

**VERMONT OXFORD NETWORK**  
**Neonatal Encephalopathy Registry Follow-Up**  
**HEALTH STATUS REPORT**

Center Number: \_\_\_\_\_ Center Name: \_\_\_\_\_  
 Network ID Number: \_\_\_\_\_ Year of Birth (YYYY): \_\_\_\_\_

**SECTION A: HEALTH STATUS**

1. Status at 2 years (24 months) of age:  Alive  Expired  Unknown  
 2. Consent obtained at the follow-up visit:  Yes  No

**SECTION B: LIVING SITUATION**

3. Maternal Age at Infant Birth: \_\_\_\_ years  Unknown  
 4. Home Child Resides:  Parent/Family member  Foster care  Chronic care facility  
 5. Caregiver(s):  Single parent  Single parent extended family  Institutional  
     Check (✓) only one.  Two parent  Two parent extended family  
 6. Primary Caregiver Education:  Some high school or less  Some college/university  
     Check (✓) only one.  High school degree/GED  College/university degree  
      Not applicable  Unknown

**USA CENTERS ONLY:**

7. Income Below 2006 HHS Poverty Guideline:  Yes  No  Unknown  
     See Income Appendix: 2006 PAGE 2  
 8. Caregiver(s) Primary Language:  English  Spanish  Other

**SECTION C: SUPPORT AT FOLLOW-UP**

9. Support at follow-up: Check (✓) all that apply.  
 1. Tracheostomy  
 2. Ventilator  
 3. Oxygen  
 4. Gastrostomy  
 5. Tube feedings  
 6. Apnea or Cardio-Respiratory monitor  
 7. Anti-convulsant medications  
 8. Physical or Occupational therapy  
 9. None

**SECTION D: MEDICAL RE-HOSPITALIZATIONS & SURGERIES**

10. Medical re-hospitalizations after ultimate discharge:  
 Yes  No  Unsure
- |   |                             |
|---|-----------------------------|
| a. <b>If Yes, Category:</b> Check (✓) all that apply.         | <b>Number of Admissions</b> |
| <input type="checkbox"/> 1. Respiratory illness               | _____                       |
| <input type="checkbox"/> 2. Nutrition/Failure to Thrive       | _____                       |
| <input type="checkbox"/> 3. Seizure disorder                  | _____                       |
| <input type="checkbox"/> 4. Shunt complication                | _____                       |
| 5. Infections (not respiratory or shunt infections):          |                             |
| <input type="checkbox"/> a. Meningitis                        | _____                       |
| <input type="checkbox"/> b. Urinary tract infection           | _____                       |
| <input type="checkbox"/> c. Gastrointestinal infection        | _____                       |
| <input type="checkbox"/> d. Other infection:                  | _____                       |
| _____ (specify)   |                             |
| <input type="checkbox"/> 6. Other Medical Re hospitalization: | _____                       |
| _____ (specify)   |                             |
11. Surgical Procedures After Discharge:  
 Yes  No  Unsure **Number of Procedures**  
 (P-Codes) \_\_\_\_\_ \_\_\_\_\_  
 \_\_\_\_\_ \_\_\_\_\_

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**Birth Year 2007**

**HEALTH STATUS REPORT: PAGE 2**

**INCOME APPENDIX: 2006**

**HHS Poverty Guidelines (UNITED STATES)**

Persons in Household	
2	\$ 13,200
3	\$ 16,600
4	\$ 20,000
5	\$ 23,400
6	\$ 26,800
7	\$ 30,200
8	\$ 33,600
9	\$ 37,000
10	\$ 40,400
Each additional person	\$ 3,400

**Source:** Federal Register, Vol.71, No. 15, January 24, 2006. pp.3848-3849

**SURGICAL PROCEDURE CODES (P –CODES)**

<b>CODE</b>	<b>PROCEDURE</b>
	<b><u>Central Nervous System Surgery</u></b>
P-101	Shunt or shunt revision for hydrocephalus
P-102	Other neurosurgical procedure
	<b><u>Congenital Heart Defect Surgery</u></b>
P-201	Cardiac surgery
	<b><u>Gastrointestinal Surgery</u></b>
P-301	Gastrostomy tube placement
P-302	Inguinal hernia repair
P-303	Other gastrointestinal surgical procedure
P-304	Fundoplication
	<b><u>Genitourinary Surgery</u></b>
P-401	Circumcision
P-402	Other genitourinary surgical procedure
	<b><u>Otolaryngology Surgery</u></b>
P-501	Tracheostomy
P-502	Typanostomy tubes
P-503	Other ENT surgical procedure
	<b><u>Ophthalmologic Surgery</u></b>
P-603	Strabismus surgery
P-604	Other ophthalmological surgical procedure
P-900	<b><u>Other Surgical Procedure</u></b>

