This is the recommended format in which data items should appear on the data entry screen for electronic data entry. Supplemental data items must be submitted electronically.

VERMONT OXFORD NETWORK
SUPPLEMENTAL DATA FORM - *Infants Born in 2010*

Center Number: ___________ **Center Name:** ______________________________________

Network ID Number: ☐☐☐☐☐ **Year of Birth:** ___________

S1. Treatments:

A. 1. Duration of Assisted Ventilation After Admission:

☐ None ☐ <4 hours ☐ 4-24 hours ☐ > 24 hours ☐ N/A

2. If > 24 hours, total days of assisted ventilation after admission: ________

B. ECMO at your Hospital: ☐ Yes ☐ No ☐ N/A

C. Hypothermic Therapy at Your Hospital:

1. Was Hypothermic Therapy Performed at Your Hospital: ☐ Yes ☐ No

2. If *Yes*, Cooling Method: ☐ Selective Head ☐ Whole Body

S2. Diagnoses:

A. 1. Hypoxic-Ischemic Encephalopathy: ☐ Yes ☐ No ☐ N/A

2. HIE Severity (check one): ☐ Mild ☐ Moderate ☐ Severe ☐ N/A

B. 1. Meconium Aspiration: ☐ Yes ☐ No

2. Tracheal Suction for Meconium Attempted in the DR:

☐ Yes ☐ No ☐ N/A

C. Seizures: ☐ Yes ☐ No ☐ N/A

These data items are to be completed by participants in the

Expanded Database and /or the Neonatal Encephalopathy Registry only.

Supplemental data must be submitted electronically.

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