Neonatal Research Network	**GENERIC DATABASE (GDB)** SCREENING LOG **(NG01)**	**NG01 vs 5.0** **January 1, 2023**
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 20 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
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	
		___	__ __/__ __/__ __ __ __	__ __ / __	__ __ __ __	__ __ __ __ __ __ BN	___	

***For instruction on creating the Network Number see MOP page 3-2, section 3.1.4**

Neonatal Research Network	GENERIC DATABASE (GDB) BASELINE FORM (NG02)	NG02 vs 6.1 February 16, 2023
Center: __ __ Site: __	Network No: __ __ __ __ __ __ BN	Mother's Initials (optional) __ __ __

Section 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 3 = Private 5 = Self-pay/uninsured 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 2 = White 3 = American Indian or Alaskan Native 4 = Asian 5 = Native Hawaiian or Other Pacific Islander 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

Section B. Pregnancy Complications		
1. Multiple birth?	❒ Yes ❒ No	
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?	❒ Yes ❒ No	
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?	❒ Yes ❒ No ❒ Unk	
4. Diabetes prior to pregnancy?	❒ Yes ❒ No	
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 5 = None 6 = Unknown	___
5. Gestational diabetes (diagnosed during the pregnancy)?	❒ Yes ❒ No ❒ Unk	
If YES, a. Treatment given	1 = Insulin 2 = Oral hypoglycemic medication 3 = Diet only 5 = None 6 = Unknown	___

Completed by: __ __ __

Section B. Pregnancy Complications			
6. Hypertension?	❒ Yes	❒ No	
If YES, a. Hypertension existed prior to pregnancy?	❒ Yes	❒ No	❒ Unk
7. Antepartum hemorrhage?	❒ Yes	❒ No	
8. Was chorioamnionitis documented in the mother's medical record?	❒ Yes	❒ No	
9. Was placental pathology performed?	❒ Yes	❒ No	
If YES, a. Was histologic chorioamnionitis documented?	❒ Yes	❒ No	
b. Was acute funisitis documented?	❒ Yes	❒ No	

Section 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?	❒ Yes	❒ No	❒ 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?	❒ Yes	❒ No	❒ Unk	
3. Were antenatal steroids given to accelerate fetal maturity?	❒ Yes	❒ No	❒ 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?	❒ Yes	❒ No	❒ Unk	
c. Was more than one course of antenatal steroids given?	❒ Yes	❒ No	❒ 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?	❒ Yes	❒ No	❒ Unk	
If YES, a. List antibiotics given: (See Code Sheet in Appendix B)	1.__ __ 2.__ __	3. __ __ 4. __ __	5. __ __ 6. __ __	
5. Was magnesium sulfate given during this admission prior to delivery?	❒ Yes	❒ No	❒ Unk	
6. Was there documentation of electronic fetal heart rate monitoring within 12 hours prior to birth?	❒ Yes	❒ No	❒ Unk	
7. Final mode of delivery:	1 = Vaginal vertex 2 = Vaginal breech	3 = Cesarean section 5= Unknown		___

Section D. Neonatal Information		
1. Date and time of birth:		
a. Date:	__ __ /__ __ /__ __ __ __ Month Day Year	
b. Time:	__ __ : __ __ Hour Min	
2. Was the infant outborn?	❒ Yes ❒ No	
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?	❒ Yes ❒ No	
If YES, a. Diagnosis:	__ __ __ ; __ __ __ ; __ __ __ ; __ __ __ ; __ __ __	
i. If 'Other', specify:	_____	
4. Did the infant die ≤ 12 hours after birth?	❒ Yes ❒ No	
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. Apgar score – 10 minutes:		___ ___
10. Birth resuscitation/stabilization		
a. Oxygen?	❒ Yes ❒ No	
b. Positive pressure ventilation?	❒ Yes ❒ No	
c. CPAP?	❒ Yes ❒ No	
d. Intubation?	❒ Yes ❒ No	
e. Chest compression?	❒ Yes ❒ No	
f. Epinephrine?	❒ Yes ❒ No	
11. Is there documentation of delayed cord clamping?	❒ Yes ❒ No	
If YES, a. Timing of cord clamping delay:	1 = < 30 seconds 4 = > 3 min – prior to stop of pulsation 2 = 30 – 60 seconds 5 = Until stop of pulsation 3 = > 1 min – 3 min 6 = Other, specify _____	___
12. Is there documentation of cord milking?	❒ Yes ❒ No	
13. Birth weight (grams):		___ ___ ___ ___

Section D. Neonatal Information				
14. Length (cm):				___ ___ . ___
15. Head circumference (cm):				___ ___ . ___
16. Was any thermal product used to improve temperature regulation?	❒ Yes	❒ No	❒ Unk	
17. 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	___

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

Part 1: Status Information

Section A. Status		
1. Status of infant at time of completion of form:	1 = Discharged to home; 2 = Still in-hospital at 120 days; 3 = Transferred to another facility; 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):	__ __ . __	

Section B. 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?	❒ Yes	❒ No
2. Were the following treatments withheld, limited, or withdrawn at any time with the intent to limit care?		
a. Intubation/ventilation	❒ Yes	❒ No
b. Nutrition/hydration	❒ Yes	❒ No
3. Palliative care consult obtained?	❒ Yes	❒ No
4. Ethics consult obtained?	❒ Yes	❒ No

Section C. 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	___

Section D. Discharge Alive			
Complete this section if status (Q.A1) 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?	❒ Yes	❒ No	
3. Discharged home on any of the following medications?	❒ Yes	❒ No	
If YES, a. Diuretics?	❒ Yes	❒ No	❒ Trial
b. Bronchodilators?	❒ Yes	❒ No	❒ Trial
c. Anticonvulsants?	❒ Yes	❒ No	❒ Trial
d. Antireflux medications?	❒ Yes	❒ No	❒ Trial
e. Antihypertensive medications?	❒ Yes	❒ No	❒ Trial
f. Methylxanthines?	❒ Yes	❒ No	❒ Trial
g. Inhaled steroids?	❒ Yes	❒ No	❒ Trial
h. Systemic steroids?	❒ Yes	❒ No	❒ Trial
i. Other?	❒ Yes	❒ No	❒ Trial
	If Yes, or Trial, specifiy_____		
4. Discharged home receiving any human milk?	❒ Yes **(complete D4a)**	❒ No	
a. **If YES,** type of milk:	1 = Maternal Milk	2 = Donor Milk	3 = Both ___

Section E. 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 (such as blood culture results, late entered discharge notes, etc.)		
1. Date of death:	__ __ /__ __ /__ __ __ __ Month Day Year	
2. Autopsy performed?	❒ Yes ❒ No	
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 29 = BPD with pulmonary hypertension	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), code "31" (Sepsis, specify organism), or code "90" (other), specify:	_____	

Part 2: 36 Week Information

Section F. 36 Week Information					
1. Status at 36 weeks:	1 = Discharged **(skip to Section C)**	2 = In-hospital **(complete B1a-d)**	3 = Transferred **(skip to Section C)**	5 = Death **(skip to Section C)**	___
If "2", (In-hospital): a. Date of 36 weeks measurement:	__ __ /__ __ /__ __ __ __ Month Day Year				
b. Weight (g):	__ __ __ __				
c. Length (cm):	__ __ . __				
d. Head circumference (cm):	__ __ . __				

Part 3: Organ Systems

Section G. Pulmonary					
1. Did the baby receive surfactant?	❒ Yes **(complete G1a-e)**	❒ No **(skip to G2)**			
If YES, a. Date of First dose:	__ __ /__ __ /__ __ __ __ Month Day Year				
b. Was first dose given in the delivery room?	❒ Yes	❒ No			
c. Type of surfactant given:	1 = Beractant (Survanta)	2 = Poractant alfa (Curosurf)	3 = Calfactant (Infasurf)	9 = Other	___
d. Was the surfactant mixed with budesonide?	❒ Yes	❒ No	❒ Trial		
e. Method of administration:	1 = ETT	2 = LISA/MIST	3 = Aerosolized	4 = LMA	9 = Other ___
2. Pneumothorax?	❒ Yes	❒ No			
3. PIE?	❒ Yes	❒ No			
4. Pulmonary hemorrhage?	❒ Yes	❒ No			
5. Steroids for BPD/CLD?	❒ Yes **(complete G5a-d)**	❒ No **(skip to G6)**			
If YES, a. Date of First dose:	__ __ /__ __ /__ __ __ __ Month Day Year				
b. Was more than one course given?	❒ Yes	❒ No			

Section G. Pulmonary				
c. Was total exposure > 14 days?	❒ Yes	❒ No		
d. Drugs prescribed:	2 = Dexamethasone	6 = Hydrocortisone	7 = Predisnolone	___
6. Did infant receive inhaled nitric oxide?	❒ Yes **(complete G6a)**	❒ No **(skip to G7)**		
If YES, a. Date of First exposure:				__ __ /__ __ /__ __ __ __ Month Day Year
7. Did infant receive Vitamin A?	❒ Yes	❒ No	❒ Trial	

Section H. Cardiovascular				
1. Patent ductus arteriosus (PDA)?	❒ Yes **(complete H1a-f)**	❒ No **(skip to H2)**		
If YES, treatment**:** a. Indomethacin?	❒ Yes	❒ No	❒ Trial	
b. Ibuprofen?	❒ Yes	❒ No	❒ Trial	
c. Acetominophen?	❒ Yes	❒ No		
d. Cardiac catheterization for PDA closure?	❒ Yes **(complete H1d1-2)**	❒ No **(skip to H1e)**		
1. Date of cardiac catheterization for PDA closure				__ __ /__ __ /__ __ __ __ Month Day Year
2. Was the cardiac catheterization for PDA closure successful?	❒ Yes	❒ No		
e. Surgery?	❒ Yes	❒ No		
f. Other? If **YES,** specify_____	❒ Yes	❒ No		
2. Was infant treated for hypotension in the first 24 hours of life?	❒ Yes	❒ No		
If **YES**, a. Volume bolus:	❒ Yes	❒ No		
b. Initiation of vasopressors?	❒ Yes	❒ No		
c. Initiation of systemic steroid?	❒ Yes	❒ No		
3. Was an echocardiogram done to monitor for pulmonary hypertension?	❒ Yes	❒ No		
If YES, a. Date:				__ __ /__ __ /__ __ __ __ Month Day Year
b. Results: Evidence of pulmonary hypertension?	1 = Yes	2 = No	3 = Equivocal	___

Section I. Neurology				
1. Was indomethacin given within the first 24 hours of life?	❒ Yes	❒ No	❒ Trial	
2. Were seizures confirmed by EEG?	❒ Yes	❒ No		
3. Were any cranial sonograms done within 28 days of birth?	❒ Yes **(complete I3a)**	❒ No **(skip to I6)**		
a. **If YES,** are all studies without evidence of intracranial hemorrhage, periventricular leukomalacia, or ventriculomegaly?	❒ Yes **(skip to I6)**	❒ No **(Complete I3b-i)**		
b. Date of sonogram with most severe findings:				__ __ /__ __ /__ __ __ __ Month Day Year
c. Blood/echodensity in germinal matrix/subpendymal area?	❒ Yes	❒ No		

d. Blood/echodensity in the ventricle?	(1) RIGHT		(2) LEFT	
	❒ Yes	❒ No	❒ Yes	❒ No
e. Ventricular size enlarged with concurrent or prior blood in the ventricles?	❒ Yes	❒ No	❒ Yes	❒ No
f. Ventricular size enlarged without concurrent or prior blood in the ventricles?	❒ Yes	❒ No	❒ Yes	❒ No

Section I. Neurology

g. Blood/echodensity in the parenchyma?	❒ Yes **(complete I3g1)**	❒ No **(skip to I3h)**	❒ Yes **(complete I3g1)**	❒ No **(skip to I3h)**
1. **If YES,** Midline shift?	❒ Yes	❒ No		
h. Blood/echodensity in the basal ganglia or the thalamus?	❒ Yes	❒ No		
i. Cerebellar hemorrhage?	❒ Yes	❒ No		
	(1) RIGHT		**(2) LEFT**	
4. Cystic periventricular leukomalacia within 28 days?	❒ Yes	❒ No	❒ Yes	❒ No
5. Porencephalic cyst within 28 days?	❒ Yes	❒ No	❒ Yes	❒ No
6. Were any cranial imaging studies done after day 28?	❒ Yes	❒ No **(skip to Section J)**		
7. Was a sonogram performed after day 28?	❒ Yes **(complete I7a-b)**	❒ No **(skip to I8)**		
If YES, record information for the sonogram closest to 36 weeks postmenstrual age				
a. Date of image:	__ __ /__ __ /__ __ __ __ Month Day Year			
b. Normal study?	❒ Yes **(skip to I8)**	❒ No **(complete I7c-e)**		
If NO,	**(1) RIGHT**		**(2) LEFT**	
c. Ventricular size enlarged?	❒ Yes	❒ No	❒ Yes	❒ No
d. Cystic periventricular leukomalacia?	❒ Yes	❒ No	❒ Yes	❒ No
e. Porencephalic cyst?	❒ Yes	❒ No	❒ Yes	❒ No
8. Was an MRI performed after day 28?	❒ Yes **(complete I8a-b)**	❒ No **(skip to Section J)**		
If YES, record information for the MRI closest to 36 weeks postmenstrual age				
a. Date of image:	__ __ /__ __ /__ __ __ __ Month Day Year			
b. Normal study?	❒ Yes **(skip to Section J)**	❒ No **(complete I8c-e)**		
If NO,	**(1) RIGHT**		**(2) LEFT**	
c. Ventricular size enlarged?	❒ Yes	❒ No	❒ Yes	❒ No
d. Cystic periventricular leukomalacia?	❒ Yes	❒ No	❒ Yes	❒ No
e. Porencephalic/posthemorrhagic cyst/multicystic encephalomalacia?	❒ Yes	❒ No	❒ Yes	❒ No

Section J. Gastrointestinal

1. Total days of parenteral nutrition:	__ __ __			
2. Did the baby receive enteral feeds?	❒ Yes **(complete J2a-f)**	❒ No **(skip to J3)**		
If YES, treatment**:** a. Type of first enteral feeding:	1 = Maternal milk	2 = Donor milk	3 = Formula	___
b Date of first enteral feed:	__ __ /__ __ /__ __ __ __ Month Day Year			
c. Did enteral feeds reach 120 ml/kg/day?	❒ Yes **(complete J1c1)**	❒ No **(skip to J1d)**		
1. If YES, date first achieved:	__ __ /__ __ /__ __ __ __ Month Day Year			
d. Type of human milk received in the first 28 days: (check all that apply)	1 = Maternal	2 = Donor	4 = None	__ , __
e. Type of fortification of human milk:	1 = Bovine-based fortifier	2 = Human milk-based fortifier	3 = Both	4 = Neither __
f. Did the infant receive probiotics in the first 28 days?	❒ Yes	❒ No	❒ Trial	

Section J. Gastrointestinal					
3. Proven NEC:	0 = Absent/Suspect **(skip to J4)**	2 = Proven, no surgery **(complete J3a-c)**	3 = Proven, surgery **(complete J3a-c)**	4 = Proven, autopsy **(complete J3a-c)**	___
If **proven NEC**, a. Date of first episode:				__ __ /__ __ /__ __ __ __ Month Day Year	
b. Did the infant restart feeding after first episode of NEC?	❒ Yes **(complete J3b1)**	❒ No **(skip to J3c)**			
If YES, b1. Date feeding restarted after first episode of NEC:				__ __ /__ __ /__ __ __ __ Month Day Year	
c. Was creatinine measured?	❒ Yes	❒ No			
If YES, c1. Highest value (mg/dL): ___ . ___ ___	c2. Date:			__ __ /__ __ /__ __ __ __ Month Day Year	
4. Spontaneous gastrointestinal perforation without proven NEC?	❒ Yes **(complete J4a)**	❒ No **(skip to J5)**			
a. **If YES,** date of the first spontaneous GI perforation:				__ __ /__ __ /__ __ __ __ Month Day Year	
5. Did the infant receive any type of enema as therapy for meconium ileus or obstruction?	❒ Yes **(complete J5a)**	❒ No **(skip to J6)**			
a. **If YES,** date of the first enema:				__ __ /__ __ /__ __ __ __ Month Day Year	
6. Did the infant have GI surgery that resulted in short gut?	❒ Yes	❒ No			

Section K. Hearing			
1. Was a hearing screen performed prior to status?	❒ Yes **(complete K1a-b)**	❒ No **(skip to K2)**	
If YES, a. Was otoacoustic emissions (OAE) testing performed?	❒ Yes **(complete K1a1)**	❒ No **(skip to K2)**	
If YES, 1. Was OAE failed?	❒ Yes **(complete K1a1i)**	❒ No **(skip to K1b)**	
If YES, i. Unilateral or bilateral fail?	1 = Unilateral	2 = Bilateral	___
b. Was automated auditory brainstem response (AABR) performed?	❒ Yes **(complete K1b1)**	❒ No **(skip to K2)**	
If YES, 1. Was AABR failed?	❒ Yes **(complete K1b1i)**	❒ No **(skip to K2)**	
If YES, i. Unilateral or bilateral fail?	1 = Unilateral	2 = Bilateral	___
2. Was a diagnostic auditory brainstem response (ABR) performed prior to status?	❒ Yes **(complete K2a)**	❒ No **(skip to Section L)**	
If YES, a. Was hearing loss documented?	❒ Yes **(complete K2a1)**	❒ No **(skip to Section L)**	
If YES, 1. Unilateral or bilateral hearing loss?	1 = Unilateral	2 = Bilateral	___

L. Ophthalmology		
1. Was an exam performed for ROP?	❒ Yes **(complete L1a)**	❒ No **(skip to Section M)**
If YES, a. Was ROP diagnosed in either eye?	❒ Yes **(complete L1a1-3)**	❒ No **(skip to L1c)**
If YES, 1. Did ROP reach stage 3 or worse in either eye?	❒ Yes	❒ No
2. Did plus disease develop in either eye?	❒ Yes	❒ No
3. Did infant have stage 1 or stage 2 ROP diagnosed in Zone 1?	❒ Yes	❒ No
b. Intervention therapies:		
1. Was retinal ablation performed in either eye (laser and/or cryotherapy)?	❒ Yes	❒ No

2. Was scleral buckle or vitrectomy performed in either eye?	❒ Yes	❒ No	
3. Avastin or other anti-VEGF drug?	❒ Yes	❒ No	❒ Trial
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. If "3 = Undetermined" code reason:			___

1. Determined, Favorable:	2. Determined, Severe	3. Undetermined
• 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	• ROP surgery • Retinal detachment • Avastin injection or anti-VEGF	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

M. Hematology

1. Blood Type:	1 = A	2 = B	3 = AB	4 = O	5 = Unknown ___
a. Rh (Rhesus) factor:	1 = Positive	2 = Negative	3 = Unknown ___		
2. Was the infant transfused with pRBC?	❒ Yes **(complete M2a-c)**	❒ No **(skip to M3)**			
If YES, a. Date of first pRBC transfusion:	__ __/__ __/__ __ __ __ Month Day Year				
b. Lowest hemoglobin OR hematocrit prior to first transfusion:	__ __.__(g/dL)	__ __ . __ %			
c. Total number of pRBC transfusions:	__ __				
3. Was the infant transfused with platelets?	❒ Yes **(completed M3a-b)**	❒ No **(skip to M4)**			
If YES, a. Date of first platelet transfusion:	__ __/__ __/__ __ __ __ Month Day Year				
b. Lowest platelet count before transfusion:	__ __ __				
4. Did the infant receive erythropoietin or another erythropoiesis stimulating agent?	❒ Yes	❒ No	❒ Trial		

Section N. Renal

1. Clinical diagnosis of AKI?	❒ Yes **(complete N1a-b)**	❒ No **(skip to N2)**	
If YES, a. Date of diagnosis:	__ __/__ __/__ __ __ __ Month Day Year		
b. Inpatient consultation with or referral to outpatient nephrology?	❒ Yes	❒ No	
2. Blood pressure at status (mmHg):	a. Systolic: __ __ __	b. Diastolic: __ __ __	
3. Diagnosis of hypertension?	❒ Yes **(complete N3a)**	❒ No **(skip to Section O)**	
If YES, a. Were antihypertensives used?	❒ Yes **(complete N3b-d)**	❒ No **(skip to Section O)**	

(b) Week #	(c) Maximum Creatinine Date	(c1) Maximum Creatinine Value (mg/dL)	(d) Minimum Creatinine Date	(d1) Minimum Creatinine Value (mg/dL)
1 (Days 1-4)	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
1 (Days 5-7)	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
2	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
3	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
4	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
5	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __
6	__ __/__ __/__ __ __ __	__ . __ __	__ __/__ __/__ __ __ __	__ . __ __

Part 4: Diagnoses and Treatments

Section O. Infection

1. Early onset septicemia/bacteremia (≤ 72 hours)?	❒ Yes **(complete O1a-b)** ❒ No **(skip to O2)**
If YES, complete organism code(s):	a. __ __ __ b. __ __ __
2. Did the infant receive antibiotics for ≥ 5 days, starting within the first 72 hours?	❒ Yes **(complete O2a)** ❒ No **(skip to O3)**
a. Reason:	1 = Sepsis 2 = Meningitis 3 = UTI 4 = Pneumonia 5 = Other ___
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 septicemia/ bacteremia (>72 hours)?	❒ Yes **(complete O4a-f)** ❒ No **(skip to O5)**

(a) Episode #	(b1) Start Date	(b2) Stop Date	(c1) Organism	(c2) Organism	(c3) Organism	(d) CLABSI?
1	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
2	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
3	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
4	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
5	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
6	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No

e. If late onset sepsis, was creatinine measured?	❒ Yes **(complete O4e1-2)** ❒ No **(skip to O4f)**
(e1) **If YES,** highest value: __ . __ __ (mg/dL)	(e2) Date __ __/__ __/__ __ __ __ Month Day Year
5. Was the infant diagnosed with UTI?	❒ Yes **(complete O5a-b)** ❒ No **(skip to O6)**
(a) **If YES,** Organism: __ __ __	(b) Date __ __/__ __/__ __ __ __ Month Day Year
6. Did the infant have an LP as part of a sepsis evaluation (not for hydrocephalus)?	❒ Yes **(complete O6a)** ❒ No **(skip to O7)**

a. Record Date of LP(s):

LP #1	__ __/__ __/__ __ __ __	LP # 2	__ __/__ __/__ __ __ __	LP # 3	__ __/__ __/__ __ __ __	LP #4	__ __/__ __/__ __ __ __	LP #5	__ __/__ __/__ __ __ __

7. Meningitis?	❒ Yes **(complete O7a-d)** ❒ No **(skip to O8)**

(a) Episode #	(b) Date	(1) Organism	(2) Organism	(3) Organism	(c) Confirmed by PCR?
1	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No
2	__ __/__ __/__ __ __ __	__ __ __	__ __ __	__ __ __	❒ Yes ❒ No

8. Was the infant diagnosed with any of the following other proven infections?	❒ Yes **(complete O8a-b1)** ❒ No **(skip to O9)**

(a) Diagnosis #	(b) Date of Diagnosis	(1) Diagnosis Code	(a) Diagnosis #	(b) Date of Diagnosis	(1) Diagnosis Code
1	__ __/__ __/__ __ __ __	___	4	__ __/__ __/__ __ __ __	___
2	__ __/__ __/__ __ __ __	___	5	__ __/__ __/__ __ __ __	___
3	__ __/__ __/__ __ __ __	___	6	__ __/__ __/__ __ __ __	___

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

9. Was a congenital infection diagnosed?	❒ Yes **(complete O9a-b)** ❒ No **(skip to Section P)**

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

Section O. Infection	
a. What organism?	__ __ __
b. Was it treated?	❒ Yes ❒ No

Section P. Syndromes and/or Malformations						
1. Syndromes and/or major malformations?			❒ Yes **(complete P1a-b)**	❒ No **(skip to Section Q)**		
a. **If YES,** code**:**	1) = __ __ __	2) = __ __ __	3) = __ __ __	4) = __ __ __	5) = __ __ __	6) = __ __ __
b. If a syndrome is coded as 'Other', specify:_____						

Section Q. Surgeries and Catheterization Procedures

1. Did the infant have surgery or catheterization procedure? ❒ Yes ❒ No

a. If YES, code:

	(i) Date (mm/dd/yyyy)	(ii) Surgery code(s)	(iii) Surgical site infection?		
1	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown
2	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown
3	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown
4	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown
5	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown
6	__ __ /__ __ /__ __ __ __	__ __ __; __ __ __; __ __ __; __ __ __	❒ Yes	❒ No	❒ Unknown

b. If surgery is coded as 'Other' (codes ending in 99), specify: _____

If surgery is coded as '703' answer Q1c.

c. Did the infant initiate any new vasoactive drugs within 24 hours after PDA closure (ligation or catheterization)? ❒ Yes ❒ No

Neonatal Research Network	GENERIC DATABASE (GDB) CLINICAL OUTCOME FORM (NG03E)	NG03E vs. 6.0 January 1, 2023 Revised April 13, 2023
Center: __ __ Site: __	Network No: __ __ __ __ __ __ (BN)	Mother's Initials (optional) __ __ __

Complete this form if the infant died at ≤ 12 hours of age.

Section A: Early Death				
1. Medical therapy initiated:				
a. Antibiotics?	❒ Yes	❒ No		
b. Surfactant replacement therapy?	❒ Yes	❒ No		
If YES, 1. Type of surfactant given:	1 = Beractant (Survanta)	2 = Poractant alfa (Curosurf)	3 = Calfactant (Infasurf)	9 = Other ___
2. Was the surfactant mixed with budesonide?	❒ Yes	❒ No	❒ Trial	
3. Method of administration:	1 = ETT	2 = LISA/MIST	3 = Aerosolized	4 = LMA 9 = Other ___
c. Pressor support?	❒ Yes	❒ No		
d. Volume support?	❒ Yes	❒ No		
e. Intubation and Ventilation?	❒ Yes	❒ No		
f. IV fluids?	❒ Yes	❒ No		
2. Autopsy performed?	❒ Yes	❒ No		
3. At any time after birth (prior to NG03E Status), was there documentation of discussion with parents to limit, withdraw or not escalate care?	❒ Yes	❒ No		
4. Were the following treatments withheld, limited or withdrawn at any time with the intent to limit care?				
a. Intubation/ventilation	❒ Yes	❒ No		
b. Nutrition/hydration	❒ Yes	❒ No		
5. Palliative care consult obtained?	❒ Yes	❒ No		
6. Ethics consult obtained?	❒ Yes	❒ No		
7. No intention to resuscitate (comfort care only)	❒ Yes	❒ No		
8. 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 29 = BPD with pulmonary hypertension 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			
9. If contributory cause of death is code "10" (Congenital malformation), code "31" (Sepsis, specify organism), or code "90" (other), specify:	_____			

Completed by: ___ ___ ___

Neonatal Research Network	GENERIC DATABASE (GDB) LATE CLINICAL OUTCOME FORM (NG05)	NG05 vs. 6.0 January 1, 2023

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

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.

Section A. Status				
1. Status of infant at time of completion of form:	1 = Discharged to home	3 = Transferred to another facility	5 = Death	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):				__ __ . __

Section B. Extended Stay Information				
1. What problem(s) caused hospitalization greater than 120 days (answer all that apply)?				
a. Pulmonary?	❒ Yes	❒ No		
b. Cardiac?	❒ Yes	❒ No		
c. Neurologic?	❒ Yes	❒ No		
d. Gastrointestinal?	❒ Yes	❒ No		
e. Multiple Malformations?	❒ Yes	❒ No		
f. Social?	❒ Yes	❒ No		
g. Ophthalmologic?	❒ Yes	❒ No		
h. Sepsis/Infection?	❒ Yes	❒ No		
i. Renal?	❒ Yes	❒ No		
j. Apnea?	❒ Yes	❒ No		
k. Feeding?	❒ Yes	❒ No		
l. Other?	❒ Yes	❒ No		
	If Yes, specify_____			
2. Did either eye receive therapy for ROP after 120 days?	❒ Yes **(Complete 2a)**	❒ No **(Skip to 3)**	❒ Trial **(Complete 2a)**	
2a. **If YES or Trial**, list all therapies done for either eye:	1 = Laser	2 = Cryotherapy	3 = Scleral Buckle	___
	4 = Vitrectomy	5 = Avastin or anti-VEGF	6 = Other	
	If 6 = Other, specify for either eye _____			
3. Was a hearing screen performed after 120 days?	❒ Yes **(Complete 3a)**	❒ No **(Skip to 3b)**		
If YES, a. Was otoacoustic emissions (OAE) testing performed?	❒ Yes **(Complete 3a1)**	❒ No **(Skip to 3b)**		
1. Was OAE failed?	❒ Yes **(Complete 3a1i)**	❒ No **(Skip to 3b)**		
i. **If YES,** Unilateral or bilateral fail?	1 = Unilateral	2 = Bilateral		___
b. Was automated auditory brainstem response (AABR) performed?	❒ Yes **(Complete 3b1)**	❒ No **(Skip to 4)**		
1. Was AABR failed?	❒ Yes **(Complete 3b1i)**	❒ No **(Skip to 4)**		
i. **If YES,** Unilateral or bilateral fail?	1 = Unilateral	2 = Bilateral		___
4. Was a diagnostic auditory brainstem response (ABR) performed prior to discharge?	❒ Yes **(Complete 4a)**	❒ No		

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

Section B. Extended Stay Information				
If YES, a. Was hearing loss documented?	❒ Yes **(Complete 4a1)**	❒ No	❒ Unknown	
1. **If YES,** Unilateral or bilateral hearing loss?	1 = Unilateral	2 = Bilateral		___

Section C. Ethics/Palliative Care		
1. Was there documentation of discussion with parents to limit, withdraw, or not escalate care after 120 days?	❒ Yes	❒ No
2. Were the following treatments withheld, limited, or withdrawn after 120 days with the intent to limit care?		
a. Intubation/ventilation	❒ Yes	❒ No
b. Nutrition/hydration	❒ Yes	❒ No
3. Palliative care consult obtained?	❒ Yes	❒ No
4. Ethics consult obtained?	❒ Yes	❒ No

Section 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		

Section 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?	❒ Yes	❒ No	
3. Discharged home on any of the following medications?	❒ Yes	❒ No	
If YES, a. Diuretics?	❒ Yes	❒ No	❒ Trial
b. Bronchodilators?	❒ Yes	❒ No	❒ Trial
c. Anticonvulsants?	❒ Yes	❒ No	❒ Trial
d. Antireflux medications?	❒ Yes	❒ No	❒ Trial
e. Antihypertensive medications?	❒ Yes	❒ No	❒ Trial
f. Methylxanthines?	❒ Yes	❒ No	❒ Trial
g. Inhaled steroids?	❒ Yes	❒ No	❒ Trial
h. Systemic steroids?	❒ Yes	❒ No	❒ Trial
i. Other?	❒ Yes	❒ No	❒ Trial
	If Yes or Trial, specify _____		
4. Discharged home receiving any human milk?	❒ Yes **(complete D4a)**	❒ No	❒ Unknown
a. **If YES,** type of milk:	1 = Maternal Milk	2 = Donor Milk	3 = Both ___

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

Section F. Death

Complete this section if status of infant is '5 = Death'

1. Date of death:	__ __ /__ __ /__ __ __ __ Month Day Year
2. Autopsy performed?	❒ Yes ❒ No
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
- 29 = BPD with pulmonary hypertension

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 contributory cause of death is code "10" (Congenital malformation), Code "31" (Sepsis, specify organism), or code "90" (other), specify: _____

Initials of person completing form: ___ ___ ___

Neonatal Research Network	GENERIC DATABASE (GDB) RESPIRATORY SUPPORT FORM (NG07)	NG07 vs. 8.0 January 1, 2023 Revised April 13, 2023
Center: __ __ Site: __	Network No: __ __ __ __ __ __ BN	Mother's Initials (optional) __ __ __

Section A. Respiratory Support	Snapshot @ 24 Hours	Day 3	Day 7	Day 14	Day 28	36 Weeks	Status
1. Number of days on HFV		__	__	__ __	__ __	__ __	__ __ __
2. Number of days on CV		__	__	__ __	__ __	__ __	__ __ __
3. Number of days on nasal ventilation		__	__	__ __	__ __	__ __	__ __ __
4. Number of 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	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __	__ . __ __ __
9. Weight (grams)		__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __	__ __ __ __

* 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.

Section B. Physiologic Challenge Eligibility		
1. Is infant enrolled in the PDA Trial or the BiB Trial?	❒ Yes **(Continue to B1a)**	❒ No **(Infant is not eligible and form is complete)**
a. Is infant eligible for a physiologic challenge (see below)?	❒ Yes **(Continue to B1b)**	❒ No **(Infant is not eligible and form is complete)**
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		
b. Was the pyshologic challenge performed?	❒ Yes **(Continue to B1b1)**	❒ No **(Skip to B1b3)**
1. Date of challenge	___ ___ / ___ ___ /___ ___ ___ ___ Month Day Year	
2. Did infant pass challenge?	❒ Yes	❒ No
If **NO**, (physiologic challenge performed) 3. Reason not performed (use codes below)		____

CODES

1 = Increased FiO_2
2 = Increases 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
If '9 = Other,' explain _____

Initials of person completing form ___ ___ ___

Complete this form for all infants from time of birth until NG03 Status is reached.

Section A. Maternal Information

1. Was the mother tested for active SARS-CoV-2 infection? ❐ Yes **(Complete a – f)** ❐ No ❐ Unknown

(a) Test Number	(b) Test Result	(c) Type of Test	(d) Reason(s) for Testing			(e) Date of Test	(f) Testing Time Period
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	___	___	___	___	__ __/ __ __/ __ __ __ __ Month Day Year	___

(b) Test Result Codes:	1 = Positive	2 = Negative	3 = Inconclusive	
(c) Type of Test:	1 = Lab/pharmacy test	3 = At-Home test		
(d) Reason for Testing Codes:	1 = Symptomatic	2 = Exposure	3 = Screening	4 = Other
(f) Testing Time Period:	1 = During pregnancy	2 = At delivery	3 = Postpartum	4 = Unknown

2. Was the mother tested for SARS CoV-2 antibodies? ❐ Yes **(Complete a – d)** ❐ No ❐ Unknown

(a) Test Number	(b) Test Result	(c) Date of Test	(d) Testing Time Period
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___
__ __	___	__ __/ __ __/ __ __ __ __ Month Day Year	___

(b) Test Result Codes:	1 = Positive	2 = Negative	3 = Inconclusive	
(d) Testing Time Period:	1 = During pregnancy	2 = At delivery	3 = Postpartum	4 = Unknown

Section B. Infant Information

1. Was the infant tested for active SARS-CoV-2 infection? ❒ Yes **(Complete a – f)** ❒ No ❒ Unknown

(a) Test Number	(b) Test Result	(c) Type of Test	(d) Date of Test	(e) Reason(s) for Testing (Code all that apply)	(f) Sample Site(s)
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___
__ __	___	___	__ __/__ __/__ __ __ __ Month Day Year	___ ___ ___ ___ ___	___ ___ ___

Completed by: __ __ __

(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 thought to be exposed to someone besides mother with COVID-19 (e.g., father, sibling, healthcare healthcare worker	3 = Infant has clinical signs consistent with infection that might include COVID-19	4 = Screening	5 = Other **(Complete 2ei)**
	i. If 5 = Other, specify: _____				
(f) Sample Site(s) Codes:	1 = Nasopharynx	2 = Oropharynx (throat)	3 = Stool/rectum	4 = Tracheal aspirate	5 = Serum/blood	6 = Other **(Complete 2fi)**
	i. If 6 = Other, specify: _____					