

NICU WORKSHEET		
PATIENT DATA		<input type="checkbox"/> Readmission
*Last Name _____	*First Name _____	
*Birth Hospital Med Rec# _____	*Birth Hospital Name _____	
*Birth Date ____ / ____ / _____	Birth Time ____ : ____	Birth Weight _____ gms
Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Plurality _____	*Birth Order _____ 0=singleton; 1=first multiple etc
Cord pH: <input type="radio"/> Yes <input type="radio"/> No Cord pH Value: _____ Cord pH Type: <input type="checkbox"/> UA <input type="checkbox"/> UV <input type="checkbox"/> Not Assigned		
1 minute Apgar ____ 5 minute Apgar ____ 10 minute Apgar (if 5 minute < 6) ____		
Gestational Age Determined by:		Delivery Mode:
<input type="checkbox"/> Early sono (<24 weeks) EDC by early sono _____	<input type="checkbox"/> LMP Date & Physical Exam LMP _____	<input type="checkbox"/> Vaginal
<input type="checkbox"/> Physical Exam Only Exam ____ weeks ____ days		<input type="checkbox"/> C-section
Resuscitation at Birth: <input type="radio"/> Yes <input type="radio"/> No		
<input type="checkbox"/> Oxygen	<input type="checkbox"/> Bag/mask	<input type="checkbox"/> Endotracheal tube ventilation
<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Cardiac compressions	
Tracheal suctioning for meconium aspiration : <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A		
ADMISSION DATA		
Hospital Med Rec # _____ Admit Date _____ Admit Time _____		
* Infant location prior to admission to your NICU:		
<input type="checkbox"/> Labor & Delivery (Inborn)	Readmissions / Admissions Post Discharge:	
<input type="checkbox"/> Normal Newborn Nursery (Inborn)	<input type="checkbox"/> Home (Inborn)	<input type="checkbox"/> Other (Inborn)
<input type="checkbox"/> ER (Inborn)	<input type="checkbox"/> Home (Outborn)	<input type="checkbox"/> Other (Outborn)
<input type="checkbox"/> Other Location (Outborn)		
If from a prior NICU, indicate NICU hospital name _____		
MOTHER / DEMOGRAPHIC DATA		
Mother's Last Name _____		Mother's First Name _____
Mother's Maiden Name: _____		Mother's SSN: _____
		Mother's DOB: _____
Street Address: _____		City: _____
		State: _____
Zip Code: _____	County: _____	Telephone Number: _____
Maternal Transfer: <input type="radio"/> Yes <input type="radio"/> No If yes, transferred from: _____		
Referring Hosp Med. Rec. Num: _____		
Tocolysis: <input type="radio"/> Yes <input type="radio"/> No	Antenatal Steroids: <input type="radio"/> Yes <input type="radio"/> No Dose: <input type="checkbox"/> Incomplete <input type="checkbox"/> Complete	
Maternal History:		

Last Name: _____ First Name.: _____ DOB: _____

Hospital Med Rec #: _____ Admit Date: _____ Admit Time: _____	
*Location prior to admission to your NICU _____	Other _____
INITIAL STATUS AFTER BIRTH DATA	
DR Death include all ≥ 400 grams <input type="radio"/> Yes <input type="radio"/> No Transport Death include all ≥ 400 grams <input type="radio"/> Yes <input type="radio"/> No	
If DR Death or Transport Death, respond to Care Deemed Futile under NICU Disposition Data.	
Positive Pressure: <input type="radio"/> Yes <input type="radio"/> No	
MAP/PEEP _____	FiO2: _ . _ _ (must be no greater than 1.00)
Assessment date: _____	Assessment Time: _____
Initial Blood pH: <input type="radio"/> Yes <input type="radio"/> No Value: _____	Base Excess/Deficit: _____
Draw Date: _____	Draw Time: _____ Draw Type: <input type="checkbox"/> Arterial <input type="checkbox"/> Capillary <input type="checkbox"/> Venous
Pressor support: _____	Volume Expansion: <input type="radio"/> Yes <input type="radio"/> No Pharmacologic: <input type="radio"/> Yes <input type="radio"/> No
First Measured Temperature in Nursery ($^{\circ}$ C.): ___ Date: ___/___/___ Time: ___:___	
NUTRITION DATA	
Enteral Feeding: <input type="radio"/> Yes <input type="radio"/> No	
Date of FIRST Enteral Feeding: _____	Type: <input type="radio"/> Breast <input type="radio"/> Formula <input type="radio"/> Both
FIRST Date Without IV Nutrition: _____	Type: <input type="radio"/> Breast <input type="radio"/> Formula <input type="radio"/> Both
OPHTHALMOLOGY DATA	
Retinopathy of Prematurity: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Assessed	
If <u>Yes</u> , Specify Stage and Zone for Each Eye Based on Worst Exam	
Indicate PLUS disease with a + sign after Stage designation:	
Stage Left Eye _____	Stage Right Eye _____
Zone Left Eye _____	Zone Right Eye _____
Cryotherapy/Laser Therapy <input type="radio"/> Yes <input type="radio"/> No If <u>Yes</u> , Type: <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral	

Last Name: _____

First Name.: _____

DOB: _____

NICU DISPOSITION DATA

NICU Disposition:

- Discharged Home Date: _____ Time: _____ **(see below)**
- Transferred Date: _____ Time: _____ **(see below)**
- Expired Date: _____ Time: _____ **(see below)**
- In House Transfer Date: _____ Time: _____ **(see below)**

If Transferred, Where: _____

If Transferred, Reason:

- Back transfer (reverse) Chronic Care Growth & Discharge Planning
- Parental Request Surgery Medical/Diagnostic Services
- Other _____

If Expired, Consent for Autopsy: Yes No

If Expired, including DR or Transport Death: Care Deemed Futile: Yes No

If Yes, Where: Before Level III/RPC Staff Evaluation By Level III/RPC Staff

- Reason: No support, poor prognosis No support, lethal anomaly
- Support withdrawn, lethal anomaly Support withdrawn, poor neuro-logical prognosis
- Progressive failure despite support

If In House Transfer, Where/Why: **(complete disposition information below)**

- Normal Newborn Nursery PICU Pediatrics Other
- In House Transfer Reason: _____

FOR ALL PATIENTS

Disposition Weight: _____ grams O2 Support: Cardiac-Apnea Monitor:

Yes No Yes No

Hearing Screen: Passed Didn't Pass Not Done Date Rescreen Scheduled: _____

Primary Care Physician/Group: _____

Feeding Type: Breast Formula Both None

In House Transfer Disposition:

- Discharged Home Date: _____ Time: _____
- Transferred Date: _____ Time: _____
- Expired Date: _____ Time: _____
- Readmit to NICU Date: _____ Time: _____

REFERRAL DATA

County Public Health Nurse: Early Intervention: Developmental Testing:

Yes No Yes No Yes No

Other: _____

HOME NURSING DATA

Home Nursing for Chronic Care

Provided by:

Certified Home Health Agency Public Health Nurse Hospital Based Agency

Other (specify): _____