Neonatal Research Network	**GENERIC DATABASE (GDB)** SCREENING LOG **(NG01)**	**NG01 vs 5.0** **January 1, 2016**
Center: __ __ Site: __		Page__ of __

Enter on this form any infant who meets any of the following criteria: 1) Inborn, between 401 and 1000 g inclusive; 2) Inborn, between 22 0/7 and 28 6/7 wk inclusive and/or 3) enrolled in an NRN trial requiring GDB forms.

***************** Not Keyed in DMS *****************								
Infant's Name (Last, First)	Infant's Hospital #	GDB Consent (Y/N/NA)	Date of Birth (Month/Day/Year)	Gestational Age (wks/days)	Birth Weight (Grams)	Network Number* (The last digit is always the pt's birth number)	Enrolled in NRN Study Y/N	Comments
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ (Birth#)	___	

***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	
3 = 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 __ __ __ 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? ____

1= No	2 = Limited	3 = Adequate

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 Unk
4. Diabetes prior to pregnancy? Y N

   If YES,

   a. Type of diabetes? ____

1 = Type 1	2 = Type 2	3 = Unknown

   b. Treatment given ____

1 = Insulin	2 = Oral hypoglycemic medication	3 = Diet only	4 = None/Unknown

5. Gestational diabetes (diagnosed during the pregnancy)? Y N Unk

   If YES,

   a. Treatment given ____

1 = Insulin	2 = Oral hypoglycemic medication	3 = Diet only	4 = None/Unknown

6. Hypertension? Y N

   If YES,

   a. Hypertension existed prior to pregnancy? Y N Unk
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 Unk

   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 Unk
3. Were antenatal steroids given to accelerate fetal maturity? Y N Unk

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: __ __ / __ __ / __ __ __ __ (Month Day 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: __ __/__ __/__ __ __ __ (Month Day Year)
b. Time of first dose: __ __: __ __ (Hour Min)
c. Was first dose given in the delivery room? Y N

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: __ __ / __ __ / __ __ __ __ (Month Day 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: __ __ / __ __ / __ __ __ __ (Month Day 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: __ __ / __ __ / __ __ __ __ (Month Day Year)
   c. Blood/echodensity in germinal matrix/subependymal area? Y N

	(1) RIGHT		(2)LEFT	
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

   If YES,

	(1) RIGHT		(2)LEFT	
a. Cystic periventricular leukomalacia within 28 days?	Y	N	Y	N
b. Porencephalic cyst within 28 days?	Y	N	Y	N

6. Were any cranial imaging studies done after day 28? Y N

   If NO, Go to Section E.

7. Was a sonogram performed after day 28? Y N

If YES, record information for the sonogram closest to 36 weeks postmenstrual age

a. Date of image: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

b. Normal study? Y N

If NO,

	(1) RIGHT		(2) LEFT	
c. Ventricular size enlarged?	Y	N	Y	N
d. Cystic periventricular leukomalacia?	Y	N	Y	N
e. Porencephalic cyst?	Y	N	Y	N

8. Was an MRI performed after day 28? Y N

If YES, record information for the MRI closest to 36 weeks postmenstrual age

a. Date of image: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

b. Normal study? Y N

If NO,

	(1) RIGHT		(2) LEFT	
c. Ventricular size enlarged?	Y	N	Y	N
d. Cystic periventricular leukomalacia?	Y	N	Y	N
e. Porencephalic/posthemorrhagic cyst/multicystic encephalomalacia?	Y	N	Y	N

9. Was a CT scan performed after day 28? Y N

If YES, record information for the CT scan closest to 36 weeks postmenstrual age

a. Date of image: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

b. Normal study? Y N

If NO,

	(1) RIGHT		(2) LEFT	
c. Ventricular size enlarged?	Y	N	Y	N
d. Cystic periventricular leukomalacia?	Y	N	Y	N
e. Porencephalic/posthemorrhagic cyst/multicystic encephalomalacia?	Y	N	Y	N

E. INFECTION

1. Early onset septicemia/bacteremia (≤ 72 hours)? Y N

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 culture positive septicemia/bacteremia (>72 hours)? Y N

If YES, Organism code(s) and date of first 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?
1	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N
2	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N
3	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N
4	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N
5	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N
6	__ __ /__ __ /__ __ __ __	__ __ __	__ __ __	__ __ __	Y N

5. Did the infant have an LP as part of a sepsis evaluation (not for hydrocephalus)? Y N

If YES, (a) LP #	(b) Date	(c) WBC (mm^3)	(d) RBC (mm^3)	(e) GS*	(f), if GS is Other, specify
1	__ __ /__ __ /__ __ __ __	__ __ __ __ __ __	__ __ __ __ __ __	__	_____
2	__ __ /__ __ /__ __ __ __	__ __ __ __ __ __	__ __ __ __ __ __	__	_____
3	__ __ /__ __ /__ __ __ __	__ __ __ __ __ __	__ __ __ __ __ __	__	_____
4	__ __ /__ __ /__ __ __ __	__ __ __ __ __ __	__ __ __ __ __ __	__	_____
5	__ __ /__ __ /__ __ __ __	__ __ __ __ __ __	__ __ __ __ __ __	__	_____

**Gram Stain (GS) codes:*

1 = Not Done	3 = Gram Positive	5 = Yeast
2 = Negative	4 = Gram Negative	6 = Other (Specify)

6. Meningitis? Y N

If YES,

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

7. Was the infant diagnosed with any other proven infection? 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
	7=Other, specify _____

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)

b. Did enteral feeds reach 120 ml/kg/day? Y N

1. **If YES**, date first achieved: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

c. Type of human milk infant received in the first 28 days? ___ , ___, ___

1 = Maternal 2 = Donor 3 = Trial 4= None

d. Did the infant receive probiotics in the first 28 days? Y N T

3. Proven NEC: ____

0 = Absent/Suspect 2 = Proven, no surgery 3 = Proven, surgery 4 = Proven, autopsy

a. If proven NEC, date of first episode? __ __ / __ __ / __ __ __ __ (Month / Day / Year)

4. Spontaneous gastrointestinal perforation without proven NEC? Y N

a. If **YES**, date of the first spontaneous GI perforation: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

5. Did the infant have GI surgery that resulted in short gut? Y N

G. HEARING

1. Was a hearing screen performed prior to status? Y N

If YES,

a. Was otoacoustic emissions (OAE) testing performed? Y N

1. Was OAE failed? Y N

If YES,

i. Unilateral or bilateral fail? ____

1 = Unilateral 2 = Bilateral

b. Was automated auditory brainstem response (AABR) performed? Y N

1. Was AABR failed? Y N

IF YES,

i. Unilateral or bilateral fail? ____

1 = Unilateral 2 = Bilateral

2. Was a 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

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

I. HEMATOLOGY

1. Blood Type ____

1 = A 2 = B 3 = AB 4 = O 5 = Unk

a. Rh (Rhesus) factor ____

1= Positive 2 = Negative 3 = Unknown

2. 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, transfer, status or death __ __ . __(g/dL) __ __ . __ %

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? Y N

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? Y N

a. If **YES**, code:

	i. Date (mm/dd/yyyy)	ii. Surgery code(s)	iii. Surgical Site Infection?
1.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk
2.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk
3.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk
4.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk
5.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk
6.	___ __/__ __/__ __ __ __	___ ___ ___ ; ___ ___ ___ ; ___ ___ ___ ; ___ ___ ___	Y N Unk

b. If a surgery is coded as 'Other' (codes ending in 99), 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) __ __ __ __

c. Length (cm): __ __. __

d. Head circumference (cm): __ __. __

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. Methylxanthines? 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 ___ ___

Malformation
- 10 = Congenital malformation

Pulmonary
- 20 = RDS
- 21 = RDS with severe intracranial hemorrhage
- 22 = RDS with infection
- 23 = RDS with massive pulmonary hemorrhage
- 25 = BPD
- 26 = BPD with infection
- 27 = BPD with severe CNS insult
- 28 = PPHN

Infection
- 30 = Suspect sepsis/infection
- 31 = Proven sepsis/infection

GI
- 40 = NEC
- 41 = NEC with sepsis
- 42 = Spontaneous perforation
- 43 = Short bowel syndrome
- 44 = Liver failure

CNS Insult
- 50 = Severe intracranial hemorrhage
- 51 = Severe intracranial hemorrhage with infection

Renal
- 70 = Renal failure

Other
- 60 = Immaturity without active neonatal treatment
- 90 = Other
- 99 = Unknown

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: ____

Malformation
- 10 = Congenital malformation

Pulmonary
- 20 = RDS
- 21 = RDS with severe intracranial hemorrhage
- 22 = RDS with infection
- 23 = RDS with massive pulmonary hemorrhage

Infection
- 30 = Suspect sepsis/infection
- 31 = Proven sepsis/infection

CNS Insult
- 50 = Severe intracranial hemorrhage
- 51 = Severe intracranial hemorrhage with infection

Other
- 60 = Immaturity without active neonatal treatment
- 90 = Other
- 99 = Unknown

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: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

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, 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

If YES,

i. Unilateral or bilateral fail? ____

1 = Unilateral	2 = Bilateral

b. Was automated auditory brainstem response (AABR) performed? Y N

1. Was AABR failed? Y N

If YES,

i. Unilateral or bilateral fail? ____

1 = Unilateral	2 = Bilateral

4. Was a diagnostic auditory brainstem response (ABR) performed prior to discharge? Y N

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? 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. 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

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: __ __

Malformation
- 10 = Congenital malformation

Pulmonary
- 25 = BPD
- 26 = BPD with infection
- 27 = BPD with severe CNS insult
- 28 = PPHN - Pulmonary

Infection
- 30 = Suspect sepsis/infection
- 31 = Proven sepsis/infection

GI
- 40 = NEC
- 41 = NEC with sepsis
- 42 = Spontaneous perforation
- 43 = Short bowel syndrome
- 44 = Liver failure

Renal
- 70 = Renal failure

CNS Insult
- 50 = Severe intracranial hemorrhage
- 51 = Severe intracranial hemorrhage with 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	Snapshot @ 24 Hours	Day 3	Day 7	Day 14	Day 28	36 Weeks	Status
1. Number days on HFV		__	__	__ __	__ __	__ __	__ __ __
2. Number days on CV		__	__	__ __	__ __	__ __	__ __ __
3. Number of days on nasal ventilation		__	__	__ __	__ __	__ __	__ __ __
4. Number days on CPAP		__	__	__ __	__ __	__ __	__ __ __
5. Number of days on supplemental O_2		__	__	__ __	__ __	__ __	__ __ __
6. Highest FiO_2 on day	__ . __ __	__ . __ __	__ . __ __	__ . __ __	__ . __ __	__ . __ __	__ . __ __
7. Highest mode of support on day*	__	__	__	__	__	__	__
8. If mode '5', record Flow Rate	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __

*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, **the infant is eligible for Physiologic Evaluation**. Complete section B

B. Physiologic Evaluation

1. Weight on day of 36 weeks (grams) ___ ___ ___ ___

2. 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

3. Was the physiologic challenge performed? Y N

If YES,

a. Date of challenge (mmddyyyy) __ __/__ __/__ __ __ __

b. Did infant pass challenge? Y N

If NO, (physiologic challenge performed)

c. Reason not performed (use codes below) ____

CODES
1 = Increased FiO2
2 = Increased respiratory support (CPAP or vent)
3 = Instability (including surgery/sepsis)
4 = Parent/physician refusal
6 = Weaned to room air on/before day of evaluation/challenge
9 = Other- explain_____

Initials of person completing form ___ ___ ___