbox"/> Unknown</p>	<p>Medications Given*</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p>Comments</p> <p>(e.g. type of injury)</p>
<p>Date</p> <p>___/___/___</p>		<p>Fever**</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	

Proc 1	<p>CPT Code</p> <p>9 <input type="checkbox"/> Unknown</p>	<p>Date</p> <p>___/___/___</p>	<p>Anesthesia</p> <p>1 <input type="checkbox"/> Conscious Sedation 2 <input type="checkbox"/> Local 3 <input type="checkbox"/> Epidural 4 <input type="checkbox"/> General 9 <input type="checkbox"/> Unknown</p>	<p>Medications Given</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p>Comments</p> <p>(e.g. type of injury)</p>
	<p>Name of Procedure</p>			<p>Fever</p>	

Proc 2	<p>CPT Code</p> <p>9 <input type="checkbox"/> Unknown</p>	<p>Date</p> <p>___/___/___</p>	<p>Anesthesia</p> <p>1 <input type="checkbox"/> Conscious Sedation 2 <input type="checkbox"/> Local 3 <input type="checkbox"/> Epidural 4 <input type="checkbox"/> General 9 <input type="checkbox"/> Unknown</p>	<p>Medications Given</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p>Comments</p> <p>(e.g. type of injury)</p>
	<p>Name of Procedure</p>			<p>Fever</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	

Proc 3	<p>CPT Code</p> <p>9 <input type="checkbox"/> Unknown</p>	<p>Date</p> <p>___/___/___</p>	<p>Anesthesia</p> <p>1 <input type="checkbox"/> Conscious Sedation 2 <input type="checkbox"/> Local 3 <input type="checkbox"/> Epidural 4 <input type="checkbox"/> General 9 <input type="checkbox"/> Unknown</p>	<p>Medications Given</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	<p>Comments</p> <p>(e.g. type of injury)</p>
	<p>Name of Procedure</p>			<p>Fever</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p>	

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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					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info
2					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info

P. MEDICATIONS								<input type="checkbox"/> NO INFO	
3					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info
4					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info
5					___ / ___ / ___ <input type="checkbox"/> Unknown	_____	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ___ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info

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P. MEDICATIONS								<input type="checkbox"/> NO INFO	
6					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	
7					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	
8					____ / ____ / ____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Variable	<input type="checkbox"/> gm <input type="checkbox"/> mg <input type="checkbox"/> mcg <input type="checkbox"/> mU <input type="checkbox"/> cc/ml <input type="checkbox"/> other	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN <input type="checkbox"/> Every ____ hrs <input type="checkbox"/> Per week <input type="checkbox"/> Total Dose <input type="checkbox"/> No Info	

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Q. BLOOD PRODUCT TRANSFUSIONS		<input type="checkbox"/> NO INFO
Exclude normal saline partial exchange transfusion for polycythemia and albumin infusions for hypotension		
1. Total #		
1 <input type="checkbox"/> None 2 <input type="checkbox"/> One 3 <input type="checkbox"/> More than one		
<input checked="" type="checkbox"/> 2. Reasons for transfusions		
Iatrogenic anemia	Thrombocytopenia	Hyperbilirubinemia
Anemia of prematurity	DIC	Other (<i>specify</i>): _____
Other anemia (<i>specify</i>): _____	Other clotting factor deficiency	
3. Comments		

R. NEUROLOGY CONSULTS		<input type="checkbox"/> NO INFO			
Neurology Codes: 1 = Birth asphyxia 2 = Brachial plexus injury 3 = Seizures 8 = Other (<i>specify in comments</i>)					
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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
2	Date: ___/___/___	Refer No. or Reason	Neurology Code	Medication Given* 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
3	Date: ___/___/___	Refer No. or Reason	Neurology Code	Medication Given* 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments
4	Date: ___/___/___	Refer No. or Reason	Neurology Code	Medication Given* 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Comments

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S. SEIZURES		<input type="checkbox"/> 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 (<i>specify in comments</i>), 9 = Unknown			
1. Date ____/____/____	Time ____ : ____	<input checked="" type="checkbox"/> Describe episode	<input checked="" type="checkbox"/> Witnessed by
		Clonic/convulsive	RN
Proximate cause ₁		Tonic/posturing	MD
Proximate cause ₂		Myoclonic	Parent
Meds given (specify in Section P) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Subtle	Other (<i>specify</i>): _____
		Other (<i>specify</i>): _____	
Comments			
2. Date ____/____/____	Time ____ : ____	<input checked="" type="checkbox"/> Describe episode	<input checked="" type="checkbox"/> Witnessed by
		Clonic/convulsive	RN
Proximate cause ₁		Tonic/posturing	MD
Proximate cause ₂		Myoclonic	Parent
Meds given (specify in Section P) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Subtle	Other (<i>specify</i>): _____
		Other (<i>specify</i>): _____	
Comments			
3. Date ____/____/____	Time ____ : ____	<input checked="" type="checkbox"/> Describe episode	<input checked="" type="checkbox"/> Witnessed by
		Clonic/convulsive	RN
Proximate cause ₁		Tonic/posturing	MD
Proximate cause ₂		Myoclonic	Parent
Meds given (specify in Section P) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		Subtle	Other (<i>specify</i>): _____
		Other (<i>specify</i>): _____	
Comments			

T. CRANIAL ULTRASOUNDS NO INFO

Please record all ultrasounds.

1. Date ____/____/____	Results 1 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 3 <input type="checkbox"/> 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
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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 <input type="checkbox"/> Normal 2 <input type="checkbox"/> Abnormal 3 <input type="checkbox"/> 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
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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 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Final Impression	Comments
2. Date __/__/__	Code	Results 1 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> Unknown	Final Impression	Comments
3. Date __/__/__	Code	Results 1 <input type="checkbox"/> Normal 3 <input type="checkbox"/> Equivocal 2 <input type="checkbox"/> Abnormal 9 <input type="checkbox"/> 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					<input type="checkbox"/> NO INFO
1. Date of DC ____/____/____	2. HC ____ (cm) ____ (in)	3. Height/ Length ____ (cm) ____ (in)	4. Weight ____ (gm) ____ (lbs)	5. Discharged to: 1 <input type="checkbox"/> Home with biological parent(s) 2 <input type="checkbox"/> Foster care 3 <input type="checkbox"/> Adopted 4 <input type="checkbox"/> Custodial care 8 <input type="checkbox"/> Other (<i>specify</i>)	
6. Medications at Discharge 1 <input type="checkbox"/> Yes (<i>Fill out Section P</i>) 2 <input type="checkbox"/> No					
<input checked="" type="checkbox"/> 7. Referrals <input type="checkbox"/> 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 <input type="checkbox"/> Bottle 2 <input type="checkbox"/> Breast 3 <input type="checkbox"/> Breast and Bottle 4 <input type="checkbox"/> Tube 8 <input type="checkbox"/> Other (<i>specify</i>) _____		Respiratory support 1 <input type="checkbox"/> Oxygen 2 <input type="checkbox"/> Respiratory support 3 <input type="checkbox"/> Apnea monitor 8 <input type="checkbox"/> Other (<i>specify</i>) _____		Other (<i>specify</i>) _____
8. Seizure status at time of discharge			9. Comments		
1 <input type="checkbox"/> No history of seizures 2 <input type="checkbox"/> Controlled with meds 3 <input type="checkbox"/> Resolved, not under treatment 4 <input type="checkbox"/> Unresolved, still under treatment 9 <input type="checkbox"/> Unknown					