

Center Number: _____

Network ID Number:

VERMONT OXFORD NETWORK Registry for Neonatal Encephalopathy Delivery Room Death Booklet for 2008

The Neonatal Encephalopathy Registry (NER) forms for infants who died in the delivery room on the following pages and the NER Eligibility Form below are provided to aid Registry participants in collecting and organizing NER patient data. **Since data on some of the forms include patient identifiers, do not submit this booklet or any of the paper forms to the Vermont Oxford Network.** All Registry data collected should be submitted to the Vermont Oxford Network as electronic files using the Network's eNICQ software. Data files submitted using the eNICQ software do not include any protected health care information, as defined by the U.S. Health Insurance Portability and Accountability Act of 1996. No dates or times will be exported to the Vermont Oxford Network. The Vermont Oxford Network does not accept protected health care information.

Contents:

- I: Eligibility Form
- II: OB/Initial Status Form
- III: Neurological Form
- IV: Diagnoses and Discharge Form

I. ELIGIBILITY FORM

EL1. Hypothermic Therapy Received?

Yes No Unknown

EL2. Gestational Age \geq 36 Weeks 0 Days or More?

Yes No Unknown

If yes to EL2, answer items EL3 through EL 8 below.

EL3. Major CNS Congenital Malformation?

Yes No Unknown

EL4. Stupor or Coma within 72 Hours?

Yes No Unknown

EL5. Seizures within 72 Hours?

Yes No Unknown

EL6. Paralysis Induced for First 72 Hours?

Yes No Unknown

EL7. Apgar Score at 5 Minutes of 3 or Less?

Yes No Unknown

EL8. Eligible for NER?

Yes No



--	--	--	--	--

II. OB/INITIAL STATUS FORM

PART A, OBSTETRIC-PERINATAL HISTORY

OB1. Mode of Delivery (select one):

- Vaginal without Vacuum or Forceps
 Vacuum and/or Forceps Assisted Vaginal
 C Section Before Labor Started
 C Section After Labor Started
 C Section After Failed Vacuum or Forceps Delivery
 Unknown

OB2. Presentation (select one):

- Vertex Breech Transverse Other Unknown

OB3. Ruptured Membranes 24 Hours or More Prior to Delivery?

- Yes No Unknown

OB4. Cord Prolapse?

- Yes No Unknown

OB5. Uterine Rupture?

- Yes No Unknown

OB6. Antepartum Hemorrhage?

- Yes No Unknown

OB7. Chorioamnionitis?

- Yes No Unknown

OB8. Maternal Temperature during Labor and Delivery:

a. Maternal Temperature Recorded?

- Yes No Unknown

b. Temperature of Mother:

Record the highest intrapartum maternal temperature and the units in which it was recorded.

Use a single decimal place, e.g. 36.7° C or 98.2° F: ° C ° F

OB9. Maternal Hypertension, Pre-eclampsia, or Eclampsia?

- Yes No Unknown

OB10. Maternal Diabetes?

- Yes No Unknown



Center Number: _____

Network ID Number:

OB11. Maternal Hypothyroidism?

Yes No Unknown

OB12. Non-Reassuring Fetal Assessment:

a. Bradycardia Prior to Delivery?

Yes No Unknown

b. Tachycardia Prior to Delivery?

Yes No Unknown

c. Decreased FHR Variability Prior to Delivery?

Yes No Unknown

d. Prolonged or Recurrent Decelerations Prior to Delivery?

Yes No Unknown

OB13. Arterial Cord Blood Sampling:

a. Arterial Cord Blood Sampling Performed?

Yes No Unknown

If "Yes to a, answer questions b and c below.

b. pH from Arterial Cord Blood Sample:

Record the lowest arterial cord blood pH to 2 decimal places: .

c. Base Deficit from Arterial Cord Blood Sample:

Record the worst arterial cord blood base deficit: _____ mmoles/liter

OB14. Assisted Reproduction?

Yes No Unknown

OB15. Placenta Sent for Pathology?

Yes No Unknown

PART B, INFANT'S INITIAL CLINICAL STATUS

OB16. Date and Time of Birth:

a. Date of Birth (mm/dd/yyyy): ___/___/_____

b. Time of Birth (hh:mm, AM/PM): ___ : ___ AM PM

OB17 NOT APPLICABLE



Center Number: _____

Network ID Number:

OB18. Apgar Score at 10 Minutes: _____

OB19. Arterial Blood Gas:

a. Arterial Blood Gas Obtained during First 24 Hours?

Yes No Unknown

If "Yes" to a, answer questions b and c below.

b. pH from Arterial Blood Gas:

Record the lowest arterial pH obtained within 24 hours after birth to
2 decimal places: .

c. Base Deficit from Arterial Blood Gas:

Record the worst arterial base deficit obtained within 24 hours after birth: _____ mmoles/liter

OB20. Temperature of Infant:

a. Infant Temperature Recorded within 72 Hours of Birth?

Yes No Unknown

If "Yes" to a, answer questions b and c below.

b. Highest Temperature of Infant:

Record the highest temperature within 72 hours of birth and the units in which it was recorded.

Use a single decimal place, e.g. 36.7° C or 98.2° F: . ° C ° F

c. Lowest Temperature of Infant:

Record the lowest temperature within 72 hours of birth and the units in which it was recorded.

Use a single decimal place, e.g. 36.7° C or 98.2° F: . ° C ° F



--	--	--	--	--

III. NEUROLOGICAL

PART A, NEUROLOGICAL INDICATORS ON DAY 1

	Neuro Status Day 1
NU1. Infant Alive During Examination Period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
NU2. Paralysis for the Entire Examination Period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If infant was alive and not paralyzed during the examination period, complete item NU3 through NU11 below based on the <u>worst</u> state during the examination period.	
NU3. Conscious State: (Select the worst)	<input type="checkbox"/> Normal <input type="checkbox"/> Irritability <input type="checkbox"/> Lethargy <input type="checkbox"/> Stupor <input type="checkbox"/> Coma <input type="checkbox"/> Unknown
NU4. Brainstem Function:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
NU5. Movements:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
NU6. Posturing:	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown
NU7. Tone:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
NU8. Reflexes:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
NU9. Feeding:	<input type="checkbox"/> No enteral feedings <input type="checkbox"/> No feedings by mouth <input type="checkbox"/> Some feedings by mouth <input type="checkbox"/> All feedings by mouth <input type="checkbox"/> Unknown
NU10. Assisted Ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
NU11. Clinical Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

NU12 – 33 NOT APPLICABLE



IV. DIAGNOSES AND DISCHARGE FORM

PART A, DIAGNOSES

DD1 – DD7 NOT APPLICABLE

DD8. Prenatal TORCH Infection:

a. Prenatal TORCH Infection Present?

Yes No Unknown

If "Yes" to a, indicate which of the prenatal infections in b through f below were present.

b. Toxoplasmosis?

Yes No

c. Rubella?

Yes No

d. Syphilis?

Yes No

e. Cytomegalovirus?

Yes No

f. Herpes Simplex?

Yes No

DD9. Congenital Neuromuscular Disorder?

Yes No Unknown

If "Yes", describe: _____

DD10. Birth Trauma?

a. Traumatic Birth Injury?

Yes No Unknown

If "Yes" to a, answer questions b through h below:

b. Spinal Cord Injury?

Yes No

c. Brachial Plexus Injury?

Yes No

d. Skull Fracture?

Yes No

e. Long Bone Fracture?

Yes No



Center Number: _____

Network ID Number:

f. Clavicle Fracture?

Yes No

g. Cephalhematoma?

Yes No

h. Other Traumatic Birth Injury?

Yes No

If "Yes", describe: _____

DD11 – DD 16 NOT APPLICABLE

DD17. Autopsy Status:

- N/A
- Autopsy performed
- Autopsy Permission Requested and Denied
- Autopsy Permission Not Requested
- Unknown

