Enter on this form any infant who meets any of the following criteria:  1) Inborn, between 401 and 1000 g inclusive; 2) Inborn, between 20 0/7 and 28 6/7 wk inclusive and/or 3) enrolled in an NRN trial requiring GDB forms.

<table>
<thead>
<tr>
<th>Infant’s Name (Last, First)</th>
<th>Infant’s Hospital #</th>
<th>GDB Consent (Y/N/NA)</th>
<th>Date of Birth (Month/Day/Year)</th>
<th>Gestational Age (wks/days)</th>
<th>Birth Weight (Grams)</th>
<th>Network Number* (The last digit is always the pt’s birth number)</th>
<th>Enrolled in NRN Study Y/N</th>
<th>Comments</th>
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</tbody>
</table>

*For instruction on creating the Network Number see MOP page 3-2, section 3.1.2
A. MATERNAL INFORMATION

1. Mother's age (years): ___ ___
2. Pregnancy history (include this pregnancy):
   a. Gravidity: ___ ___
   b. Parity: ___ ___
3. Marital Status: ___
   1 = Married   2 = Single   6 = Unknown
4. Highest level of education achieved by the Biological Mother: ___
   1 = 8th grade or less   5 = Partial college or Associate’s degree
   2 = 9th to 12th grade   6 = College degree
   3 = High School diploma   7 = Graduate degree
   4 = Trade or Technical School   8 = Unknown
5. Mother's medical insurance: ___ ___ ___ ___
   10 = Public Insurance   5 = Self-pay/uninsured
   5 = Private   6 = Unknown   9 = Other
6. Mother's ethnic categories: ___
   1 = Hispanic or Latino   2 = Not Hispanic or Latino
   3 = Unknown or Not Reported
7. Mother's racial categories: ___
   1 = Black   4 = Asian
   2 = White   5 = Native Hawaiian or Other Pacific Islander
   3 = American Indian or Alaskan Native   6 = More than One Race
   7 = Unknown or Not Reported
8. Mother’s height ___ in ___ cm
9. Mother’s weight prior to pregnancy or during the first trimester ___ ___ lb ___ ___ ___ kg
10. Mother’s weight at delivery ___ ___ lb ___ ___ ___ kg

B. PREGNANCY COMPLICATIONS

1. Multiple birth? Y N
   If YES,
   a. Number of fetuses: ___
2. Is there evidence of prenatal health care in this pregnancy? ___
3. Was fetal ultrasound dating obtained during pregnancy? Y N
   a. If yes, gestational age determined from first ultrasound: Weeks: ___ ___ Days: ___
   b. If gestational age at ultrasound unknown, was ultrasound obtained during the first trimester? Y N
4. Diabetes prior to pregnancy? Y N
   If YES,
   a. Type of diabetes? 1 = Type 1   2 = Type 2   3 = Unknown
5. Gestational diabetes (diagnosed during the pregnancy)? Y N
   If YES,
   a. Treatment given ___
6. Hypertension? Y N
   If YES,
   a. Hypertension existed prior to pregnancy? Y N
7. Antepartum hemorrhage? Y N
8. Was chorioamnionitis documented in the mother’s medical record? Y N
9. Was placental pathology performed? Y N
   If YES,
   a. Was histologic chorioamnionitis documented? Y N
   b. Was acute funisitis documented? Y N

C. LABOR AND DELIVERY

1. Date and time of mother’s admission to hospital for this delivery:
   a. Date __ __/__ __/__ __ __ __ Month   Day   Year
   b. Time: __ __: __ __ Hour   Min
2. Was there rupture of membranes (ROM) prior to delivery? Y N
   If YES,
   a. Date: __ __/__ __/__ __ __ __ Month   Day   Year
   b. Time: __ __: __ __ Hour   Min
   c. If date and/or time unknown, was ROM estimated at >18 hours? Y N
3. Were antenatal steroids given to accelerate fetal maturity? Y N
   If YES,
a. Type of antenatal steroid given: __

1 = Betamethasone 2 = Dexamethasone 3 = Both 4 = Unknown

b. Was a complete course of antenatal steroids given? Y N Unk

c. Was more than one course of antenatal steroids given? Y N Unk

d. When was the last dose of antenatal steroids given?
   i. Date __ __/__ __/__ __ __ __ Month Day Year
   ii. Time: __ __: __ __ Hour Min

4. Were maternal antibiotics given within 72 hours prior to birth? Y N Unk

   If YES,
   a. List antibiotics given: (See Code Sheet in Appendix B)
      1. ___ 3. ___ 5. ___
      2. ___ 4. ___ 6. ___

5. Was magnesium sulfate given during this admission prior to delivery? Y N Unk

6. Was there documentation of electronic fetal heart rate monitoring within 12 hours prior to birth? Y N Unk

7. Final mode of delivery: __

1 = Vaginal vertex 2 = Vaginal breech 3 = Cesarean section 5 = Unknown

D. NEONATAL INFORMATION

1. Date and time of birth:
   a. Date: __ __/__ __/__ __ __ __ Month Day Year
   b. Time: __ __: __ __ Hour Min

2. Was the infant outborn? Y N

   If YES,
   a. Date admitted to NICU: __ __/__ __/__ __ __ __ Month Day Year

3. Was a prenatal diagnosis made that influenced the decision to withdraw or limit intensive care? Y N

   If YES,
   a. Diagnosis: __ __ __ __ ; __ __ __ __ ; __ __ __ __ ; __ __ __ __ ; __ __ __ __
      i. If ‘Other’ specify: ________________________________________

4. Did the infant die ≤ 12 hours after birth? Y N

5. Sex:

   1 = Male 2 = Female 3 = Ambiguous

6. Gestational age: Weeks _____ Days ___

   a. Method used to determine reported gestational age: __

   1 = Obstetric Estimate 2 = Neonatal Estimate

7. Apgar score - 1 minute: ___ ___

8. Apgar score - 5 minutes: ___ ___

9. Birth resuscitation/stabilization
   a. Oxygen? Y N
   b. Positive pressure ventilation? Y N
   c. CPAP? Y N
   d. Intubation? Y N
   e. Chest compression? Y N
   f. Epinephrine? Y N

10. Is there documentation of delayed cord clamping? Y N

11. Is there documentation of cord milking? Y N

12. Birth weight (grams): __ __ __ __

13. Length (cm): ___ ___

14. Head circumference (cm): ___ ___

15. Was any thermal product used to improve temperature regulation? Y N Unk

16. Record infant’s first temperature documented after admission to nursery

   a. Celsius: ___ ___
   b. Fahrenheit: ___ ___

   c. Date: __ __/__ __/__ __ __ __ Month Day Year
   d. Time: __ __: __ __ Hour Min

   e. Source: __________

   1 = Rectal 2 = Axillary 3 = Skin

Initials of person completing form: __ __
A. STATUS
1. Status of infant at time of completion of form:
   1 = Discharged to home   3 = Transferred to another facility
   2 = Still in hospital at 120 days   5 = Death

2. Date of status: ___ / ___ / ___ ___ Year

3. Weight at status (grams): ___ ___ ___ ___

4. Length at status (cm): ___ ___ ___.

5. Head circumference at status (cm): ___ ___ ___.

B. PULMONARY
1. Did the baby receive surfactant? Y N
   If YES,
   a. Date of first dose: ___ / ___ / ___ ___ Year
   b. Time of first dose: ___ ___ ___ Hour ___ Min ___
   c. Was first dose given in the delivery room? Y N
   d. Type of surfactant given:
      1 = Beractant (Survanta) 2 = Poractant alfa (Curosurf) 3 = Calfactant (Infasurf) 9 = Other

   e. Was the surfactant mixed with budesonide? Y N T
   f. Method of administration:
      1 = ETT 2 = LISA/MIST 3 = Aerosolized 4 = LMA 9 = Other

2. Pneumothorax? Y N
3. PIE? Y N
4. Pulmonary hemorrhage? Y N
5. Steroids for BPD/CLD? Y N T
   a. If YES or Trial, Date of first dose: ___ / ___ / ___ ___ Year
   b. Type:
      2 = Dexamethasone 6 = Hydrocortisone 9 = Other

6. Did infant receive inhaled nitric oxide? Y N T
   a. If YES or Trial, Date of first exposure: ___ / ___ / ___ ___ Year

7. Did the infant receive vitamin A? Y N T

C. CARDIOVASCULAR
1. Patent ductus arteriosus (PDA)? Y N
   If YES, treatment:
   a. Indomethacin Y N T
   b. Ibuprofen Y N T
   c. Acetaminophen? Y N
   d. Cardiac catheterization for PDA closure? Y N
   e. Surgery? Y N
   f. Other? Y N
   If YES, specify ______________________________

2. Was the infant treated for hypotension in the first 24 hrs of life? Y N

D. NEUROLOGY
1. Was indomethacin given within the first 24 hours of life? Y N T
2. Were seizures treated with an anticonvulsant for >72 hours? Y N T
3. Were seizures confirmed by EEG? Y N
4. Were any cranial sonograms done within 28 days of birth? Y N
   If NO, Go to Question D6
   a. If YES, are all studies without evidence of intracranial hemorrhage, periventricular leukomalacia or ventriculomegaly? Y N
   If YES, Go to Question D6, If NO, continue with question 4.b
   b. Date of sonogram with most severe findings: ___ / ___ / ___ ___ Year
      (1) RIGHT  (2) LEFT
   c. Blood/echodensity in germinal matrix/subependymal area? Y N
   d. Blood/echodensity in the ventricle? Y N Y N
   e. Ventricular size enlarged with concurrent or prior blood in the ventricles? Y N Y N
   f. Ventricular size enlarged without concurrent or prior blood in the ventricles? Y N Y N
   g. Blood/echodensity in the parenchyma? Y N Y N
   If YES,
   1. Midline shift Y N
   h. Blood/echodensity in the basal ganglia or the thalamus? Y N
   i. Cerebellar hemorrhage? Y N
5. Cystic area(s) in the parenchyma within 28 days? Y N
### E. Infection

1. Early onset sepsis/episode of bacteremia (<72 hours)?
   - If YES, complete organism code(s)
     - (a) 
     - (b) 

2. Did the infant receive antibiotics for ≥ 5 days, starting within the first 72 hours?
   - Y N

3. Number of episodes of late onset blood culture negative clinical infection (>72 hours to status) treated with antibiotics for ≥ 5 days:

4. Late onset blood culture positive sepsis/episode of bacteremia (>72 hours)?
   - If YES, organism code(s) and date of first blood positive culture for each episode for which the infant was treated with antibiotics for ≥ 5 days:
   - (a) Episode
   - (b) Date
   - (c1) Organism
   - (c2) Organism
   - (c3) Organism
   - (d) CLABSI?

5. Did the infant have an LP as part of a sepsis evaluation (not for hydrocephalus)?
   - (f), if GS is Other, specify (g)

### (c) WBC

### (d) RBC

### (e) GS

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Organism</th>
<th>Other, specify</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>*Gram Stain (GS) codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Not Done</td>
</tr>
<tr>
<td>2 = Negative</td>
</tr>
<tr>
<td>3 = Gram Positive</td>
</tr>
<tr>
<td>4 = Gram Negative</td>
</tr>
<tr>
<td>5 = Yeast</td>
</tr>
<tr>
<td>6 = Other (Specify)</td>
</tr>
</tbody>
</table>

6. Meningitis?
   - If YES, Y N
BN

(a) Episode # (b) Date (1) Organism (2) Organism (3) Organism
1 ____/__/______ __________ __________ __________
2 ____/__/______ __________ __________ __________

7. Was the infant diagnosed with any of the following other proven infections? Y N
   If YES,
   (a) Diagnosis # (b) Date of Diagnosis (1) Diagnosis Code
   1 ____/__/______ __________ __________
   2 ____/__/______ __________ __________
   3 ____/__/______ __________ __________
   4 ____/__/______ __________ __________
   5 ____/__/______ __________ __________

1 = Neonatal herpes 4 = Congenital syphilis
2 = Congenital CMV (diagnosed ≤ 3 weeks old) 5 = Congenital toxoplasmosis
3 = Acquired CMV (diagnosed > 3 weeks old) 6 = HIV infection

F. GASTROINTESTINAL
1. Total days of parenteral nutrition: __________
2. Did the baby receive enteral feeds? Y N
   If YES,
   a. Date of first enteral feed: Month Day Year
   Y N
   b. Did enteral feeds reach 120 ml/kg/day?
   1. If YES, date first achieved:
      Month Day Year
   Y N
   c. Type of human milk infant received in the first 28 days?
      1 = Maternal 2 = Donor 3 = Trial 4 = None
   Y N T
   d. Did the infant receive probiotics in the first 28 days?
   Y N T
3. Proven NEC: [0 = Absent/Suspect 1 = Proven, no surgery 2 = Proven, surgery 3 = Proven, autopsy 4 = Proven, autopsy]
a. If proven NEC, date of first episode:
   Month Day Year
   Y N
4. Spontaneous gastrointestinal perforation without proven NEC?
   a. If YES, date of the first spontaneous GI perforation:
      Month Day Year
      Y N
5. Did the infant have GI surgery that resulted in short gut?

G. HEARING
1. Was a hearing screen performed prior to status? Y N
   If YES,
   a. Was otoacoustic emissions (OAE) testing performed? Y N
   b. Was automated auditory brainstem response (AABR) performed? Y N
      1. Was AABR failed? Y N
         If YES,
         a. Unilateral or bilateral fail?
      1 = Unilateral 2 = Bilateral
   c. Was diagnostic auditory brainstem response (ABR) performed prior to status? Y N
      If YES,
      a. Was hearing loss documented? Y N
         If YES,
         1. Unilateral or bilateral hearing loss?
            1 = Unilateral 2 = Bilateral

H. OPHTHALMOLOGY
1. Was an exam performed for ROP? Y N
   (if NO, no other questions are required in this section)
   If YES,
   a. Was ROP diagnosed in either eye? Y N
      If YES,
      1) Did ROP reach stage 3 or worse in either eye? Y N
      2) Did plus disease develop in either eye? Y N
      3) Did infant have stage 1 or stage 2 ROP diagnosed in Zone 1? Y N
   b. Intervention therapies:
      1. Was retinal ablation performed in either eye (laser and/or cryotherapy)? Y N
      2. Was scleral buckle or vitrectomy performed in either eye? Y N
      3. Avastin or other anti-VEGF drug Y N T
      4. Other therapies
         (if yes, specify): ____________________________ Y N
Neonatal Research Network

GENERIC DATABASE (GDB)

CLINICAL OUTCOME FORM (NG03)

January 1, 2016
Revised February 3, 20

Mother’s Initials (optional): __ __

BN

Page 4 of 5

c. At the time of reaching status, indicate the most appropriate:

1 = Determined, favorable in both eyes
2 = Determined, severe ROP in either eye
3 = Undetermined ROP status in either eye (and neither had “severe ROP”)

1. Determined Favorable:
• Mature vessels (fully vascularized)
• Immature vessels in zone III for two consecutive exams
• ROP of stage 1 or 2 in zone III for two consecutive exams
• ROP in zone II or zone III but determined to be clearly regressing

2. Determined-Severe:
• ROP surgery
• Retinal detachment
• Avastin injection or anti-VEGF

1. If “3 = Undetermined” code reason:

3. Undetermined:
1. Immature vessels in zone I and II
2. Immature vessels reaching zone III for only 1 exam
3. Stage 1 or 2 ROP in zone III for only 1 exam
4. Stage 3 ROP in zone III
5. ROP in zone I or zone II
6. Plus disease

1. Blood Type

1 = A  2 = B  3 = AB  4 = O  5 = Unk
a. Rh (Rhesus) factor

1 = Positive  2 = Negative  3 = Unknown

b. Was the infant transfused with pRBC?

Y  N

If YES,

a. Date of first pRBC transfusion

Month / Day / Year

b. Lowest hemoglobin OR hematocrit prior to first transfusion __ __ __ (g/dL) __ __ __ %

3. Was the infant transfused with other blood products?

a. Fresh Frozen Plasma

Y  N

b. Platelets

Y  N

4. Highest total serum bilirubin in first 14 days (mg/dL)

5. Last hemoglobin or hematocrit before discharge.

6. Did the infant receive erythropoietin or another erythropoiesis stimulating agent?

Y  N  T

J. SYNDROMES AND/OR MALFORMATIONS

1. Syndromes and/or major malformations?

a. If YES, code:

1) = ________  2) = ________  3) = ________
4) = ________  5) = ________  6) = ________

b. If a syndrome is coded as ‘Other’, specify:_________________________________________________

K. SURGERIES

1. Did the infant have surgery?

a. If YES, code:

i. Date (mm/dd/yyyy)

ii. Surgery code(s)

iii. Surgical Site Infection?

Y  N  Unk

b. If a surgery is coded as ‘Other’, specify:______________________________________________

L. 36 WEEK INFORMATION

1. Status at 36 weeks:

1 = Discharged  2 = In hospital  3 = Transferred  5 = Death

If “2”, (In hospital):

a. Date of 36 weeks measurement:

Month / Day / Year

b. Weight (g)

Y  N

c. Length (cm):

Y  N

d. Head circumference (cm):

Y  N
M. ETHICS/PALLIATIVE CARE

1. At any time after birth (prior to NG03 Status), was there documentation of discussion with parents to limit, withdraw or not escalate care? Y N

2. Were the following treatments withheld, limited or withdrawn at any time with the intent to limit care?
   a. Intubation/ventilation Y N
   b. Nutrition/hydration Y N
   c. Medication Y N

N. TRANSFER

Complete this section if status (Q.A1) of infant at time of completion of this form is "3" (transferred).

1. Date of transfer: __ __ / __ __ / __ __ __ __ Month Day Year

2. Final outcome: __ __
   1 = Died in hospital
   2 = Discharged to home
   6 = Remains in hospital at one year

O. DISCHARGE ALIVE

Complete this section if status (Q.A1) of infant at time of completion of this form is "1" (d/c to home).

1. Date of discharge to home: __ __ / __ __ / __ __ __ __ Month Day Year

2. Discharged home on continuous oxygen? Y N

3. Discharged home on any of the following medications? Y N

   If YES,
   a. Diuretics? Y N T
   b. Bronchodilators? Y N T
   c. Anticonvulsants? Y N T
   d. Antireflux medications? Y N T
   e. Antihypertensive medications? Y N T
   f. Methyloxanthines? Y N T
   g. Other? Y N T

   If YES or Trial specify ____________________________

4. Discharged home receiving any human milk? Y N T

   a. If YES, type of milk
      1 = Maternal Milk
      2 = Donor Milk
      3 = Both
      4 = Unknown

P. DEATH

Complete this section if status of infant at time of completion of this form is 'Death' (Status Code = 5) or if the final outcome for a transferred infant is 'Died in hospital.' Include additional information about death that becomes available after status is reached prior to the follow-up visit.

1. Date of death: __ __ / __ __ / __ __ __ __ Month Day Year

2. Autopsy performed? Y N

3. Contributory cause of death

<table>
<thead>
<tr>
<th>Malformation</th>
<th>Pulmonary</th>
<th>CNS Insult</th>
<th>Renal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 = Congenital malformation</td>
<td>20 = RDS</td>
<td>50 = Severe intracranial hemorrhage</td>
<td>70 = Renal failure</td>
<td>60 = Immaturity without active neonatal treatment</td>
</tr>
<tr>
<td>40 = NEC</td>
<td>51 = Severe intracranial hemorrhage with infection</td>
<td>30 = Suspect sepsis/infection</td>
<td>90 = Other</td>
<td>99 = Unknown</td>
</tr>
<tr>
<td>41 = NEC with sepsis</td>
<td>60 = NEC with severe intracranial hemorrhage</td>
<td>31 = Proven sepsis/infection</td>
<td>99 = Unknown</td>
<td></td>
</tr>
<tr>
<td>42 = Spontaneous perforation</td>
<td>70 = Renal failure</td>
<td>32 = PPHN</td>
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<tr>
<td>43 = Short bowel syndrome</td>
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<tr>
<td>44 = Liver failure</td>
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<tr>
<td>50 = Severe intracranial hemorrhage</td>
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<tr>
<td>21 = RDS with severe intracranial hemorrhage</td>
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<tr>
<td>22 = RDS with infection</td>
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<tr>
<td>23 = RDS with massive pulmonary hemorrhage</td>
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<tr>
<td>24 = BPD</td>
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<tr>
<td>25 = BPD with infection</td>
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<tr>
<td>26 = BPD with infection</td>
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<tr>
<td>27 = BPD with severe CNS insult</td>
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<tr>
<td>28 = PPHN</td>
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</tbody>
</table>

4. If contributory cause of death is code "10" (Congenital malformation), or code "90" (other), specify:__________________________________________

Initials of person completing this form: __ __ __
To be completed if the infant died at ≤ 12 hours of age.

1. Medical therapy initiated:
   a. Antibiotics? Y N
   b. Surfactant replacement therapy? Y N
   c. Pressor support? Y N
   d. Volume support? Y N
   e. Intubation and Ventilation? Y N
   f. IV fluids? Y N

2. Autopsy performed? Y N

3. At any time after birth (prior to NG03E Status), was there documentation of discussion with parents to limit, withdraw or not escalate care? Y N

4. Were the following treatments withheld, limited or withdrawn at any time with the intent to limit care?
   a. Intubation/ventilation Y N
   b. Nutrition/hydration Y N
   c. Medication Y N

5. No intention to resuscitate (comfort care only) Y N

6. Contributory cause of death:

<table>
<thead>
<tr>
<th>Malformation</th>
<th>CNS Insult</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 = Congenital malformation</td>
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<td>60 = Immaturity without active neonatal treatment</td>
<td>90 = Other</td>
</tr>
<tr>
<td>99 = Unknown</td>
<td>99 = Unknown</td>
</tr>
</tbody>
</table>

7. If contributory cause of death is code “10” (Congenital malformation) or code “90” (other), specify:

   __________________________________________________________

   Initials of person completing this form: __ __ __
This form is to be used for infants who are in this hospital for greater than 120 days. Form NG03 should be completed through day 120. This form should be completed after the infant dies, is discharged, is transferred or reaches one year post-natal age.

A. STATUS

1. Status of infant at time of completion of form
   1 = Discharged to home  5 = Death
   3 = Transferred to another facility  6 = Remains in hospital at one year

2. Date of status: __ __ / __ __ / __ __ __ __

3. Weight at status (grams): __ __ __ __

4. Length at status (cm): __ __ __ __

5. Head circumference at status (cm): __ __ __ __

B. EXTENDED STAY INFORMATION

1. What problem(s) caused hospitalization greater than 120 days:
   (answer all that apply)
   a. Pulmonary? Y N
   b. Cardiac? Y N
   c. Neurologic? Y N
   d. Gastrointestinal? Y N
   e. Multiple Malformations? Y N
   f. Social? Y N
   g. Ophthalmologic? Y N
   h. Sepsis/infection? Y N
   i. Renal? Y N
   j. Other? Y N

   1) If YES, specify: ________________________________

2. Did either eye receive therapy for ROP after 120 days? Y N T
   If YES or Trial, a. List all therapies done for either eye (Use codes below).
   1= Laser  3= Scleral buckle  5 = Avastin or anti-VEGF
   2= Cryotherapy  4= Vitrectomy  6= Other (specify) for either eye

3. Was a hearing screen performed after 120 days? Y N
   If YES, a. Was otoacoustic emissions (OAE) testing performed? Y N
      1. Was OAE failed? Y N
         i. Unilateral or bilateral fail? Y N
            1 = Unilateral  2 = Bilateral
      b. Was automated auditory brainstem response (AABR) performed?
         1. Was AABR failed? Y N
            i. Unilateral or bilateral fail? Y N
               1 = Unilateral  2 = Bilateral

4. Was a diagnostic auditory brainstem response (ABR) performed prior to discharge?
   If YES,
   a. Was hearing loss documented? Y N Unk
      If YES,
      1. Unilateral or bilateral hearing loss?
         1 = Unilateral  2 = Bilateral
C. ETHICS/PALLIATIVE CARE
1. Was there documentation of discussion with parents to limit, withdraw or not escalate care after 120 days? 
   Y N
2. Were the following treatments withheld, limited or withdrawn after 120 days with the intent to limit care?
   a. Intubation/ventilation Y N
   b. Nutrition/Hydration Y N
   c. Medication Y N

D. TRANSFER
Complete this section if status of infant is ‘3=Transferred to another facility’
1. Date of transfer: ___ ___ / ___ ___ / ___ ___ ___ ___
   Month Day Year
2. Final outcome:
   1 = Died in hospital  2 = Discharged to home  3 = Remains in hospital at one year

E. DISCHARGE ALIVE
Complete this section if status of infant at time of completion of this form is ‘1= Discharged to home’
1. Date of discharge to home: ___ ___ / ___ ___ / ___ ___ ___ ___
   Month Day Year
2. Discharged home on continuous oxygen? Y N
3. Discharged home on any of the following medications?
   If YES,
   a. Diuretics? Y N T
   b. Bronchodilators? Y N T
   c. Anticonvulsants? Y N T
   d. Antireflux medications? Y N T
   e. Antihypertensive medications? Y N T
   f. Methylxanthines? Y N T
   g. Other, specify ____________________________ Y N T

4. Discharged home receiving any human milk? Y N Unk
   a. If YES, type of milk
      1 = Maternal Milk  2 = Donor Milk  3 = Both  4 = Unknown

F. DEATH
Complete this section if status of infant is ‘5=Death’
1. Date of death: ___ ___ / ___ ___ / ___ ___ ___ ___
   Month Day Year
2. Autopsy performed? Y N
3. Contributory Cause of death:
   ____________________________________________
   GI
   40 = NEC
   41 = NEC with sepsis
   42 = Spontaneous perforation
   Malformation
   10 = Congenital malformation
   43 = Short bowel syndrome
   44 = Liver failure
   Pulmonary
   25 = BPD
   70 = Renal failure
   26 = BPD with infection
   27 = BPD with severe CNS insult
   28 = PPHN - Pulmonary
   CNS Insult
   50 = Severe intracranial hemorrhage
   51 = Severe intracranial hemorrhage with infection
   Infection
   30 = Suspect sepsis/infection
   31 = Proven sepsis/infection
   Other
   90 = Other
   99 = Unknown
4. If cause of death is code “10” (Congenital malformation), or code “90” (Other) specify:
   ____________________________________________
   Initials of person completing this form: ___ ___ ___
A. RESPIRATORY SUPPORT

<table>
<thead>
<tr>
<th>A. RESPIRATORY SUPPORT</th>
<th>Snapshot @ 24 Hours</th>
<th>Day 3</th>
<th>Day 7</th>
<th>Day 14</th>
<th>Day 28</th>
<th>36 Weeks</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number days on HFV</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>2. Number days on CV</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>3. Number of days on nasal ventilation</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>4. Number days on CPAP</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>5. Number of days on supplemental O₂</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>6. Highest FiO₂ on day</td>
<td>__ __ __ __ __ __ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>7. Highest mode of support on day*</td>
<td>__ __ __ __ __ __ __</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
<tr>
<td>8. If mode ‘5’, record Flow Rate</td>
<td>__ __ __ __ __ __ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __</td>
<td>__ __ __</td>
<td>__ __ __</td>
</tr>
</tbody>
</table>

*Code Highest mode of support on day
1 = HFV 2 = CV 3 = Nasal ventilation 4 = CPAP 5 = NC 6 = Hood 7 = No Support 8 = Temporarily out of unit

If Section ‘A’ 36 weeks’ question 7 is answered with mode = 5 or 6, evaluate infant for physiologic challenge eligibility in section B. If not, form is complete.

B. Physiologic Challenge Eligibility

1. Is infant enrolled in the PDA Trial or the BiB Trial? Y N

If NO, infant is not eligible and form is complete.

If YES,

a. Weight on day of 36 weeks (grams) __ __ __ __ __ __

b. Is infant eligible for a physiologic challenge* (see below)? Y N

Infants eligible to have a physiologic challenge performed must meet one of the following:
- Effective oxygen <27% AND majority of saturations ≥90%
- Effective oxygen 27%-30% AND majority of saturations ≥96%
- Room air by nasal cannula

c. Was the physiologic challenge performed? Y N

If YES,

1. Date of challenge (mm/dd/yyyy) __ __ __/ __ __ __/ __ __ __

2. Did infant pass challenge? Y N

If NO, (physiologic challenge was not performed)

3. Reason not performed (use codes below) __ __ __

<table>
<thead>
<tr>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Increased FiO2</td>
</tr>
<tr>
<td>2 = Increased respiratory support (CPAP or vent)</td>
</tr>
<tr>
<td>3 = Instability (including surgery/sepsis)</td>
</tr>
<tr>
<td>4 = Parent/physician refusal</td>
</tr>
<tr>
<td>6 = Weaned to room air on/before day of evaluation/challenge</td>
</tr>
</tbody>
</table>
| 9 = Other- explain __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __.__
Complete this form for all infants from time of birth until NG03 Status is reached.

A. MATERNAL INFORMATION

1. Was the mother tested for active SARS-CoV-2 infection? Y N Unk

If YES,

<table>
<thead>
<tr>
<th>Test Number</th>
<th>Test Result</th>
<th>Reason(s) for Testing</th>
<th>Date of Test</th>
<th>Testing Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>3</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

(b) Test Result Codes
1 = Positive 2 = Negative 3 = Inconclusive

(c) Reason for Testing Codes:
1 = Symptomatic 2 = Exposure 3 = Other

(e) Testing Time Period
1 = During pregnancy 2 = At delivery 3 = Postpartum

2. Was the mother tested for SARS-CoV-2 antibodies? Y N Unk

If YES,

<table>
<thead>
<tr>
<th>Test Number</th>
<th>Test Result</th>
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<th>Testing Time Period</th>
</tr>
</thead>
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<td>1</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) Test Result Codes
1 = Positive 2 = Negative 3 = Inconclusive

(c) Type of Test
1 = Molecular assay (e.g. PCR) or antigen detection 2 = Serology: IgM

(e) Reason(s) for Testing Codes:
1 = Mother suspected or has COVID-19 2 = Infant exposed to someone besides mother 3 = Infant has clinical signs consistent with infection

(d) Sample Site(s)
1 = Nasopharynx 2 = Oropharynx (throat) 3 = Stool/rectum 4 = Tracheal aspirate 5 = Serum/blood 6 = Other (name site) ________

*Code all that apply.

B. INFANT INFORMATION

1. Was the infant tested for active SARS-CoV-2 infection? Y N Unk

If YES,

<table>
<thead>
<tr>
<th>Test #</th>
<th>Test Result</th>
<th>Type of Test</th>
<th>Date of Test</th>
<th>Reason(s) for Testing</th>
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1 = Nasopharynx 2 = Oropharynx (throat) 3 = Stool/rectum 4 = Tracheal aspirate 5 = Serum/blood 6 = Other (name site) ________

*Code all that apply.

Initials of person completing form: __ __ __
### A. MATERNAL INFORMATION

1. Was the mother tested for active SARS-CoV-2 infection?

<table>
<thead>
<tr>
<th>(a) Test Number</th>
<th>(b) Test Result</th>
<th>(c) Reason(s) for Testing</th>
<th>(d) Date of Test</th>
<th>(e) Testing Time Period</th>
</tr>
</thead>
<tbody>
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<td>Unk</td>
</tr>
</tbody>
</table>

2. Was the mother tested for SARS-CoV-2 antibodies?

If YES,

<table>
<thead>
<tr>
<th>(a) Test Number</th>
<th>(b) Test Result</th>
<th>(c) Date of Test</th>
<th>(d) Testing Time Period</th>
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</thead>
<tbody>
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<td>Unk</td>
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</table>

### B. INFANT INFORMATION

1. Was the infant tested for active SARS-CoV-2 infection?

<table>
<thead>
<tr>
<th>(a) Test #</th>
<th>(b) Test Result</th>
<th>(c) Type of Test</th>
<th>(d) Date of Test</th>
<th>(e) Reason(s) for Testing*</th>
<th>(f) Sample Site(s)*</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Center:</td>
<td>Site:</td>
<td>Network No:</td>
<td>Mother’s Initials (optional):</td>
<td></td>
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Page __ of __