



Center Number: \_\_\_\_\_

Network ID Number:

## LENGTH OF STAY CALCULATION WORKSHEET FOR INFANTS BORN IN 2011

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

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

Find the day numbers corresponding to dates using the Day Number Chart for 2011-2012 ([www.vtoxford.org](http://www.vtoxford.org)).

### Part A. Initial Length Of Stay

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

Subtract Date of Admission to Your Hospital (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.

### Part B. Total Length Of Stay

**Only For Infants Transferred From Your Hospital to Another Hospital.**

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.

### SAMPLE CALCULATION OF INITIAL LENGTH OF STAY

Enter Date of Initial Discharge, Transfer or Death: 02 / 26 / 2011  57 Day #

Subtract Date of Admission: 01 / 13 / 2011 -  13 Day #

Add 1: ..... +           1

L1. INITIAL LENGTH OF STAY = .....  45 Days

Explanation: Date of 02/26/2011 is Day Number 57. Date of 01/13/2011 is Day Number 13. The day numbers for each date are found in the 2011-2012 Day Number Chart on the Network web site, [www.vtoxford.org](http://www.vtoxford.org).

**PLEASE DO NOT SUBMIT THIS WORKSHEET**

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# 28 DAY FORM - For Infants Born in 2011



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 <sup>th</sup> ):	<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	
	f) Nasal CPAP	<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, first Temperature after Admission (in degrees centigrade to nearest 10 <sup>th</sup> ):	<input type="text"/> <input type="text"/> . <input type="text"/>	
17.	Bacterial Sepsis on or before Day 3:	<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, Worst Grade of PIH (0-4):	_____	
	c) If PIH, Where PIH First Occurred:	<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** (at any time after leaving the delivery room/initial resuscitation area):

- a) Oxygen after Initial Resuscitation:  Yes  No
- b) Conventional Ventilation after Initial Resuscitation:  Yes  No
- c) High Frequency Ventilation after Initial Resuscitation:  Yes  No
- d) High Flow Nasal Cannula after Initial Resuscitation:  Yes  No
- e) Nasal IMV or Nasal SIMV after Initial Resuscitation:  Yes  No

- 22. a) Nasal CPAP after Initial Resuscitation:  Yes  No
- b) If Yes, NCPAP before ETT Vent:  Yes  No

- 23. a) Surfactant during Initial Resuscitation:  Yes  No
- b) Surfactant at Any Time:  Yes  No (Item 23.b must be Yes if Item 23.a is Yes)
- If Yes, 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. Respiratory Support at 36 Weeks** (See Manual for N/A criteria):

- a) Oxygen at 36 Weeks:  Yes  No  N/A
- b) Conventional Ventilation at 36 Weeks:  Yes  No  N/A
- c) High Frequency Ventilation at 36 Weeks:  Yes  No  N/A
- d) High Flow Nasal Cannula at 36 Weeks:  Yes  No  N/A
- e) Nasal IMV or SIMV at 36 Weeks:  Yes  No  N/A
- f) Nasal CPAP at 36 Weeks:  Yes  No  N/A

- 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

- 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. If Yes to NEC Surgery or Other Surgery, Surgical Codes** (See Appendix D): If NEC Surgery, one or more of the following codes is required: S302, S303, S307, S308, S309, S333. Indicate location of surgery for each surgery code.

- 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:**



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) Coagulase 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. Major Birth Defect:**  Yes  No

*If Yes, enter codes:* \_\_\_\_\_

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 (check only one):**
- Home
  - Died
  - Transferred to another Hospital (★ Complete 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)

# TRANSFER & READMISSION FORM - *For Infants Born in 2011*



Center Number: \_\_\_\_\_ Center Name: \_\_\_\_\_

Network ID Number:  Year of Birth: \_\_\_\_\_

## Part A. Complete for ALL Transferred Infants

If an infant is transferred to another hospital, complete Items 51 - 53. Post Transfer Disposition (Item 53) refers to the infant's disposition upon leaving the "transferred to" hospital.

51. Reason for Transfer: (Check Only One)  Growth/Discharge Planning  Medical/Diagnostic Services  
 Surgery  ECMO  Chronic Care  Other

52. Transfer Code of Center to which Infant Transferred: \_\_\_\_\_ (List available at [www.vtoxford.org](http://www.vtoxford.org))

### 53. Post Transfer Disposition (check only one):

- Home *Skip Parts B and C. Complete Part D.*
- Transferred Again to Another Hospital (2<sup>nd</sup> Transfer) *Skip Part B. Complete Parts C and D when data are available.*
- Died *Skip Parts B and C. Complete Part D.*
- Readmitted to Any Location in Your Hospital *Complete Parts B and D (and C if applicable) when data are available.*
- Still Hospitalized as of First Birthday *Skip Parts B and C. Complete Part D.*

## Part B. Complete ONLY for Readmitted Infants

If a patient is readmitted to your center after transferring once to another hospital without having been home, answer Items 54 - 55. When infants are readmitted to your center, continue to update Items 17 - 19 on the 28 Day Form, and Items 21 - 46 on the Discharge Form based on all events at both hospitals until the date of Disposition after Readmission. If your hospital participates in the Expanded Database and definition criteria are met, update Items S1.B, S1.C1, S1.C2, S2.A1, S2.A2 and S2.C based on events that occur following transfer and readmission.

### 54. Disposition after Readmission (check only one):

- Home *Skip Part C. Complete Part D.*
- Died *Skip Part C. Complete Part D.*
- Transferred Again to Another Hospital *Complete Parts C and D when data are available.*
- Still Hospitalized as of First Birthday *Skip Part C. Complete Part D.*

55. Weight at Disposition after Readmission: \_\_\_\_\_ grams

## Part C. Complete ONLY for Infants Who Transferred More Than Once

Answer Item 56 if an infant transferred from your center to another hospital and was then either (1) transferred again to another hospital, or (2) readmitted to your center and then transferred again to another hospital.

### 56. Ultimate Disposition (check only one):

- Home *Complete Part D.*
- Died *Complete Part D.*
- Still Hospitalized as of First Birthday *Complete Part D.*

## Part D. Complete for ALL Transferred Infants

Complete this item when the infant has been discharged Home, Died or is Still Hospitalized as of First Birthday, whichever comes first.

57. Total Length of Stay: \_\_\_\_\_ day(s) (Item L2 on Length of Stay Calculation Worksheet)

# SUPPLEMENTAL DATA FORM - *For Infants Born in 2011* (Expanded Database Hospitals)

Center Number: \_\_\_\_\_ Center Name: \_\_\_\_\_

Network ID Number:

Year of Birth: \_\_\_\_\_

<b>S1. Treatments:</b>				
<p><b>A. 1. Duration of Assisted Ventilation:</b></p> <p style="text-align: center;"> <input type="checkbox"/> None                <input type="checkbox"/> &lt;4 hours                <input type="checkbox"/> 4-24 hours                <input type="checkbox"/> &gt; 24 hours                <input type="checkbox"/> N/A         </p> <p><b>2. If &gt; 24 hours, Total Days of Assisted Ventilation:</b> _____</p>				
<p><b>B. ECMO at your Hospital:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No                <input type="checkbox"/> N/A         </p>				
<p><b>C. Hypothermic Therapy at Your Hospital:</b></p> <p><b>1. Was Hypothermic Therapy Performed at Your Hospital:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No         </p> <p><b>2. If Yes, Cooling Method:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Selective Head                <input type="checkbox"/> Whole Body         </p>				
<b>S2. Diagnoses:</b>				
<p><b>A. 1. Hypoxic-Ischemic Encephalopathy:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No                <input type="checkbox"/> N/A         </p> <p><b>2. HIE Severity (check one):</b></p> <p style="text-align: center;"> <input type="checkbox"/> Mild                <input type="checkbox"/> Moderate                <input type="checkbox"/> Severe                <input type="checkbox"/> N/A         </p>				
<p><b>B. 1. Meconium Aspiration:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No         </p> <p><b>2. Tracheal Suction for Meconium Attempted in the DR:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No                <input type="checkbox"/> N/A         </p>				
<p><b>C. Seizures:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Yes                <input type="checkbox"/> No                <input type="checkbox"/> N/A         </p>				