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.

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<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>
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*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
   - 2 = 9th to 12th grade
   - 3 = High School diploma
   - 4 = Trade or Technical School
   - 5 = Partial college or Associate’s degree
   - 6 = College degree
   - 7 = Graduate degree
   - 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: ___
5. Gestational diabetes (diagnosed during the pregnancy)? Y N
   
   If YES,
   a. Treatment given
8. Hypertension? Y N
   
   If YES,
   a. Hypertension existed prior to pregnancy? Y N
   b. Antepartum hemorrhage? Y N
9. Was chorioamnionitis documented in the mother’s medical record? Y N
10. 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: __ __/__ __/__ __
   b. Time: ___: ___
2. Was there rupture of membranes (ROM) prior to delivery? Y N
   
   If YES,
   a. Date: __ __/__ __/__ __
   b. Time: ___: ___
   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 __ __/ __ __/ __ __ __
   ii. Time: __ __: __ __

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: __ __/ __ __/ __ __ __
   b. Time: __ __: __ __

2. Was the infant outborn? Y N

If YES,

a. Date admitted to NICU: __ __/ __ __/ __ __ __

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

If YES,

a. Diagnosis: __ __ __ __ __ ____; __ __ __ __ __ __;
   b. 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: __ __/ __ __/ __ __ __
   d. Time: __ __: __ __
   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
   a. Blood/echodensity in germinal matrix/subependymal area? Y N
   b. Blood/echodensity in the ventricle? Y N (1) RIGHT (2) LEFT
   c. Blood/echodensity in the parenchyma? Y N
   d. Blood/echodensity in the basal ganglia or the thalamus? 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**

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<td>e. Porencephalic cyst?</td>
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8. Was an MRI performed after day 28?  Y  N  
**If YES, record information for the MRI closest to 36 weeks postmenstrual age**

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<td>c. Ventricular size enlarged?</td>
<td>Y</td>
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<td>d. Cystic periventricular leukomalacia?</td>
<td>Y</td>
<td>N</td>
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<td>e. Porencephalic/posthemorrhagic cyst/multicystic encephalomalacia?</td>
<td>Y</td>
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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**

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**E. INFECTION**

1. Early onset septicemia/bacteremia (≤ 72 hours)?  Y  N  
   **If YES, complete organism code(s)**

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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:**

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5. Did the infant have an LP as part of a sepsis evaluation (not for hydrocephalus)?  Y  N  
   **If YES, record information for each episode for which the infant was treated with antibiotics for ≥ 5 days:**

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*Gram Stain (GS) codes: 1 = Not Done  2 = Negative  3 = Gram Positive  4 = Gram Negative  5 = Yeast  6 = Other (Specify)
6. Meningitis? Y N
   If YES, 
   (a) Episode #  
   (b) Date  
   (c) Organism
   1. __/__/______  ___________  ____________
   2. __/__/______  ___________  ____________

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

1 = Neonatal herpes  
2 = Congenital CMV (diagnosed ≤ 3 weeks old)  
3 = Acquired CMV (diagnosed > 3 weeks old)  
4 = Congenital syphilis  
5 = Congenital toxoplasmosis  
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
   a. Was otoacoustic emissions (OAE) testing performed? Y N
      1. Was OAE failed? Y N
         i. Unilateral or bilateral fail? ____
   b. Was automated auditory brainstem response (AABR) performed? Y N
      1. Was AABR failed? Y N
         i. Unilateral or bilateral fail? ____
   2. Was a diagnostic auditory brainstem response (ABR) performed prior to status? Y N
      a. Was hearing loss documented? Y N
         1. Unilateral or bilateral hearing loss? ____

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
      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
Neonatal Research Network

GENERIC DATABASE (GDB)

CLINICAL OUTCOME FORM (NG03)

Center: __ __            Site: ___
Network No: __ __ __ __ __ ___
Mother's Initials (optional): __ __ __

Page 4 of 5

BN

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
   (if yes, specify): ____________________________
   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")

I. 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

II. DETERMINED-SEVERE:
   • ROP surgery
   • Retinal detachment
   • Avastin injection or anti-VEGF

III. 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

II. 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)  __ ___ . %
      c. Was the infant transfused with other blood products?
         a. Fresh Frozen Plasma Y N
         b. Platelets Y N
      3. Highest total serum bilirubin in first 14 days (mg/dL)
         __ ___ . __

5. Last hemoglobin or hematocrit before discharge, __ ___ . __ (g/dL)  __ ___ . %
   transfer, status or death
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? Y N Unk
         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: ____________________________

? =   __ ___ ___
     ___ ___ ___
     ___ ___ ___
     ___ ___ ___
Neonatal Research Network

GENERIC DATABASE (GDB)

CLINICAL OUTCOME FORM (NG03)

January 1, 2016
Revised December 7, 2017

Page 5 of 5

BN

1. Status at 36 weeks: _____

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

If “2”, (In hospital):

   a. Date of 36 weeks measurement: _______/_____/______

   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: _______/_____/______

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: _______/_____/______

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

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>
<td>50 = Severe intracranial hemorrhage</td>
</tr>
<tr>
<td>20 = RDS</td>
<td>51 = Severe intracranial hemorrhage with infection</td>
</tr>
<tr>
<td>21 = RDS with severe intracranial hemorrhage</td>
<td></td>
</tr>
<tr>
<td>22 = RDS with infection</td>
<td></td>
</tr>
<tr>
<td>23 = RDS with massive pulmonary hemorrhage</td>
<td>60 = Immaturity without active neonatal treatment</td>
</tr>
<tr>
<td>30 = Suspect sepsis/infection</td>
<td>90 = Other</td>
</tr>
<tr>
<td>31 = Proven sepsis/infection</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, 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? ___

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

      1. Was AABR failed? Y N

         i. Unilateral or bilateral fail? ___

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? ___
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: __ __ / __ __ / __ __ __ __
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: __ __ / __ __ / __ __ __ __
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

F. DEATH
Complete this section if status of infant is ‘5=Death’
1. Date of death: __ __ / __ __ / __ __ __ __
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

Renal
70 = Renal failure

GI
40 = NEC
41 = NEC with sepsis
42 = Spontaneous perforation

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**

<table>
<thead>
<tr>
<th>Number days on HFV</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>
</table>

<table>
<thead>
<tr>
<th>Number days on CV</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>
</table>

<table>
<thead>
<tr>
<th>Number of days on nasal ventilation</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>
</table>

<table>
<thead>
<tr>
<th>Number days on CPAP</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>
</table>

<table>
<thead>
<tr>
<th>Number of days on supplemental O₂</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>
</table>

<table>
<thead>
<tr>
<th>Highest FiO₂ on day</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>
</table>

<table>
<thead>
<tr>
<th>Highest mode of support on day*</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>
</table>

<table>
<thead>
<tr>
<th>If mode ‘5’, record Flow Rate</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>
</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, **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 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 

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**敕下研究ネットワーク**

**GENERIC DATABASE (GDB)**

**RESPIRATORY SUPPORT FORM (NG07)**

**NG07 vs 5.0**

**January 1, 2016**

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