

DIAGNOSES AND TREATMENTS BY SYSTEM

RESPIRATORY DATA

Anomaly - Diaphragmatic Hernia

Anomaly - Pulmonary Hypoplasia

Secondary to: Pleural Effusion Abdominal Defect Oligohydramnios

Anomaly - Other (specify): _____

Delayed Transition

Transient Tachypnea (TTN)

Meconium Aspiration

Persistent Pulmonary Hypertension (PPHN)

Pulmonary Air Leak

Type: Pulmonary Interstitial Emphysema

Pneumothorax

Pneumopericardium

Pneumomediastinum

Respiratory Distress Syndrome/ Hyaline Membrane Disease

Other Respiratory Diagnosis (specify): _____

RESPIRATORY SUPPORT (After Leaving the Delivery Room)

Don't enter if initiated only for surgical procedure and discontinued within 72 hours post surgery

No Respiratory Support/ Room Air Only

Nasal Cannula or Hood

Start Date

End Date

1 st	_____	_____
2 nd	_____	_____
3 rd	_____	_____
4 th	_____	_____

CPAP

Start Date

End Date

1 st	_____	_____
2 nd	_____	_____
3 rd	_____	_____
4 th	_____	_____

Was CPAP administered prior to positive pressure ventilation Yes No

Mechanical Ventilation

Ventilation Type

Start Date

End Date

<input type="radio"/> IMV <input type="radio"/> HIFI (HFOV) <input type="radio"/> Jet	1 st	_____	_____
<input type="radio"/> IMV <input type="radio"/> HIFI (HFOV) <input type="radio"/> Jet	2 nd	_____	_____
<input type="radio"/> IMV <input type="radio"/> HIFI (HFOV) <input type="radio"/> Jet	3 rd	_____	_____
<input type="radio"/> IMV <input type="radio"/> HIFI (HFOV) <input type="radio"/> Jet	4 th	_____	_____

Surfactant First Dose at: <1/2 hr PNA >=1/2 hr PNA Total Number of Doses _____

Systemic Steroids
for lung disease

Start Date

End Date

1 st	_____	_____
2 nd	_____	_____
3 rd	_____	_____

Nitric Oxide Treatment

1 st	_____	_____
2 nd	_____	_____

ECMO

Chest Tube(s)

Other Respiratory Treatment (specify): _____

Last Name: _____ First Initial.: _____ Medical Record #: _____

CARDIOVASCULAR DATA

Anomaly - Congenital Heart Disease

Treated with: Prostaglandins Surgery Resulting in: Congestive Heart Failure

Hypertension (*treated with antihypertensive medication*)

Hypotension (*treated with volume or pressors*)

Patent Ductus Arteriosus

Specify: Ligation (even if PDA criteria is not met) Indomethacin Other Pharmacologic

Other (specify) _____

CENTRAL NERVOUS SYSTEM DATA

Anomaly - Congenital Hydrocephalus

Anomaly - Microcephaly (*microcephaly, hydromicrocephaly, microencephalon*)

Anomaly - Neural Tube Defect: (*spina bifida, meningocele, myelocele, myelomeningocele, myelocystocele, syringomyelocele, hydromeningocele, rachischisis*)

Other: (*acrania, anencephaly, hemianencephaly, amyelocephalus, hemiccephaly, encephalocele, other CNS malformations, subarachnoid hemorrhage {SAH}*) (specify): _____

Seizures (*treated with anticonvulsive medication*)

Hypoxic-Ischemic Encephalopathy (HIE)

Indicate severity:

- mild (normal to hyperalert)
- moderate (lethargy or mild stupor)
- severe (deep stupor or coma)

Indomethacin (prophylaxis) at < 24hrs PNA

Intraventricular Hemorrhage assessed (*cranial ultrasound on or before day 28*) with status:

None Grade I Grade II Grade III Grade IV

Hydrocephalus, post hemorrhage, shunt required

PVL Assessed (before 3 Weeks of Age) PVL Imaging Date: _____

PVL Imaging outcome: _____

PVL Assessed (after 3 Weeks of Age) PVL Imaging Date: _____

PVL Imaging outcome: _____

PVL Confirmed: Yes No

GASTROINTESTINAL DATA

Anomaly - Omphalocele / Gastroschisis

Anomaly - Tracheo-Esophageal Fistula / Esophageal Atresia

Other (*Imperforate anus/rectum, stricture of anus/rectum, other malformations of the gastrointestinal system*) (specify): _____

Focal Isolated Perforation (*Reason other than NEC*)

Necrotizing Enterocolitis (*NEC*)

- Surgically Confirmed (Treated) Clinically Suspected (Pneumatosis/Portal Air)
- Diagnosed by PostMortem Examination Only

Cholestatic Jaundice

Last Name: _____ First Initial.: _____ Medical Record #: _____

GENITOURINARY/RENAL DATA

Renal Agenesis

Renal Failure: (*creatinine >2*)

Other (*hydronephrosis, other malformation of genitourinary system*)
(specify): _____

HEMATOLOGY DATA

Coombs Positive

Direct Bilirubin >3mg/dl

Exchange Transfusion Partial Complete

RBC Transfusion Single Multiple

Recombinant Erythropoietin Start Date _____ End Date _____

Other (*dehydration/hyperbili*) (specify): _____

INFECTIOUS DISEASE DATA

Anomaly - Confirmed Congenital Infection (TORCH) of Type:

Toxoplasmosis Rubella CMV Herpes

Syphilis Parvovirus Other (specify) _____

Early Onset Sepsis –Suspected, Culture Negative (***cultures obtained*** on or before day 3 of life), Treatment Discontinued

Early Onset Sepsis –Suspected, Culture Negative (***cultures obtained*** on or before day 3 of life), Treatment Continued

Early Onset Sepsis –Confirmed, Culture Positive (***cultures obtained*** on or before day 3 of life)

Please provide a date and time that culture was obtained for each organism selected.

1st Date: _____ Time: _____ 1st Organism Identified _____

2nd Date: _____ Time: _____ 2nd Organism Identified _____

3rd Date: _____ Time: _____ 3rd Organism Identified _____

4th Date: _____ Time: _____ 4th Organism Identified _____

5th Date: _____ Time: _____ 5th Organism Identified _____

Sepsis, Nosocomial, Culture Positive (***cultures obtained*** after day 3 of life)

Please provide a date and time that culture was obtained for each organism selected.

1st Date: _____ Time: _____ 1st Organism Identified _____

2nd Date: _____ Time: _____ 2nd Organism Identified _____

3rd Date: _____ Time: _____ 3rd Organism Identified _____

4th Date: _____ Time: _____ 4th Organism Identified _____

5th Date: _____ Time: _____ 5th Organism Identified _____

Last Name: _____ First Initial.: _____ Medical Record #: _____

MISCELLANEOUS DATA

- Anomaly - Abnormal Appearance (undiagnosed, Specify) _____
- Anomaly - Chromosomal (Specify) _____
- Anomaly – Ear, Nose and Throat (Specify) _____
- Anomaly - Musculoskeletal (Specify) _____
- Birth Related Trauma (*visceral hemorrhage, subgaleal hematoma, depressed skull fracture, Erb's palsy, etc.*)
- Hydrops: Immune
- Hydrops: Nonimmune
- Other Diagnosis (Specify) _____

Discharge Planning Details

CONSULTS/OTHER SERVICES

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Endocrine | <input type="checkbox"/> ENT |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> GI | <input type="checkbox"/> GU | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Metabolic | <input type="checkbox"/> Neurology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Ophth |
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> OT/PT | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other (Specify) _____ | | | |