

Center Number: _____

Network ID Number:

LENGTH OF STAY CALCULATION WORKSHEET

INFANTS BORN IN 2010

Protected Health Care Information. DO NOT SUBMIT this Worksheet to Vermont Oxford Network.

Refer to the Manual of Operations, Release 14.0, for instructions on completing this Worksheet.

Please use items W5, W8 and W9 from the Patient Identification Worksheet when completing this form.

Part A. Initial Length Of Stay

Calculate Initial Length of Stay using the Day Number Chart in the appendices of the Manual of Operations, Rel 14.0

Enter Date of Initial Discharge, Transfer or Death (W8): ____/____/____ Day #

Subtract Date of Admission (W5): ____/____/____ - Day #

For inborn infants, the date of admission is the Date of Birth.

For outborn infants, the date of admission is the date the infant was admitted to your hospital.

Add 1: + 1

L1. INITIAL LENGTH OF STAY = Days

Note: the maximum value of Initial Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

(Enter Initial Length of Stay in Item 50 on the Discharge Form.)

PLEASE CHECK YOUR MATH!

Part B. Total Length Of Stay

Only For Infants Transferred From Your Hospital to Another Hospital.

Calculate Total Length of Stay (for transferred infants only) using the Day Number Chart in the appendices of the Manual of Operations, Release 14.0.

Enter Date of Final Discharge or Death (W9): ____/____/____ Day #

Subtract Date of Admission (W5): ____/____/____ - Day #

For inborn infants, the date of admission is the Date of Birth.

For outborn infants, the date of admission is the date the infant was admitted to your hospital.

Add 1: + 1

L2. TOTAL LENGTH OF STAY = Days

Note: the maximum value of Total Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

(Enter Total Length of Stay in Part D, Item 57 of the Transfer and Readmission Form.)

PLEASE CHECK YOUR MATH!

SAMPLE CALCULATION OF INITIAL LENGTH OF STAY

Enter Date of Initial Discharge, Transfer or Death: 02 / 26 / 2010 Day #

Subtract Date of Admission: 01 / 13 / 2010 - Day #

Add 1: + 1

L1. INITIAL LENGTH OF STAY = Days

Explanation: Date of 02/26/2010 is Day Number 57. Date of 01/13/2010 is Day Number 13. The numbers for each date are found in the Day Number Chart in the appendices of the Manual of Operations, Release 14.0.

PLEASE DO NOT SUBMIT THIS WORKSHEET

Protected Health Care Information



28 DAY FORM - *Infants Born in 2010*



Center Number: _____

Center Name: _____

Network ID Number:

Year of Birth: _____

1. Birth Weight:	_____ grams		
2. Gestational Age:	a) Weeks _____	b) Days (0-6) _____	
3. Died in Delivery Room:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If Yes, Use Delivery Room Death Form.)
4. a) Location of Birth:	<input type="checkbox"/> Inborn	<input type="checkbox"/> Outborn	
	b) If Outborn, Day of Admission to Your Hospital (Range: 1 to 28. Date of Birth is Day 1): _____		
	c) If Outborn, Transfer Code of Center from which Infant Transferred: _____		
5. Head Circumference at Birth (in cm to nearest 10 th):	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Maternal Ethnicity/Race (Answer both a and b):			
a) Ethnicity of Mother:	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Not Hispanic	
b) Race of Mother:	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Asian or Pacific Islander
	<input type="checkbox"/> Native American	<input type="checkbox"/> Other	
7. Prenatal Care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Antenatal Steroids:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Chorioamnionitis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Maternal Hypertension, Chronic or Pregnancy-Induced:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Mode of Delivery:	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Cesarean Section	
12. Sex of Infant:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
13. a) Multiple Gestation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	b) If Yes, Number of infants delivered: _____
14. APGAR Scores:	a) 1 minute _____	b) 5 minutes _____	
15. Initial Resuscitation:			
a) Oxygen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Face Mask Vent:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) Endotracheal Tube Vent:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
d) Epinephrine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
e) Cardiac Compression:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16. a) Temperature Measured within the First Hour after Admission to <u>Your</u> NICU:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
b) If Yes, enter first Temperature after admission (in degrees centigrade to nearest 10 th):	<input type="text"/>	<input type="text"/>	<input type="text"/>
17. Bacterial Sepsis, Early (on or before Day 3 of life):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
18. Oxygen on Day 28:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A (See Manual for N/A criteria)
19. Periventricular-Intraventricular Hemorrhage (PIH):			
a) Cranial Imaging (US/CT/MRI) on or before Day 28:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) If Yes, enter Worst Grade of PIH (0-4):	_____		
c) Where PIH first occurred (See Manual for definition):	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> N/A
20. Died Within 12 Hours of Admission to Your NICU:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	



Center Number: _____ Center Name: _____

Network ID Number:

Year of Birth: _____

INTERVENTIONS

21. Respiratory Support (After Leaving DR):

- a) Oxygen: Yes No
- b) Con Vent: Yes No
- c) HIFI Vent: Yes No
- d) High Flow Nasal Cannula: Yes No
- e) Nasal IMV or Nasal SIMV: Yes No

22. a) Nasal CPAP: Yes No

b) *If Yes, NCPAP before ETT Vent:* Yes No

23. a) Surfactant in the DR: Yes No

b) **Surfactant at Any Time:** Yes No (Item 23.b must be **Yes** if Item 23.a is **Yes**)

If Yes, enter Age at First Dose: **c) Hours** _____ **d) Minutes (0-59)** _____

24. a) Inhaled Nitric Oxide: Yes No

b) *If Yes, where given:* Your Hospital Other Hospital Both

25. Oxygen at 36 Wks (Corrected GA): Yes No N/A (See Manual for N/A criteria)

26. a) Steroids for CLD: Yes No

b) *If Yes, where given:* Your Hospital Other Hospital Both

27. Indomethacin for Any Reason: Yes No

28. Ibuprofen for PDA: Yes No

Surgery:

29. a) PDA Ligation: Yes No

b) *If Yes, where done:* Your Hospital Other Hospital Both

30. a) ROP Surgery: Yes No

b) *If Yes, where done:* Your Hospital Other Hospital Both

31. NEC Surgery: Yes No (If **Yes**, a Surgery Code is Required in item 33a)

32. Other Surgery: Yes No (If **Yes**, a Surgery Code is Required in item 33a)

33a. Surgical Codes:

For **NEC Surgery**, enter at least one of the following codes and location of where done: **S302, S303, S307, S308, S309, S333.**

For **Other Surgery**, use **Appendix D** in the Manual to select proper codes.

Surgery Code 1: _____ Your Hospital Other Hospital Both

Surgery Code 2: _____ Your Hospital Other Hospital Both

Surgery Code 3: _____ Your Hospital Other Hospital Both

Surgery Code 4: _____ Your Hospital Other Hospital Both

Surgery Code 5: _____ Your Hospital Other Hospital Both

Surgery Code 6: _____ Your Hospital Other Hospital Both

Surgery Code 7: _____ Your Hospital Other Hospital Both

Surgery Code 8: _____ Your Hospital Other Hospital Both

Surgery Code 9: _____ Your Hospital Other Hospital Both

Surgery Code 10: _____ Your Hospital Other Hospital Both

33b. Include description for codes S100, S200, S300, S400, S500, S600, S700, S800, S900, S1000 & S1001:

DISCHARGE FORM - *Infants Born in 2010* PAGE 2



Center Number: _____ Center Name: _____

Network ID Number:

Year of Birth: _____

DIAGNOSES

34. Respiratory Distress Syndrome: Yes No
35. a) Pneumothorax: Yes No
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both
36. Patent Ductus Arteriosus: Yes No
37. a) Necrotizing Enterocolitis: Yes No
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both
38. a) Gastrointestinal Perforation: Yes No
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both

Sepsis and/or Meningitis, Late (after day 3 of life): (See Manual for N/A criteria)

39. a) Bacterial Pathogen: Yes No N/A
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both
40. a) Coag Negative Staph: Yes No N/A
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both
41. a) Fungal Infection: Yes No N/A
 b) *If Yes, where occurred:* Your Hospital Other Hospital Both

42. Cystic Periventricular Leukomalacia: Yes No N/A (See Manual for N/A criteria)

43. ROP: a) Retinal Exam Done: Yes No
 b) *If Yes, Worst Stage of ROP (0-5):* _____

44. Birth Defect Present: Yes No
If Yes, enter codes (see Appendix C in Manual of Operations): _____
 Include description for Codes 100, 504, 601, 605, 901, 902, 903, 904 & 907: _____

DISCHARGE

45. Enteral Feeding at Discharge:
 None
 Human Milk Only
 Formula Only
 Human milk in combination with either fortifier or formula

46. Oxygen and Monitor at Discharge:
 a) Oxygen at Discharge: Yes No
 b) Monitor at Discharge: Yes No

47. Initial Disposition from Your Hospital (check only one):
 Home
 Died
 Transferred to Another Hospital (★ Complete separate Transfer and Readmission Form)
 Still Hospitalized as of First Birthday

48. Weight at Initial Disposition: _____ grams

49. Head Circumference at Initial Disposition (in cm to nearest 10th):

50. Initial Length of Stay: _____ day(s) (Item L1 on Length of Stay Calculation Worksheet)