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VERMONT OXFORD NETWORK
Registry for Neonatal Encephalopathy Booklet for 2008

The Neonatal Encephalopathy Registry (NER) forms 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
V. Hypothermic Therapy Form (Use form only for infants who received hypothermic therapy.)

I. ELIGIBILITY FORM

EL1. Hypothermic Therapy Received?

☐ Yes ☐ No ☐ Unknown

EL2. Gestational Age ≥ 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

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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

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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. Date/Time of Admission:

a. Date of Admission to Your NICU (mm/dd/yyyy): __ __/__ __/__ __ __ __

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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

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III. NEUROLOGICAL

PART A, NEUROLOGICAL INDICATORS ON DAY 1, DAY 3 AND DAY 7 (± 1 DAY) OF LIFE

	Neuro Status Day 1	Neuro Status Day 3	Neuro Status Day 7 (± 1 Day)
NU1. Infant Alive During Examination Period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU2. Paralysis for the Entire Examination Period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If infant was alive and not paralyzed during the examination period, complete item NU3 through NU11 below based on the worst state during the examination period.			
NU3. Conscious State: (Select the worst)	☐ Normal ☐ Irritability ☐ Lethargy ☐ Stupor ☐ Coma ☐ Unknown	☐ Normal ☐ Irritability ☐ Lethargy ☐ Stupor ☐ Coma ☐ Unknown	☐ Normal ☐ Irritability ☐ Lethargy ☐ Stupor ☐ Coma ☐ Unknown
NU4. Brainstem Function:	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown
NU5. Movements:	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown
NU6. Posturing:	☐ Present ☐ Absent ☐ Unknown	☐ Present ☐ Absent ☐ Unknown	☐ Present ☐ Absent ☐ Unknown
NU7. Tone:	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown
NU8. Reflexes:	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown	☐ Normal ☐ Abnormal ☐ Unknown
NU9. Feeding:	☐ No enteral feedings ☐ No feedings by mouth ☐ Some feedings by mouth ☐ All feedings by mouth ☐ Unknown	☐ No enteral feedings ☐ No feedings by mouth ☐ Some feedings by mouth ☐ All feedings by mouth ☐ Unknown	☐ No enteral feedings ☐ No feedings by mouth ☐ Some feedings by mouth ☐ All feedings by mouth ☐ Unknown
NU10. Assisted Ventilation?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
NU11. Clinical Seizures?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

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PART B, ELECTROPHYSIOLOGY, SEIZURES AND ANTICONVULSANTS

NU12. Full Channel EEG:

a. Full Channel EEG Performed?

☐ Yes ☐ No ☐ Unknown

b. EEG Background Pattern:

If "Yes" to a, select worst observed background pattern (select one):

☐ Normal
☐ Excessively Discontinuous
☐ Depressed Amplitude
☐ Burst Suppression Pattern
☐ Background Iso-Electric
☐ N/A
☐ Unknown

NU13. Bedside aEEG:

a. Bedside aEEG Performed?

☐ Yes ☐ No ☐ Unknown

b. Bedside aEEG Background Pattern:

If "Yes" to a, select worst observed background pattern (select one):

☐ Normal
☐ Moderately Abnormal or Discontinuous
☐ Severely Abnormal
☐ Unknown

NU14. Seizures Prior to Discharge:

a. Seizures Occurred Prior to Discharge?

☐ Yes ☐ No ☐ Unknown

If "Yes" to a, answer questions b through e below.

b. Evidence of Clinical Seizure?

☐ Yes ☐ No

c. Full Channel EEG Evidence of Seizure?

☐ Yes ☐ No

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d. Bedside aEEG Evidence of Seizure?

☐ Yes ☐ No

e. Date Seizures First Observed (mm/dd/yyyy): __ __/__ __/__ __ __ __

NU15. Anticonvulsants Prior to Discharge:

a. Anticonvulsants Received Prior to Discharge?

☐ Yes ☐ No ☐ Unknown

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

b. Phenobarbital Prior to Discharge?

☐ Yes ☐ No

c. Phenytoin or Fosphenytoin Prior to Discharge?

☐ Yes ☐ No

d. Lorazepam Prior to Discharge?

☐ Yes ☐ No

e. Diazepam Prior to Discharge?

☐ Yes ☐ No

f. Midazolam Prior to Discharge?

☐ Yes ☐ No

g. Topiramate Prior to Discharge?

☐ Yes ☐ No

h. Other Anticonvulsant Prior to Discharge?

☐ Yes ☐ No

If "Yes", specify which other anticonvulsant (s):______________________________

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PART C, NEUROIMAGING

	Cranial US Exam(s)	CT Scan(s)	MRI Scan(s)
NU16. Exam or Scan Performed?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
If an exam or scan was performed, complete all questions in the applicable column.			
NU17a. Date of First Exam/Scan: (mm/dd/yyyy)	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
NU17b. Date of Last Exam/Scan: (mm/dd/yyyy)	__ __/__ __/__ __	__ __/__ __/__ __	__ __/__ __/__ __
NU18. Intraventricular Hemorrhage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU19. Extra-axial, Subdural or Subarachnoid Hemorrhage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU20. Intraparenchymal Hemorrhage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU21. Subependymal Hemorrhage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU22. Abnormality in Deep Nuclear Gray Matter?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU23. Cystic White Matter Injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU24. Diffuse White Matter Injury?			☐ Yes ☐ No
NU25. Ventriculomegaly?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU26. Veno-Occlusion?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU27. Arterial Occlusion?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU28.Brainstem Injury?		☐ Yes ☐ No	☐ Yes ☐ No
NU29. Cerebellar Injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NU30. Diffuse Cortical Signal Abnormality?			☐ Yes ☐ No
NU31. Parasagittal Watershed Cortical Gray Matter Injury?			☐ Yes ☐ No
NU32. Absence of Posterior Limb of Internal Capsule?			☐ Yes ☐ No
NU33. Other Intracranial Abnormalities? If "Yes", describe:	☐ Yes ☐ No ____________ ____________	☐ Yes ☐ No ____________ ____________	☐ Yes ☐ No ____________ ____________

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Note: Shaded items indicate the item does not apply to this type of exam/scan.

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IV. DIAGNOSES AND DISCHARGE FORM

PART A, DIAGNOSES

DD1. Persistent Pulmonary Hypertension of the Newborn, PPHN?

☐ Yes ☐ No ☐ Unknown

DD2. Renal Failure?

☐ Yes ☐ No ☐ Unknown

DD3. Syndrome of Inappropriate Secretion of Antidiuretic Hormone, SIADH?

☐ Yes ☐ No ☐ Unknown

DD4. Disseminated Intravascular Coagulation, DIC?

☐ Yes ☐ No ☐ Unknown

DD5. Hepatic Dysfunction?

☐ Yes ☐ No ☐ Unknown

DD6. Hyperbilirubinemia within 7 Days of Birth?

☐ Yes ☐ No ☐ Unknown

DD7. Cardiac Dysfunction?

☐ Yes ☐ No ☐ Unknown

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

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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

f. Clavicle Fracture?

☐ Yes ☐ No

g. Cephalhematoma?

☐ Yes ☐ No

h. Other Traumatic Birth Injury?

☐ Yes ☐ No

If "Yes", describe: ______________________________

DD11. Meningitis or Encephalitis:

a. Meningitis or Encephalitis Suspected or Proven?

☐ Yes ☐ No ☐ Unknown

If "Yes" to a, complete the questions below.

b. Bacterial Meningitis or Encephalitis:

☐ None ☐ Suspected ☐ Proven

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

(1) Onset of Bacterial Meningitis or Encephalitis:

☐ Early ☐ Late ☐ Unknown

(2) Name of Bacterial Meningitis or Encephalitis Organism:

____

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c. Fungal Meningitis or Encephalitis:

☐ None ☐ Suspected ☐ Proven

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

(1) Onset of Fungal Meningitis or Encephalitis:

☐ Early ☐ Late ☐ Unknown

(2) Name of Fungal Meningitis or Encephalitis Organism:

____

d. Viral Meningitis or Encephalitis:

☐ None ☐ Suspected ☐ Proven

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

(1) Onset of Viral Meningitis or Encephalitis:

☐ Early ☐ Late ☐ Unknown

(2) Name of Viral Meningitis or Encephalitis Organism:

____

PART B, DISCHARGE STATUS

DD12. Hearing Screening:

a. Hearing Screen Exam Performed?

☐ Yes ☐ No ☐ Unknown

If "Yes" to a, enter the results of the last exam before discharge.

b. Hearing Screen Passed?

☐ Yes

☐ No

☐ Unknown

DD13. Feedings at Discharge:

☐ No Enteral Feedings

☐ Enteral Feedings, No Feedings by Mouth

☐ Enteral Feedings, Some Feedings by Mouth

☐ Enteral Feedings, All Feedings by Mouth

☐ Unknown

DD14. Tracheotomy at Discharge?

☐ Yes ☐ No ☐ Unknown

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DD15. Discharged with Ventilator?

☐ Yes ☐ No ☐ Unknown

DD16. Anticonvulsant Medication at Discharge?

a. Anticonvulsant Medication at Discharge?

☐ Yes ☐ No ☐ Unknown

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

b. Phenobarbital at Discharge?

☐ Yes ☐ No

c. Phenytoin or Fosphenytoin at Discharge?

☐ Yes ☐ No

d. Lorazepam at Discharge?

☐ Yes ☐ No

e. Diazepam at Discharge?

☐ Yes ☐ No

f. Midazolam at Discharge?

☐ Yes ☐ No

e. Topiramate at Discharge?

☐ Yes ☐ No

h. Other Anticonvulsant at Discharge?

☐ Yes ☐ No

If "Yes", specify which other anticonvulsant(s) ______________________

DD17. Autopsy Status:

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

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V. HYPOTHERMIC THERAPY FORM

Complete this form only for infants who received Hypothermic Therapy
If EL1 on the Eligibility Form is answered No or Unknown, do not complete this form.

HT1. Cooling Location and Method:

a. Cooling at Hospital from which Infant Transferred (outborn infants only):

(1) **Hypothermic Therapy at Hospital from which Transferred?**

☐ Not Outborn ☐ Yes ☐ No ☐ Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) **Cooling Method at Hospital from which Transferred:**

☐ Selective Head ☐ Whole Body ☐ Unknown

(3) **Hospital from which Infant Transferred:**

Name of Hospital: ____

City:________________________State/Prov./Country:__________________

b. Cooling During Transport to Your Hospital (outborn infants only):

(1) **Hypothermic Therapy During Transport to Your Hospital?**

☐ Not Outborn ☐ Yes ☐ No ☐ Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) **Cooling Method during Transport to Your Hospital:**

☐ Selective Head ☐ Whole Body ☐ Unknown

(3) **Hospital from which Infant Transferred:**

Name of Hospital: ____

City:________________________State/Prov./Country:__________________

c. Cooling at Your Hospital:

(1) **Hypothermic Therapy at Your Hospital?**

☐ Yes ☐ No ☐ Unknown

If "Yes" to (1), answer question (2) below.

(2) **Cooling Method at Your Hospital:**

☐ Selective Head ☐ Whole Body ☐ Unknown

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d. Cooling During Transport from Your Hospital (transferred infants only):

(1) **Hypothermic Therapy During Transport from Your Hospital?**

☐ Not Transferred ☐ Yes ☐ No ☐ Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) **Cooling Method during Transport from Your Hospital:**

☐ Selective Head ☐ Whole Body ☐ Unknown

(3) **Hospital to which Infant Transferred:**

Name of Hospital: ____

City:_______________________State/Prov./Country:_______________

e. Cooling at Hospital to which Infant Transferred (transferred infants only)

(1) **Hypothermic Therapy at Hospital to which Transferred?**

☐ Not Transferred ☐ Yes ☐ No ☐ Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) **Cooling Method at Hospital to which Transferred:**

☐ Selective Head ☐ Whole Body ☐ Unknown

(3) **Hospital to which Infant Transferred:**

Name of Hospital: ____

City:_______________________State/Prov./Country:_______________

HT2. Dates and Time Hypothermic Therapy Began:

a. Date Hypothermic Therapy Began (mm/dd/yyyy): __ __/__ __/__ __ __ __

b. Time Hypothermic Therapy Began (hh:mm, AM/PM): __ __ : __ __ ☐ AM ☐ PM

HT3. Date and Time Hypothermic Therapy Stopped:

a. Date Hypothermic Therapy Stopped:

(mm/dd/yyyy): __ __/__ __/__ __ __ __

b. Time Hypothermic Therapy Stopped and Re-Warming Began:

(hh:mm, AM/PM): __ __ : __ __ ☐ AM ☐ PM

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HT4. Core Body Temperature when Hypothermic Therapy Stopped:

a. Temperature Measured when Hypothermic Therapy Stopped? ☐ Yes ☐ No

b. Temperature when Hypothermic Therapy Stopped: Record the temperature when hypothermic therapy stopped and the units in which it was recorded. Use a single decimal place, e.g. 36.7° C or 98.2° F: ☐☐☐.☐ ☐ ° C ☐ ° F

HT5. Date and Time Re-warming Completed:

a. Date Re-warming Completed (mm/dd/yyyy): __ __/__ __/__ __ __ __

b. Time Re-warming Completed (hh:mm, AM/PM): __ __ : __ __ ☐ AM ☐ PM

HT6. Cooling Interruptions:

a. Was Cooling Interrupted for More than 30 Minutes?

☐ Yes ☐ No ☐ Unknown

If "Yes" to a, answer question b below.

b. Number of Cooling Interruptions? _________

HT7. Cooling Provided as Part of a Randomized Controlled Trial?

☐ Yes ☐ No ☐ Unknown

HT8. Adverse Events within 7 Days of Birth:

a. Cardiac Arrhythmia within 7 Days of Birth?

☐ Yes ☐ No

If "Yes" to a, indicate in (1) through (6) below, the adverse events from Cardiac Arrhythmia:

(1) Sinus Bradycardia? ☐ Yes ☐ No

(2) Sinus Tachycardia? ☐ Yes ☐ No

(3) Ventricular Tachycardia? ☐ Yes ☐ No

(4) Ventricular Fibrillation? ☐ Yes ☐ No

(5) Conduction Block? ☐ Yes ☐ No

(6) Prolonged QT interval? ☐ Yes ☐ No

(7) Other Arrhythmia? ☐ Yes ☐ No

If "Other" Arrhythmia, describe: ______________________________

b. Thrombosis within 7 Days of Birth?

☐ Yes ☐ No

c. Severe Hypotension within 7 Days of Birth?

☐ Yes ☐ No

d. Seizure during Re-Warming within 7 Days of Birth?

☐ Yes ☐ No

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e Scalp Edema within 7 Days of Birth?

☐ Yes ☐ No

f. Skin Breakdown within 7 Days of Birth?

☐ Yes ☐ No

g. Sclerema Neonatorum within 7 Days of Birth?

☐ Yes ☐ No

h. Thrombocytopenia within 7 Days of Birth?

☐ Yes ☐ No

HT9. Seizures Prior to Cooling?

☐ Yes ☐ No ☐ Unknown

HT10. Modified SARNAT Stage Prior to Cooling: ________

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