

Center Number: _____

Network ID Number:

LENGTH OF STAY CALCULATION WORKSHEET FOR INFANTS BORN IN 2012

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 2012-2013 (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 / 2012 57 Day #

Subtract Date of Admission: 01 / 13 / 2012 - 13 Day #

Add 1: +
+ 1

L1. INITIAL LENGTH OF STAY = 44 Days

Explanation: Date of 02/26/2012 is Day Number 57. Date of 01/13/2012 is Day Number 13. The day numbers for each date are found in the 2012-2013 Day Number Chart on the Network web site, www.vtoxford.org.

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information



28 DAY FORM - *For Infants Born in 2012*



Center Number: _____ 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 Center (Range: 1 to 28. Date of Birth is Day 1): _____																		
	c) If Outborn, Transfer Code of Center from which Infant Transferred: _____ <small>(List available at http://www.vtoxford.org/tools/transferlist.aspx)</small>																		
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 or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <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. Antenatal Magnesium Sulfate:	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
10. Chorioamnionitis:	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
11. Maternal Hypertension, Chronic or Pregnancy-Induced:	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
12. Mode of Delivery:	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section																		
13. Sex of Infant:	<input type="checkbox"/> Male <input type="checkbox"/> Female																		
14. a) Multiple Gestation:	<input type="checkbox"/> Yes <input type="checkbox"/> No b) If Yes, Number of Infants Delivered: _____																		
15. APGAR Scores:	a) 1 minute _____ b) 5 minutes _____																		
16. Initial Resuscitation:	<table style="width: 100%; border: none;"> <tr> <td>a) Oxygen:</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>b) Face Mask Vent:</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>c) Endotracheal Tube Vent:</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>d) Epinephrine:</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>e) Cardiac Compression:</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>f) Nasal CPAP</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>	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
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																	
17. 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, Temperature Within the First Hour after Admission to Your NICU (in degrees centigrade to nearest 10 th): <input type="text"/> <input type="text"/> . <input type="text"/>																		
18. Bacterial Sepsis on or before Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
19. Oxygen on Day 28:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual for N/A criteria)																		
20. 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 Grade 1-4, Where PIH First Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> N/A																		
21. Died Within 12 Hours of Admission to Your NICU:	<input type="checkbox"/> Yes <input type="checkbox"/> No																		



Center Number: _____ Network ID Number: Year of Birth: _____

INTERVENTIONS

- 22. 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
-
- 23.** a) **Nasal CPAP after Initial Resuscitation:** Yes No
 b) **If Yes, NCPAP before ETT Vent:** Yes No
-
- 24.** a) **Surfactant during Initial Resuscitation:** Yes No
 b) **Surfactant at Any Time:** Yes No (Item 24.b must be Yes if Item 24.a is Yes)
If Yes, Age at First Dose: c) Hours _____ d) Minutes (0-59) _____
-
- 25.** a) **Inhaled Nitric Oxide:** Yes No
 b) **If Yes, where given:** Your Hospital Other Hospital Both
-
- 26. 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
-
- 27.** a) **Steroids for CLD:** Yes No
 b) **If Yes, Where Given:** Your Hospital Other Hospital Both
-
- 28. Indomethacin for Any Reason:** Yes No
-
- 29. Ibuprofen for PDA:** Yes No
-
- 30. Probiotics:** Yes No
-
- 31. Treatment of ROP with Anti-VEGF Drug:** Yes No
-
- 32.** a) **ROP Surgery:** Yes No
 b) **If Yes, Where Done:** Your Hospital Other Hospital Both
-
- 33.** a) **PDA Ligation:** Yes No
 b) **If Yes, Where Done:** Your Hospital Other Hospital Both
-
- 34. NEC Surgery:** Yes No (If Yes, a Surgery Code is Required in item 36a)
-
- 35. Other Surgery:** Yes No (If Yes, a Surgery Code is Required in item 36a)
-
- 36a. 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

36b. Include description for codes S100, S200, S300, S400, S500, S600, S700, S800, S900, S1000 & S1001:

DISCHARGE FORM - For Infants Born in 2012

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Center Number: _____ Network ID Number: Year of Birth: _____

DIAGNOSES

- 37. Respiratory Distress Syndrome:** Yes No
- 38. a) Pneumothorax:** Yes No
b) If Yes, Where Occurred: Your Hospital Other Hospital Both
- 39. Patent Ductus Arteriosus:** Yes No
- 40. a) Necrotizing Enterocolitis:** Yes No
b) If Yes, Where Occurred: Your Hospital Other Hospital Both
- 41. 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)
- 42. a) Bacterial Pathogen:** Yes No N/A
b) If Yes, Where Occurred: Your Hospital Other Hospital Both
- 43. a) Coagulase Negative Staph:** Yes No N/A
b) If Yes, Where Occurred: Your Hospital Other Hospital Both
- 44. a) Fungal Infection:** Yes No N/A
b) If Yes, Where Occurred: Your Hospital Other Hospital Both
- 45. Cystic Periventricular Leukomalacia:** Yes No N/A (see Manual for N/A criteria)
- 46. ROP:** a) Retinal Exam Done: Yes No
 b) If Yes, Worst Stage of ROP (0-5): _____
- 47. Major Birth Defect:** Yes No
If Yes, enter codes: _____
Include description for Codes 100, 504, 601, 605, 901, 902, 903, 904 & 907: _____

DISCHARGE

- 48. Enteral Feeding at Discharge:**
 None
 Human Milk Only
 Formula Only
 Human milk in combination with either fortifier or formula
- 49. Oxygen and Monitor at Discharge:**
 a) Oxygen at Discharge: Yes No
 b) Monitor at Discharge: Yes No
- 50. Initial Disposition (check only one):**
 Home
 Died
 Transferred to another Hospital (★ Complete Transfer and Readmission Form)
 Still Hospitalized as of First Birthday
- 51. Weight at Initial Disposition:** _____ grams
- 52. Head Circumference at Initial Disposition (in cm to nearest 10th):** .
- 53. Initial Length of Stay:** _____ day(s) (Item L1 on Length of Stay Calculation Worksheet)

TRANSFER & READMISSION FORM - *For Infants Born in 2012*



Center Number: _____ Network ID Number: Year of Birth: _____

Part A. Complete for ALL Transferred Infants

If an infant is transferred to another hospital, complete Items 54 - 56. Post Transfer Disposition (Item 56) refers to the infant's disposition upon leaving the "transferred to" hospital.

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

55. Transfer Code of Center to which Infant Transferred: _____ (List available at <http://www.vtoxford.org/tools/transferlist.aspx>)

56. Post Transfer Disposition (check only one):

- Home *Skip Parts B and C. Complete Part D.*
- Transferred Again to Another Hospital (2nd 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 57 - 58. When infants are readmitted to your center, continue to update Items 18 - 20 on the 28 Day Form, and Items 22 - 49 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.

57. 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.*

58. Weight at Disposition after Readmission: _____ grams

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

Answer Item 59 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.

59. 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 Item 60 when the infant has been discharged Home, Died or is Still Hospitalized as of First Birthday, whichever comes first.

60. Total Length of Stay: _____ day(s) (Item L2 on Length of Stay Calculation Worksheet)

SUPPLEMENTAL DATA FORM - *For Infants Born in 2012*
 (For Expanded Database and NER VLBW Centers)



Center Number: _____ Network ID Number: Year of Birth: _____

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