Study ID Number

Study to Explore Early Development

NEONATAL / BIRTH HOSPITAL CHART MEDICAL RECORD ABSTRACTION FORM

This form should be used for abstraction of medical records from the hospital of delivery and early neonatal care (first 28 days of life).

Note: there may be more than one if there was a neonatal transport.

Below list all providers that contributed data to this form.

OF NOTE: It is NOT necessary to indicate the specific provider record source for each individual data item on this form. It will be too cumbersome to try and detail exactly which record(s) provided which data. Hopefully, in most cases if the same information is provided in multiple different provider records, it will be consistent and complimentary. However, there might be cases in which conflicting information is presented in 2 different records. Use the data available to make your best judgment about the correct information and then add a comment providing details of the conflict between provider sources.

Study ID Number [ ]

CONTRIBUTING PROVIDERS		
A.1. Name of Provider/Hospital		
A.2. Street Address		
A.3. City	A.4. State	A.5. Zip Code
ABSTRACTION LOG		
A.6. Date __ __/__ __/__ __ __ __	A.7. Date __ __/__ __/__ __ __ __	A.8. Date __ __/__ __/__ __ __ __
A.6.1 to A.6.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :	A.7.1 to A.7.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :	A.8.1 to A.8.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :
A.9. Date __ __/__ __/__ __ __ __	A.10. Date __ __/__ __/__ __ __ __	A.11. Date __ __/__ __/__ __ __ __
A.9.1 to A.9.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	A.10.1 to A.10.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	A.11.1 to A.11.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __

B.1. Name of Provider/Hospital		
B.2. Street Address		
B.3. City	B.4. State	B.5. Zip Code
ABSTRACTION LOG		
B.6. Date __ __/__ __/__ __ __ __	B.7. Date __ __/__ __/__ __ __ __	B.8. Date __ __/__ __/__ __ __ __
B.6.1 to B.6.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	B.7.1 to B.7.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	B.8.1 to B.8.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __
B.9. Date __ __/__ __/__ __ __ __	B.10. Date __ __/__ __/__ __ __ __	B.11. Date __ __/__ __/__ __ __ __

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B.9.1 to B.9.8 Time *(*use military time)*	B.10.1 to B.10.8 Time *(*use military time)*	B.11.1 to B.11.8 Time *(*use military time)*
Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __

C.1. Name of Provider/Hospital		
C.2. Street Address		
C.3. City	C.4. State	C.5. Zip Code

ABSTRACTION LOG

C.6. Date __ __/__ __/__ __ __ __	C.7. Date __ __/__ __/__ __ __ __	C.8. Date __ __/__ __/__ __ __ __
C.6.1 to C.6.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	C.71 to C.7.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	C.8.1 to C.8.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __
C.9. Date __ __/__ __/__ __ __ __	C.10. Date __ __/__ __/__ __ __ __	C.11. Date __ __/__ __/__ __ __ __
C.9.1 to C.9.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	C.10.1 to C.10.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __	C.11.1 to C.11.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __

D.1. Name of Provider/Hospital		
D.2. Street Address		
D.3. City	D.4. State	D.5. Zip Code

ABSTRACTION LOG

D.6. Date __ __/__ __/__ __ __ __	D.7. Date __ __/__ __/__ __ __ __	D.8. Date __ __/__ __/__ __ __ __
D.6.1 to D.6.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :	D.71 to D.7.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :	D.8.1 to D.8.8 Time *(*use military time)* Start __ __ : __ __ Stop __ __: __ __ Start __ __ : __ __ Stop __ __: __ __ Start : Stop :
D.9. Date __ __/__ __/__ __ __ __	D.10. Date __ __/__ __/__ __ __ __	D.11. Date __ __/__ __/__ __ __ __

Study ID Number [ ]

D.9.1 to D.9.8 Time *(*use military time)*	D.10.1 to D.10.8 Time *(*use military time)*	D.11.1 to D.11.8 Time *(*use military time)*
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __

E.1. Name of Provider/Hospital		
E.2. Street Address		
E.3. City	E.4. State	E.5. Zip Code

ABSTRACTION LOG

E.6. Date __ __/__ __/__ __ __ __	E.7. Date __ __/__ __/__ __ __ __	E.8. Date __ __/__ __/__ __ __ __
E.6.1 to E.6.8 Time *(*use military time)*	E.71 to E.7.8 Time *(*use military time)*	E.8.1 to E.8.8 Time *(*use military time)*
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start : Stop :	Start : Stop :	Start : Stop :
E9. Date __ __/__ __/__ __ __ __	E10. Date __ __/__ __/__ __ __ __	E11. Date __ __/__ __/__ __ __ __
E9.1 to D.9.8 Time *(*use military time)*	E10.1 to E10.8 Time *(*use military time)*	E11.1 to E11.8 Time *(*use military time)*
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __	Start __ __ : __ __ Stop __ __: __ __
Start __ __ : __ __ Stop __ __: __	Start __ __ : __ __ Stop __ __: __	Start __ __ : __ __ Stop __ __: __

(Add extra sheets as needed)

A. identifying Information

☐ NO INFORMATION FOR ANY ITEM IN SECTION

1. Baby's Name (Last, First, Middle, Suffix)			
2. Baby AKA	3. Date of birth _ _/_ _/_ _ _ _	4. Time of Birth _ _ : _ _	
5. Mother's Name (Last, First, Middle)	6. Mother's Maiden Name		
7. Street Address	8. City	9. State	10. Zip Code

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11. Birth Hospital Name					
12. Hospital Address		13. City		14. State	15. Zip code
16. Father's Name (Last, First, Middle)					
17. Time @ 4-hour Age 17a. Date _ _/_ _/_ _ _ _ 17b. Time _ _ : _ _	18. Time @ 12-hour Age 18a. Date _ _/_ _/_ _ _ _ 18b. Time _ _ : _ _		19.Time @ 24-hour Age 19a. Date _ _/_ _/_ _ _ _ 19b. Time _ _:_ _	20. Time @ 48-hour Age 20a. Date _ _/_ _/_ _ _ _ 20b. Time _ _ : _ _	
21. Comments:					

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Sections B-W: How to Document Various Types of Missing Information

A. No information -- entire section
Each section of each form will include either one or two universal missing check boxes. If either are checked, no further data are recorded for the entire section.

1. No information for any item in section
Checked if:
No relevant tests or procedures appear to have been ordered by any contributing medical care providers; and/or
No information was recorded for relevant health status, medical conditions, medications.

2. Test/procedure for one or more items in section indicated but no information on dates, results, etc.
(will only apply to certain sections as indicated)

B. Information available for one or more items within a section BUT no information for selected items

If there is information in the chart for one or more items in a given section on a given abstraction form, all pertinent data should be recorded. However, there is still the possibility that there will be missing data within these sections. Three types of missing data codes are recognized:

NA – NOT APPLICABLE (for use with certain items such as those with skip patterns and those for which multiple tests/procedures/etc. might have been performed and all are requested in abstraction form. After last relevant item is recorded, the subsequent item on abstract form is NA to indicate the end of reporting).

IL -- NOT LEGIBLE (self-explanatory)

NR – NO info in RECORD (“true missing” There ***should*** be information for an item, but it cannot be located.)

The following coding schemes will be applied to code these 3 types of missing:

Categorical variables with a finite coding scheme
77 NA
88 IL
99 NR

Dates and times – these may be completely missing or partially missing.
Data entry format is __ __/__ __/__ __ __ __ and __ __:__ __
For dates and time (military hours and minutes)

For day, month hours, and minutes, enter **77, 88, or 99** as appropriate
For year the enter **7777, 8888, or 9999** as appropriate

Thus, these can be completely missing or mixed with valid data such as:
03/99/2003 and 10:88

Continuous/open ended data items: Since it will be overly burdensome to develop and employ a missing data scheme which individually considers each data item and the appropriate number of digits for missing values use the alpha codes for missing in these instances: **NA, IL, or NR**

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B. Infant Transport

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

FIRST INFANT TRANSPORT

1a. Name of Receiving Hospital	1b. Date Arrived	1c. Date Departed	1d. Transport Service
	_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	1☐ Ambulance 2☐ Helicopter 3☐ Private car 8☐ Other *(specify)* __________________1d.*sp.* 88☐ IL 99☐ NR
1e. Reason for Transport:			

SECOND INFANT TRANSPORT

2a. Name of Receiving Hospital	2b. Date Arrived	2c. Date Departed	2d. Transport Service
	_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	1☐ Ambulance 2☐ Helicopter 3☐ Private car 8☐ Other *(specify)* __________________2d.*sp.* 88☐ IL 99☐ NR
2e. Reason for Transport			

THIRD INFANT TRANSPORT

3a. Name of Receiving Hospital	3b. Date Arrived	3c. Date Departed	3d. Transport Service
	_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _	1☐ Ambulance 2☐ Helicopter 3☐ Private car 8☐ Other *(specify)* __________________3d.*sp.* 88☐ IL 99☐ NR
3e. Reason for Transport:			

C. temperatures

☐ NO INFORMATION FOR ANY ITEM IN SECTION

1. Initial temp (nursery admit)	2. Initial temp date	3. Initial temp time
______.______ 1a. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR 1b. **Mode:** 1☐ Skin 2☐ Axillary 3☐ Rectal 88☐ IL 99☐ NR	__ __/__ __/__ __ __ __	__ __ : __ __

4. *Lowest* temp **in first 48 hrs**	5. *Highest* temp **in first 48 hrs**
______.______ 4a. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR 4b. **Mode:** 1☐ Skin 2☐ Axillary 3☐ Rectal 88☐ IL 9☐ NR	______.______ 5a. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR 5b. **Mode:** 1☐ Skin 2☐ Axillary 3☐ Rectal 88☐ IL 99☐ NR

6. Comments:

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D. FIRST BABY GASES *(within first 2 hours after birth)*

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

	Time drawn	Type	pH	Base Excess/Base Deficit
1.	1a. __ __ : __ __	1b. 1☐ Arterial/ABG 2☐ Venous/VBG 88☐ Illegible 99☐ Not Recorded	1c.	1d.
2.	2a. __ __ : __ __	2b. 1☐ Arterial/ABG 2☐ Venous/VBG 88☐ Illegible 99☐ Not Record	2c.	2d.
3.	3a. __ __ : __ __	3b. 1☐ Arterial/ABG 2☐ Venous/VBG 88☐ Illegible 99☐ Not Recorded	3c.	3d.
4.	4a. __ __ : __ __	4b. 1☐ Arterial/ABG 2☐ Venous/VBG 88☐ Illegible 99☐ Not Recorded	4c.	4d.

5. Comments:

E. RESPIRATORY SUPPORT *(within first 2 hours after birth)*

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Mode of respiratory support:

1 = IMV, 2 = (N)CPAP, 3 = Oxy hood, 4 = NC, 5 = HFV, 6 = Nitric Oxide, 8 = Other *(specify in comments)*, 88 = Illegible, 99 = Not Recorded

	Mode	Start Time	End Time	Duration	Comments
1.	1a.	1b. __ __ : __ __	1c. __ __ : __ __	1d. _ _ : _ _ : _ _ hrs min sec	1e.
2.	2a.	2b. __ __ : __ __	2c. __ __ : __ __	2d. _ _ : _ _ : _ _ hrs min sec	2e.
3.	3a.	3b. __ __ : __ __	3c. __ __ : __ __	3d. _ _ : _ _ : _ _ hrs min sec	3e.
4.	4a.	4b. __ __ : __ __	4c. __ __ : __ __	4d. _ _ : _ _ : _ _ hrs min sec	4e.

5. Comments:

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F. GLUCOSE STABILITY *(within first 24 hours after birth)*

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Screens	Date Drawn	Time Drawn	Value	Associated Clinical Symptoms
1. First glucose screen	1a. __ __/__ __/__ __	1b. __ __ : __ __	1c. ________ 1c.1. **Units:** 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	1d. (**Check all that apply**) 1d.1. 1☐ Jitters 1d.2. 2☐ Seizures 1d.3. 3☐ Shock 1d.4. 4☐ Apnea 1d.5. 5☐ Decreased Perfusion 1d.6. 8☐ Other *(specify)* ________________1d.6.*sp.* 1d.7 88☐ IL 1d.8 99☐ NR
2. If ABNL, first WNL	2a. __ __/__ __/__ __	2b. __ __ : __ __	2c. ________ 2c.1. **Units:** 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	2d. (**Check all that apply**) 2d.1. 1☐ Jitters 2d.2. 2☐ Seizures 2d.3. 3☐ Shock 2d.4. 4☐ Apnea 2d.5. 5☐ Decreased Perfusion 2d.6. 8☐ Other *(specify)* ________________2d.6.*sp.* 2d.7 88☐ IL 2d.8 99☐ NR
3. Highest glucose in first 24 hrs	3a. __ __/__ __/__ __	3b. __ __ : __ __	3c. ________ 3c.1. **Units:** 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	3d. (**Check all that apply**) 3d.1. 1☐ Jitters 3d.2. 2☐ Seizures 3d.3. 3☐ Shock 3d.4. 4☐ Apnea 3d.5. 5☐ Decreased Perfusion 3d.6. 8☐ Other *(specify)* ________________3d.6.*sp.* 3d.7 88☐ IL 3d.8 99☐ NR
4. Lowest glucose in first 24 hrs	4a. __ __/__ __/__ __	4b. __ __ : __ __	4c. ________ 4c.1. **Units:** 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	4d. (**Check all that apply**) 4d.1. 1☐ Jitters 4d.2. 2☐ Seizures 4d.3. 3☐ Shock 4d.4. 4☐ Apnea 4d.5. 5☐ Decreased Perfusion 4d.6. 8☐ Other *(specify)* ________________4d.6.*sp.* 4d.7 88☐ IL 4d.8 99☐ NR

5. Comments:

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G. BILIRUBIN *(COLLECT ALL VALUES)*

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Date Drawn	Time Drawn	Value	Treatment (check all that apply)	Antibody Reaction (check all that apply)
1. __ / __ / ____	1a. __ __ : __ __	1b. 1b.1. Total ______ 1b.2. Direct ______ 1b.3. Indirect_____ 1b.4. Units 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	1c. 1c.1. 1☐ IV Fluids 1c.2. 2☐ Photo Therapy 1c.3. 3☐Exchange Transfusion 1c.4. 4☐ None 1c.5. 88☐ IL 1c.6. 99☐ NR	1d. 1d.1. 1☐ Coombs Test → 1d.1a. 1☐ Positive 1d.1b. 2☐ Negative 1d.2. 2☐ Rh Sensitivity 1d.3. 3☐ Blood Type Antibody Tests 1d.4. 4☐ None 1d.5. 8☐ Other *(specify)* _____________1d.5.*sp.* 1d.6. 88☐ IL 1d.7. 99☐ NR
1e. Comments:				
2. __ / __ / ____	2a. __ __ : __ __	2b. 2b.1. Total ______ 2b.2. Direct ______ 2b.3. Indirect_____ 2b.4. Units 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	2c. 2c.1. 1☐ IV Fluids 2c.2. 2☐ Photo Therapy 2c.3. 3☐Exchange Transfusion 2c.4. 4☐ None 2c.5. 88☐ IL 2c.6. 99☐ NR	2d. 2d.1. 1☐ Coombs Test → 2d.1a. 1☐ Positive 2d.1b. 2☐ Negative 2d.2. 2☐ Rh Sensitivity 2d.3. 3☐ Blood Type Antibody Tests 2d.4. 4☐ None 2d.5. 8☐ Other *(specify)* _____________1d.5.*sp.* 2d.6. 88☐ IL 2d.7. 99☐ NR
2e. Comments:				
3. __ / __ / ____	3a. __ __ : __ __	3b. 3b.1. Total ______ 3b.2. Direct ______ 3b.3. Indirect_____ 3b.4. Units 1☐ mg/dL 2☐ mmol/L 88☐ IL 99☐ NR	3c. 3c.1. 1☐ IV Fluids 3c.2. 2☐ Photo Therapy 3c.3. 3☐Exchange Transfusion 3c.4. 4☐ None 3c.5. 88☐ IL 3c.6. 99☐ NR	3d. 3d.1. 1☐ Coombs Test → 3d.1a. 1☐ Positive 3d.1b. 2☐ Negative 3d.2. 2☐ Rh Sensitivity 3d.3. 3☐ Blood Type Antibody Tests 3d.4. 4☐ None 3d.5. 8☐ Other *(specify)* _____________1d.5.*sp.* 3d.6. 88☐ IL 3d.7. 99☐ NR
3e. Comments:				

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H. SCORE FOR NEONATAL ACUTE PHYSIOLOGY (SNAP)

☐ **No information for any item in section**
☐ **Test/procedure for one or more items in section indicated but no information on dates, results, etc.**

1. 1a. ☐ Transferred to a well baby setting (e.g. home, Maternal-Infant bonding room, maternal room, foster care, etc.)?
1b. ☐ 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 the information below and check here: 1c. 77☐ **NA**
Otherwise please complete the information below.

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

1d. Date of Entry into NICU __ __/__ __/__ __ __ __ **1e. Time of Entry into NICU** ____:____

2. Lowest Mean Arterial Pressure	2a. Date: _ _/_ _/_ _ _ _ 2b. Time: ___ :___	*2c. Do not include blood pressures in the delivery room* 2c.1 Systolic _______ 2c.2 Diastolic _______ 2c.3 MAP (from chart) = _______ 2c.4 MAP (calculated) = _______
3. Lowest Temperature	3a. Date: _ _/_ _/_ _ _ _ 3b. Time: ___ :___	*Do not record temps obtained by probe only* 3c. ________ 3d. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR 3e. **Mode:** 1☐ Axillary 2☐ Rectal 88☐ IL 99☐ NR
4. Highest Mean Airway Pressure	4a. Date: _ _/_ _/_ _ _ _ 4b. Time: ___ :___	*If baby was not on a ventilator during this period, score as "not done."* 4c. ____ ____ ____ mm Hg 4d. ☐ Not Done
5. Lowest PaO_2	5a. Date: _ _/_ _/_ _ _ _ 5b. Time: ___ :___	*If baby was not on supplemental O_2 during this period, count as "not done."* 5c. ____ ____ ____ mm Hg 5d. ☐ Not Done
6. Highest FiO_2	6a. Date: _ _/_ _/_ _ _ _ 6b. Time: ___ :___	*You may need to obtain this value from the Respiratory Therapy or Nursing Notes.* 6c. ____ ____ ____ mm Hg 88☐ IL 99☐ NR
7. Lowest Serum pH (free)	7a. Date: _ _/_ _/_ _ _ _ 7b. Time: ___ :___	*This may be obtained by arterial, venous, or capillary blood gas. (Do NOT include cord gases)* 7c. ______________________ 88☐ IL 99☐ NR
8. Seizures		1☐ None 2☐ Single 3☐ Multiple 88☐ IL 99☐ NR
9. Urine Output		_______ cc/24 hours *(Add up the total for the 24 hour period)*

10. Comments:

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I. BABY ADMISSION

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

1. GA By Exam (Wks)
1a. ____(wks)

2. Dubowitz Gestational Age Assessment
2a. ____(wks) 2b. ____(days)

3. Estimated Gestational Age
1☐ AGA 2☐ SGA 3☐ LGA
4☐ IUGR 88☐ IL 99☐ NR

4. Head Circumference
#__________ (cm)

5. Height/ Length
#___________ (cm)

6. Weight
#__________ (gm)

7. Hepatitis B Vaccine Given:

8. Blood Type
1☐ A+ 2☐ A- 3☐ B+ 4☐ B- 5☐ AB+ 6☐ AB- 7☐ O+
8☐ O- 88☐ IL 99☐ NR

9. Rh Type
1☐ Negative 2☐ Positive

10. Toxicology Screen:
1☐ Yes* 2☐ No 88☐ IL 99☐ NR
**(specify type)*____________________ 10.*sp.*

10a. Results:
1☐ Positive *(specify result)*
______________________10a.*sp.*
2☐ Negative
77☐ NA 88☐ IL 99☐ NR

11. Surfactant Given

12. Birth Trauma Noted *(check all that apply)*

12a. 1☐ Bruising
12b. 2☐ Laceration
12c. 3☐ Brachial Plexus Injury (e.g., Erb's Palsy)
12d. 4☐ Fractured Clavicle
12e. 5☐ DIC
12f. 6☐ TTN
12g. 8☐ Other *(specify trauma)*
___________________________12g.*sp.*
12h. 88☐ IL 12i. 99☐ NR

13. Problems/Impressions *(check all that apply)*

13a. 1☐ Birth Asphyxia
13b . 2☐ Hypoglycemia
13c. 3☐ Hypothermia
13d. 4☐ Hypotension
13e. 5☐ MAS
13f. 6☐ PDA
13g. 7☐ PFC/PPHN
13h. 8☐ Pneumothorax
13i. 9☐ RDS/HMD
13j. 10☐ Sepsis
13k. 11☐ Other *(specify problem)*
_________________________________13k.*sp.*
13l. 12☐ Other *(specify problem)*
_________________________________13l.*sp.*
13m. 88☐ IL
13n. 99☐ NR

14. Resuscitation in delivery room *(check all that apply)*

14a. 1☐ Bag & Mask:
14a.1. 1☐ < 2 min 2☐ ≥ 2 min
14b. 2☐ Intubation & ET suction for Meconium* (14b.1. below)
14c. 3☐ Intubation & positive pressure Ventilation* (14c.1. below)
14d. 4☐ Medications *(fill out Section P)*
14e. 5☐ Chest compressions:
14e.1. Duration: ____ minutes
14f. 88☐ IL 14g. 99☐ NR

15. Nutrition

15a. 1☐ Breast Only
15b. 2☐ Formula Only
15c. 3☐ Combination *(specify)*____________________ 15c.*sp.*
15d. 4☐ Tube
15e. 8☐ Other *(specify)*______________________________ 15e.*sp.*
15f. 88☐ IL 15g. 99☐ NR

16. Formula

☐ No information for any item in section

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* Describe Intubation *(as described in chart)*:	16a.1. Was formula given at anytime in the nursery/during stay?
14b.1. 1☐ Routine 2☐ Difficult 88☐ IL 9☐ NR 14c.1. 1☐ Routine 2☐ Difficult 88☐ IL 99☐ NR	1☐ Yes* 2☐ No 88☐ IL 99☐ NR *If yes, how often? Every ______ hours - 16a.*sp.* 16a.2 Type of Formula 1☐ Soy 2☐ Cow's milk 3☐ Elemental Formula* *Name of formula? *(verbatim from record)* ____ 16a.2.*sp.* 88☐ IL 99☐ NR
17. NG or OG feeds	**18. Was a referral made to a lactation consultant?**
1☐ Yes* 2☐ No 88☐ IL 99☐ NR 17a.*sp.* *How often? Every ______ hours 88☐ IL 99☐ NR	1☐ Yes 2☐ No 77☐ NA 88☐ IL 99☐ NR **19. Comments**

J. MEDICAL HISTORY

☐ **No information for any item in section**

Includes the Discharge Diagnoses

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

Precision Codes: 1 = Suspected, 2 = Definite, 88 = Not Legible, 99 = Not Recorded

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

No.	Med Hx Code	Precision Code	Date Diagnosed	Date Resolved	Medications Given*
1.	1a. *Specify:* 1a.*sp.*	1b.	1c. _ _/_ _/_ _ _ _ 9☐ Unknown	1d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	1e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
2.	2a. *Specify:* 2a.*sp.*	2b.	2c. _ _/_ _/_ _ _ _ 9☐ Unknown	2d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	2e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
3.	3a. *Specify:* 3a.*sp.*	3b.	3c. _ _/_ _/_ _ _ _ 9☐ Unknown	3d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	3e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
4.	4a. *Specify:* 4a.*sp.*	4b.	4c. _ _/_ _/_ _ _ _ 9☐ Unknown	4d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	4e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
5.	5a. *Specify:* 5a.*sp.*	5b.	5c. _ _/_ _/_ _ _ _ 9☐ Unknown	5d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	5e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR

Study ID Number

6.	6a. *Specify:* 6a.*sp.*	6b.	6c. _ _/_ _/_ _ _ _ 9☐ Unknown	6d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	6e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
7.	7a. *Specify:* 7a.*sp.*	7b.	7c. _ _/_ _/_ _ _ _ 9☐ Unknown	7d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	7e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
8.	8a. *Specify:* 8a.*sp.*	8b.	8c. _ _/_ _/_ _ _ _ 9☐ Unknown	8d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	8e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
9.	9a. *Specify* 9a.*sp.*	9b.	9c. _ _/_ _/_ _ _ _ 9☐ Unknown	9d. __ __/__ __/__ __ __ __ 1☐ Ongoing 9☐ Unknown	9e. 1☐ Yes 2☐ No 88☐ IL 99☐ NR

10. Comments:

K. INFECTIONS

☐ **No information for any item in section**

Infection Code: Refer to Table 2 for list of codes.

Temperature: Record the temperature if the range is **< 36.5ºC (97.7ºF) or ≥ 38.0ºC (100.4ºF)**; 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	Highest Temperature	Culture/ Rapid Screen	Medication
1.	1a. ________ 1.a.*sp.* ________	1b. _ _/_ _/_ _ _ _	1c. 1☐ Lab / Test* 2☐ Clinical 3☐ Suspect 88☐ IL 99☐ NR * see manual	1d. __ __ __ days	1e. **Value:** ______ 7☐ Out of range 1e.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	1f. 1☐ Yes 2☐ No 88☐ IL 99☐ NR	1g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
2.	2a. ________ 2.a.*sp.* ________	2b. _ _/_ _/_ _ _ _	2c. 1☐ Lab / Test* 2☐ Clinical 3☐ Suspect 88☐ IL 99☐ NR * see manual	2d. __ __ __ days	2e. **Value:** ______ 7☐ Out of range 2e.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	2f. 1☐ Yes 2☐ No 88☐ IL 99☐ NR	2g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR

Study ID Number | |

K. INFECTIONS

☐ No information for any item in section

3.	3a. ________ 3.a.*sp.* ________	3b. _ _/_ _/_ _ _ _	3c. 1☐ Lab / Test* 2☐ Clinical 3☐ Suspect 88☐ IL 99☐ NR * see manual	3d. __ __ __ days	3e. **Value:** ______ 7☐ Out of range 3e.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	3f. 1☐ Yes 2☐ No 88☐ IL 99☐ NR	3g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
4.	4a. ________ 4.a.*sp.* ________	4b. _ _/_ _/_ _ _ _	4c. 1☐ Lab / Test* 2☐ Clinical 3☐ Suspect 88☐ IL 99☐ NR * see manual	4d. __ __ __ days	4e. **Value:** ______ 7☐ Out of range 4e.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	4f. 1☐ Yes 2☐ No 88☐ IL 99☐ NR	4g. 1☐Yes 2☐ No 88☐ IL 99☐ NR
5.	5a. ________ 5.a.*sp.* ________	5b. _ _/_ _/_ _ _ _	5c. 1☐ Lab / Test* 2☐ Clinical 3☐ Suspect 88☐ IL 99☐ NR * see manual	5d. __ __ __ days	5e. **Value:** ______ 7☐ Out of range 5e.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	5f. 1☐ Yes 2☐ No 88☐ IL 99☐ NR	5g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR

6. Comments:

Study ID Number

L. CULTURES/RAPID STREP SCREENS RELATED TO INFECTION

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Source: 1 = blood, 2 = CSF, 3 = ear canal, 4 = nasal, 5 = sputum, 6 = stool, 7 = throat, 8 = urine, 9 = skin, 10 = eye, 11 = intravenous/broviac line, 12 = endotracheal tube aspirate, 88 = other *(specify)*, 888 = Not Legible, 99 = Not Recorded

REF: Indicate the letter and number of the event from the previous section (e.g. K2 – for Section K, #2), otherwise enter the reason from the chart.

No.	REF	Date Cultured / Rapid Screen	Source	Results	Description (e.g. organisms in screen)
1.	1a. ______	1b. __ __/__ __/__ __ __ __	1c. __________ 1.c.*sp*. __________	1d. 1☐ No growth 2☐ Normal flora 3☐ Light growth 4☐ Moderate to heavy growth 5☐ Growth noted, not specified 6☐ Urine Culture colony count (*Specify*) __________1d.1.*sp.* 7☐ Rapid strep screen beta strep positive. 8☐ Rapid strep screen beta strep negative. 9☐ Other (S*pecify)* ________________1d.2.*sp.* 77☐ NA 88☐ IL 99☐ NR	1e.
2.	2a. ______	2b. __ __/__ __/__ __ __ __	2c. __________ 2.c.*sp*. __________	2d. 1☐ No growth 2☐ Normal flora 3☐ Light growth 4☐ Moderate to heavy growth 5☐ Growth noted, not specified 6☐ Urine Culture colony count (*Specify*) __________2d.1.*sp.* 7☐ Rapid strep screen beta strep positive. 8☐ Rapid strep screen beta strep negative. 9☐ Other (S*pecify)* ________________2d.2.*sp.* 77☐ NA 88☐ IL 99☐ NR	2e.

Study ID Number [ ]

3.	3a.	3b.	3c.	3d.	3e.
	_______	__ __/__ __/__ __ __ __	___________ 3.c.*sp.* ___________	1☐ No growth 2☐ Normal flora 3☐ Light growth 4☐ Moderate to heavy growth 5☐ Growth noted, not specified 6☐ Urine Culture colony count (*Specify*) __________3d.1.*sp.* 7☐ Rapid strep screen beta strep positive. 8☐ Rapid strep screen beta strep negative. 9☐ Other (*Specify)* ________________3d.2.*sp.* 77☐ NA 88☐ IL 99☐ NR	

Fc **4. Comments:**

M. CSF ABNORMALITIES

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

1. Date __ __/__ __/__ __ __ __		2. Date __ __/__ __/__ __ __ __		3. Date __ __/__ __/__ __ __ __		4. Date __ __/__ __/__ __ __ __	
1a. Findings ***(check all that apply)***		**2a. Findings** ***(check all that apply)***		**3a. Findings** ***(check all that apply)***		**4a. Findings** ***(check all that apply)***	
1a.1.☐	↑ WBC	2a.1.☐	↑ WBC	3a.1.☐	↑ WBC	4a.1.☐	↑ WBC
1a.2.☐	↑ Protein	2a.2.☐	↑ Protein	3a.2.☐	↑ Protein	4a.2.☐	↑ Protein
1a.3.☐	↓ Glucose	2a.3.☐	↓ Glucose	3a.3.☐	↓ Glucose	4a.3.☐	↓ Glucose
1a.4.☐	⊕ Gram stain	2a.4.☐	⊕ Gram stain	3a.4.☐	⊕ Gram stain	4a.4.☐	⊕ Gram stain
1a.5.☐	Other *(specify):* ______________1a.5.*sp.*	2a.5.☐	Other *(specify):* ______________2a.5.*sp.*	3a.5.☐	Other *(specify):* ______________3a.5.*sp.*	4a.5.☐	Other *(specify):* ______________4a.5.*sp.*
1a.6.☐	NR	2a.6.☐	NR	3a.6.☐	NR	4a.6.☐	NR
1a.7.☐	IL	2a.7.☐	IL	3a.7.☐	IL	4a.7.☐	IL

N. TEMPERATURE

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Record temperatures < 36.5ºC (97.7ºF) or ≥ 38.0ºC (100.4ºF).
*** If 'yes' is checked for Medications, then complete Section P.**

No.	Date Started	Duration	Temp	Mode	Conditions	Action Taken	Medication Given*

Study ID Number | |

	1a.	1b.	1c.	1d.	1e.	1f.	1g.
1.	__ __/__ __/__ __ __ __	______ 1b.1. 1☐ Once 2☐ Hours 3☐ Days 88☐ IL 99☐ NR	______ 1c.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	1☐ Axillary 2☐ Rectal 3☐ Oral 4☐ Skin 88☐ IL 99☐ NR	1☐ Warmer 2☐ Isolette 88☐ IL 99☐ NR	1☐ Bundled 2☐ Moved to warmer 3☐ Moved to isolette 4☐ Other *(specify)* ______________1f.*sp.* 88☐ IL 99☐ NR	1☐ Yes 2☐ No 88☐ IL 99☐ NR
2.	2a. __ __/__ __/__ __ __ __	2b. ______ 2b.1. 1☐ Once 2☐ Hours 3☐ Days 88☐ IL 99☐ NR	2c. ______ 2c.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	2d. 1☐ Axillary 2☐ Rectal 3☐ Oral 4☐ Skin 88☐ IL 99☐ NR	2e. 1☐ Warmer 2☐ Isolette 88☐ IL 99☐ NR	2f. 1☐ Bundled 2☐ Moved to warmer 3☐ Moved to isolette 4☐ Other *(specify)* ______________2f.*sp.* 88☐ IL 99☐ NR	2g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR
3.	3a. __ __/__ __/__ __ __ __	3b. ______ 3b.1. 1☐ Once 2☐ Hours 3☐ Days 88☐ IL 99☐ NR	3c. ______ 3c.1. **Units:** 1☐ ºC 2☐ ºF 88☐ IL 99☐ NR	3d. 1☐ Axillary 2☐ Rectal 3☐ Oral 4☐ Skin 88☐ IL 99☐ NR	3e. 1☐ Warmer 2☐ Isolette 88☐ IL 99☐ NR	3f. 1☐ Bundled 2☐ Moved to warmer 3☐ Moved to isolette 4☐ Other *(specify)* ______________3f.*sp.* 88☐ IL 99☐ NR	3g. 1☐ Yes 2☐ No 88☐ IL 99☐ NR

4. Comments:

O. SURGICAL HISTORY

☐ **No information for any item in section**

* If 'yes' is checked for Medications or Anesthesia, then complete Section P.
** If temperature is < 36.5ºC (97.7ºF) or ≥ 38.0ºC (100.4ºF), then complete Section N.
Note: If infection occurred complete Section K.

1. Circumcision

1☐ Yes 2☐ No 77☐ NA(female) 88☐ IL 99☐ NR

1a. Date

__ __/__ __/__ __ __ __

1b. Anesthesia*

1☐ Conscious Sedation
2☐ Local
3☐ Epidural
4☐ General
5☐ None
88☐ IL
99☐ NR

1c. Medications Given*

1☐Yes 2☐ No
88☐ IL 99☐ NR

1d. Temperature**

1☐Yes 2☐ No
88☐ IL 99☐ NR

1e. Complications and Comments (e.g. type of injury), *(Specify)*

____1e.*sp.*

Proc 1 2

2a. CPT Code

____
9☐ Unknown

2b. Date

__ __/__ __/__ __ __ __
9☐ Unknown

2c. Name of Procedure *(Specify)*

______________________________ 2c.*sp.*

2d. Anesthesia*

1☐ Conscious Sedation
2☐ Local
3☐ Epidural
4☐ General
5☐ None
88☐ IL
99☐ NR

2e. Medications Given*

1☐Yes 2☐ No
88☐ IL 99☐ NR

2f. Temperature**

1☐Yes 2☐ No
88☐ IL 99☐ NR

2g. Complications and Comments (e.g. type of injury), *(Specify)*

____2g.*sp.*

Study ID Number [ ]

3 Proc 2	3a. CPT Code ________ 9☐ Unknown	3b. Date __ __/__ __/__ __ __ __ 9☐ Unknown	3d. Anesthesia* 1☐ Conscious Sedation 2☐ Local 3☐ Epidural 4☐ General 5☐ None 88☐ IL 99☐ NR	3e. Medications Given* 1☐Yes 2☐ No 88☐ IL 99☐ NR
	3c. Name of Procedure *(Specify)* ______________________ 3c.*sp.*			3f. Temperature** 1☐Yes 2☐ No 88☐ IL 99☐ NR

3g. Complications and Comments (e.g. type of injury), *(Specify)*

____ 3g.*sp.*

4 Proc 3	4a. CPT Code ________ 9☐ Unknown	4b. Date __ __/__ __/__ __ __ __ 9☐ Unknown	4d. Anesthesia* 1☐ Conscious Sedation 2☐ Local 3☐ Epidural 4☐ General 5☐ None 88☐ IL 99☐ NR	4e. Medications Given* 1☐Yes 2☐ No 88☐ IL 99☐ NR
	4c. Name of Procedure *(Specify)* ______________________ 4c.*sp.*			4f. Temperature** 1☐Yes 2☐ No 88☐ IL 99☐ NR

4g. Complications and Comments (e.g. type of injury), *(Specify)*

____ 4g.*sp.*

Study ID Number

P. MEDICATIONS

☐ No information for any item in section

REF: Indicate the letter and number of the event from the previous section (e.g. J2 – for Section J, #2), otherwise enter the reason from the 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/psychotropics, 20 = antihypertensives/diuretics, 21 = cardiovascular, 22 = narcotic antagonists, 23 = ergotrate, 24 =antidepressants, 25 = vitamins, 26 = asthma/respiratory stimulant, 27 = preterm labor prevention, 28 = neonatal resuscitation, 29 = dextrose, 30 = antipyretics, 31 = hematologic, 32 = gastrointestinal, 33 =anti-neoplastic, 88 = other *(specify)*, 888 = illegible, 999 = not recorded

Reason: Specify

	REF	Code	Drug Name	Reason	Start Date	Stop Date	Dose	Unit	Frequency
1	1a. ______	1b.	1c.	1d.	1e. __/__/____	1f. __/__/____ 1☐ Ongoing	1g. ______ 8☐ Variable* *End Dose: *(specify)* ______1g.*sp.*	1h. 1☐ gm 2☐ mg 3☐ mcg 4☐ mU 5☐ cc/ml 8☐ other 88☐ IL 99☐ NR	1i. 1☐ QD 2☐ BID 3☐ TID 4☐ QID 5☐ PRN 6. Every ___ hrs 7☐ Per week 8☐ Total Dose 88☐ IL 99☐ NR
2	2a. ______	2b.	2c.	2d.	2e. __/__/____	2f. __/__/____ 1☐ Ongoing	2g. ______ 8☐ Variable* *End Dose: *(specify)* ______2g.*sp.*	2h. 1☐ gm 2☐ mg 3☐ mcg 4☐ mU 5☐ cc/ml 8☐ other 88☐ IL 99☐ NR	2i. 1☐ QD 2☐ BID 3☐ TID 4☐ QID 5☐ PRN 6. Every ___ hrs 7☐ Per week 8☐ Total Dose 88☐ IL 99☐ NR

Study ID Number

P. MEDICATIONS

☐ No information for any item in section

	a	b	c	d	e	f	g	h	i
3	3a. ______	3b.	3c.	3d.	3e. _ _/_ _/_ _ _ _	3f. _ _/_ _/_ _ _ _ 1☐ Ongoing	3g. ________ 8☐ Variable* *End Dose: *(specify)* ______3g.*sp.*	3h. 1☐ gm 2☐ mg 3☐ mcg 4☐ mU 5☐ cc/ml 8☐ other 88☐ IL 99☐ NR	3i. 1☐ QD 2☐ BID 3☐ TID 4☐ QID 5☐ PRN 6. Every ___ hrs 7☐ Per week 8☐ Total Dose 88☐ IL 99☐ NR
4	4a. ______	4b.	4c.	4d.	4e. _/_ _/_ _ _ _	4f. _ _/_ _/_ _ _ _ 1☐ Ongoing	4g. ________ 8☐ Variable* *End Dose: *(specify)* ______4g.*sp.*	4h. 1☐ gm 2☐ mg 3☐ mcg 4☐ mU 5☐ cc/ml 8☐ other 88☐ IL 99☐ NR	4i. 1☐ QD 2☐ BID 3☐ TID 4☐ QID 5☐ PRN 6 Every ___ hrs 7☐ Per week 8☐ Total Dose 88☐ IL 99☐ NR

Study ID Number

P. MEDICATIONS

☐ No information for any item in section

5	5a.	5b.	5c.	5d.	5e.	5f.	5g.	5h.	5i.
	________				__/__/____	__/__/____ 1☐ Ongoing	________ 8☐ Variable* *End Dose: *(specify)* ______5g.*sp*	1☐ gm 2☐ mg 3☐ mcg 4☐ mU 5☐ cc/ml 8☐ other 88☐ IL 99☐ NR	1☐ QD 2☐ BID 3☐ TID 4☐ QID 5☐ PRN 6 Every ___ hrs 7☐ Per week 8☐ Total Dose 88☐ IL 99☐ NR

6. Comments

Study ID Number [ ]

Q. BLOOD PRODUCT TRANSFUSIONS

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

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

1. Total #

1☐ None 2☐ One 3☐ More than one 88☐ IL 99☐ NR

2. Reasons for transfusions *(check all that apply)*

2a. ☐	**Iatrogenic anemia**	2b. ☐	**Thrombocytopenia**	2c. ☐	**Hyperbilirubinemia**
2d. ☐	**Anemia of prematurity**	2e. ☐	**DIC**	2f. ☐	**Other** *(specify)* ____________2f.*sp.*
2g. ☐	**Other anemia** *(specify)*: ____________2g.*sp.*	2h. ☐	**Other clotting factor deficiency** *(specify)*: ____________2h.*sp.*	2i. ☐	**Other** *(specify)*: ____________2i.*sp.*

3. Comments:

R. NEUROLOGY CONSULTS

☐ No information for any item in section

Neurology Codes: 1 = Birth asphyxia 2 = Brachial plexus injury 3 = Seizures 4 = Metabolic disorders 8 = Other *(specify)* 88 = IL 99 = NR

REF.: 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.**

	a.	b.	c.	d.	e.
1.	1a. Date: __ __/__ __/__ __ __ __	1b. REF or Reason ____________1b.*sp.* 88☐ IL 99☐ NR	1c. Neurology Code	1d. Medication Given* 1☐ Yes 2☐ No 88☐ IL 99☐ NR	1e. Comments
2.	2a. Date: __ __/__ __/__ __ __ __	2b. REF or Reason ____________2b.*sp.* 88☐ IL 99☐ NR	2c. Neurology Code	2d. Medication Given* 1☐ Yes 2☐ No 88☐ IL 99☐ NR	2e. Comments
3.	3a. Date: __ __/__ __/__ __ __ __	3b. REF or Reason ____________3b.*sp.* 88☐ IL 99☐ NR	3c. Neurology Code	3d. Medication Given* 1☐ Yes 2☐ No 88☐ IL 99☐ NR	3e. Comments
4.	4a. Date: __ __/__ __/__ __ __ __	4b. REF or Reason ____________4b.*sp.* 88☐ IL 99☐ NR	4c. Neurology Code	4d. Medication Given* 1☐ Yes 2☐ No 88☐ IL 99☐ NR	4e. Comments

Study ID Number

S. SEIZURES

☐ No information for any item in section

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)*, 888 = Ilegible, 99 = Not Recorded

1. Date	1a. Time	1b. Describe episode *(check all that apply)*	1c. Witnessed by *(check all that apply)*
__ __/__ __/__ __ __ __	____ : ____	1b.1. 1☐ Clonic/convulsive 1b.2. 2☐ Tonic/posturing 1b.3. 3☐ Myoclonic 1b.4. 4☐ Subtle 1b.5. 8☐ Other *(specify):* ________1b.5.*sp.* 1b.6. 88☐ IL 1b.7. 99☐ NR	1c.1. 1☐ MD 1c.2. 2☐ RN 1c.3. 3☐ Parent 1c.4. 8☐ Other *(specify)* ________1c.4.*sp.* 1c.5. 88☐ IL 1c.6. 99☐ NR
1d. Proximate cause$_1$ ________1d.*sp.*		1e. Proximate cause$_2$ ________1e.*sp.*	
1f. Meds given in response to seizure *(specify in Section P)* 1☐ Yes 2☐ No 88☐ IL 99☐ NR		1g. Comments:	

2. Date	2a. Time	2b. Describe episode *(check all that apply)*	2c. Witnessed by *(check all that apply)*
__ __/__ __/__ __ __ __	____ : ____	1b.1. 1☐ Clonic/convulsive 1b.2. 2☐ Tonic/posturing 1b.3. 3☐ Myoclonic 1b.4. 4☐ Subtle 1b.5. 8☐ Other *(specify):* ________1b.5.*sp.* 1b.6. 88☐ IL 1b.7. 99☐ NR	1c.1. 1☐ MD 1c.2. 2☐ RN 1c.3. 3☐ Parent 1c.4. 8☐ Other *(specify)* ________1c.4.*sp.* 1c.5. 88☐ IL 1c.6. 99☐ NR
2d. Proximate cause$_1$ ________2d.*sp.*		2e. Proximate cause$_2$ ________2e.*sp.*	
2f. Meds given in response to seizure *(specify in Section P)* 1☐ Yes 2☐ No 88☐ IL 99☐ NR		2g. Comments:	

3. Date	3a. Time	3b. Describe episode *(check all that apply)*	3c. Witnessed by *(check all that apply)*
__ __/__ __/__ __ __ __	____ : ____	1b.1. 1☐ Clonic/convulsive 1b.2. 2☐ Tonic/posturing 1b.3. 3☐ Myoclonic 1b.4. 4☐ Subtle 1b.5. 8☐ Other *(specify):* ________1b.5.*sp.* 1b.6. 88☐ IL 1b.7. 99☐ NR	1c.1. 1☐ MD 1c.2. 2☐ RN 1c.3. 3☐ Parent 1c.4. 8☐ Other *(specify)* ________1c.4.*sp.* 1c.5. 88☐ IL 1c.6. 99☐ NR
3d. Proximate cause$_1$ ________3d.*sp.*		3e. Proximate cause$_2$ ________3e.*sp.*	
3f. Meds given in response to seizure *(specify in Section P)* 1☐ Yes 2☐ No 88☐ IL 99☐ NR		3g. Comments:	

Study ID Number [ ]

T. CRANIAL ULTRASOUNDS

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Please abstract all ultrasounds, unless the findings are clearly the same.

1. Date	1a. Results	Legend
__ __/__ __/__ __ __ __	1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	**Hemisphere (H):** 1=Right, 2=Left, 3=Bilateral, 88=Illegible, 99=Not Recorded **Location (L):** 1=Anterior/Frontal, 2=Posterior/Occipital, 3=Parietal, 4=Temporal, 88=Illegible, 99=Not Recorded **Size (S):** 1=Small/Mild, 2=Medium/Moderate, 3=Large/Severe, 88=Illegible, 99=Not Recorded

Findings: 1 = No, 2 = Definite, 3= Suspect, 77 = NA, 88 = IL, 99 = NR		H	L	S	Description/Comments
1b.	Ventriculomegaly	1b.1.	1b.2.	1b.3.	1b.4.
1c.	Echodensity/echogenicity	1c.1.	1c.2.	1c.3.	1c.4.
1d.	Echolucency	1d.1.	1d.2.	1d.3.	1d.4.
1e.	IVH grade (e.g. I I-IV) ____________	1e.1.	1e.2.	1e.3.	1e.4.
1f.	Germinal matrix bleed (Grade I IVH)	1f.1.	1f.2.	1f.3.	1f.4.
1g.	Other bleed	1g.1.	1g.2.	1g.3.	1g.4.
1h.	PVL/cavitation/white matter necrosis	1h.1.	1h.2.	1h.3.	1h.4.
1i.	Malformation	1i.1.	1i.2.	1i.3.	1i.4.
1j.	Subarachnoid hemorrhage/blood	1j.1.	1j.2.	1j.3.	1j.4.
1k.	Other findings, *(specify)* ________________________________1k.*sp.*	1k.1.	1k.2.	1k.3.	1k.4.

2. Date	2a. Results	Legend
__ __/__ __/__ __ __ __	1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	**Hemisphere (H):** 1=Right, 2=Left, 3=Bilateral, 88=Illegible, 99=Not Recorded **Location (L):** 1=Anterior/Frontal, 2=Posterior/Occipital, 3=Parietal, 4=Temporal, 88=Illegible, 99=Not Recorded **Size (S):** 1=Small/Mild, 2=Medium/Moderate, 3=Large/Severe, 88=Illegible, 99=Not Recorded

Findings: 1 = No, 2 = Definite, 3 = Suspect, 77 = NA, 88 = IL, 99 = NR		H	L	S	Description/Comments
2b.	Ventriculomegaly	2b.1.	2b.2.	2b.3.	2b.4.
2c.	Echodensity/echogenicity	2c.1.	2c.2.	2c.3.	2c.4.
2d.	Echolucency	2d.1.	2d.2.	2d.3.	2d.4.
2e.	IVH grade (e.g. I I-IV) ____________	2e.1.	2e.2.	2e.3.	2e.4.
2f.	Germinal matrix bleed (Grade I IVH)	2f.1.	2f.2.	2f.3.	2f.4.
2g.	Other bleed	2g.1.	2g.2.	2g.3.	2g.4.
2h.	PVL/cavitation/white matter necrosis	2h.1.	2h.2.	2h.3.	2h.4.
2i.	Malformation	2i.1.	2i.2.	2i.3.	2i.4.
2j.	Subarachnoid hemorrhage/blood	2j.1.	2j.2.	2j.3.	2j.4.
2k.	Other findings, *(specify)* ________________________________2k.*sp.*	2k.1.	2k.2.	2k.3.	2k.4.

Study ID Number

U. CRANIAL STUDIES (EEG, MRI AND CT SCAN)

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Please abstract all tests, unless the findings are clearly the same.

Code: 1 = EEG, 2 = Cranial MRI, 3 = CT scan, 8 = Other *(specify in comments)*, 88 = Illegible, 99 = Not Recorded

1. Date	1a. Code	1b. Results	1c. Final Impression *(specify)*	1d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________1c.*sp.*	
2. Date	2a. Code	2b. Results	2c. Final Impression *(specify)*	2d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________2c.*sp.*	
3. Date	3a. Code	3b. Results	3c. Final Impression *(specify)*	3d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________3c.*sp.*	
4. Date	4a. Code	4b. Results	4c. Final Impression *(specify)*	4d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________1c.*sp.*	
5. Date	5a. Code	5b. Results	5c. Final Impression *(specify)*	5d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________2c.*sp.*	
6. Date	6a. Code	6b. Results	6c. Final Impression *(specify)*	6d. Comments
__ __/__ __/__ __ __ __		1☐ Normal 2☐ Abnormal 3☐ Equivocal 88☐ IL 99☐ NR	______________________3c.*sp.*	

Study ID Number

V. OTHER PROCEDURE OR STUDY (ECG, CHEST X-RAY, GENETIC STUDY, LAB TEST, ETC.)

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

	REF/Reason	Type of Procedure	Date	Outcome
1.	1a.	1b.	1c. __/__/____	1d.
2.	2a.	2b.	2c. __/__/____	2d.
3.	3a.	3b.	3c. __/__/____	3d.
4.	4a.	4b.	4c. __/__/____	4d.
5.	5a.	5b.	5c. __/__/____	5d.
6.	6a.	6b.	6c. __/__/____	6d.
7.	7a.	7b.	7c. __/__/____	7d.
8.	8a.	8b.	8c. __/__/____	8d.
9.	9a.	9b.	9c. __/__/____	9d.
10.	10a.	10b.	10c. __/__/____	10d.
11.	11a.	11b.	11c. __/__/____	11d.
12.	12a.	12b.	12c. __/__/____	12d.
13.	13a.	13b.	13c. __/__/____	13d.
14.	14a.	14b.	14c. __/__/____	14d.

15. Comments:

Study ID Number [ ]

W. DISPOSITION AT FINAL DISCHARGE

☐ No information for any item in section
☐ Test/procedure for one or more items in section indicated but no information on dates, results, etc.

1. Date of DC	2. Head Circumference	3. Height/Length	4. Weight	5. Discharged to:
__ __/__ __/__ __ __ __	____ 1☐ in 2☐ cm 88☐ IL 99☐ NR	____ 1☐ in 2☐ cm 88☐ IL 99☐ NR	____ 1☐ Lbs 2☐ Kg 88☐ IL 99☐ NR	1☐ Home with biological parent(s) 2☐ Foster care 3☐ Adopted 4☐ Custodial care 8☐ Other *(specify)* ____________ 5.*sp.* 88☐ IL 99☐ NR

6. Medications at Discharge

1☐ Yes *(Fill out Section P)* 88☐ IL
2☐ No 99☐ NR

7. Documented Referrals *(check all that apply)* ☐ No information for any item in section

7a. ☐	Routine pediatrician appointment	7d. ☐	Home health nurse home visit(s)	7g. ☐	Ophthalmology follow-up
7b. ☐	Audiology follow-up	7e. ☐	High-risk infant follow-up clinic	7h. ☐	Public health home visit(s)
7c. ☐	Nutritional support 1☐ Breast 2☐ Formula 3☐ Combination 4☐ Tube 8☐ Other *(specify)* ____________ 7c.*sp.* 88☐ IL 99☐ NR	7f. ☐	Respiratory support 1☐ Oxygen 2☐ Respiratory support 3☐ Apnea monitor 8☐ Other *(specify)* ____________ 7f.*sp.* 88☐ IL 99☐ NR	7i. ☐	Home therapies *(specify)* ____________ 7i.*sp.*
				7j. ☐	Other *(specify)* ____________ 7j.*sp.*

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 88☐ IL 99☐ NR	