NICU WORKSHEET

PATIENT DATA ❒ Readmission

***Last Name** _____ ***First Name** _____

***Birth Hospital Med Rec#** _____ ***Birth Hospital Name** _____

***Birth Date** ____ / ____ / _____ Birth Time ___ : ___ Birth Weight _____ gms

*Birth Head Circumference (to nearest 10th cm) _ _ . _ *Birth Length (to nearest 10th cm) _ _ . _

Sex: ❒ Male ❒ Female ❒ Unknown Plurality _____ ***Birth Order** _____
0=singleton; 1=first multiple etc

Cord pH: ○ Yes ○ No **Cord pH Value**: _____ **Cord pH Type**: ❒ UA ❒ UV ❒ Not Assigned

1 minute Apgar ____ 5 minute Apgar ____ 10 minute Apgar (if 5 minute < 6) ____

Gestational Age Determined by:

❒ Early sono (<24 weeks) EDC by early sono _____

❒ LMP Date & Physical Exam LMP _____

❒ Physical Exam Only Exam ____ weeks ____ days

Delivery Mode:

❒ Vaginal

❒ C-section

Resuscitation at Birth: ○ Yes ○ No

❒ Oxygen ❒ Bag/mask ❒ Endotracheal tube ventilation

❒ Epinephrine ❒ Cardiac compressions

Tracheal suctioning for meconium aspiration : ○ Yes ○ No ○ N/A

ADMISSION DATA

Hospital Med Rec # _____ Admit Date _____ Admit Time _____

*** Infant location prior to admission to your NICU**:

❒ Labor & Delivery (Inborn)

❒ Normal Newborn Nursery (Inborn)

❒ ER (Inborn)

❒ Other Location (Outborn), specify _____

❒ Another NICU Hospital, specify _____

Readmissions / Admissions Post Discharge:

❒ Home (Inborn) ❒ Other (Inborn)

❒ Home (Outborn) ❒ Other (Outborn)

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: ○ Yes ○ No If yes, transferred from:_____
Referring Hosp Med. Rec. Num: _____

Tocolysis: ○ Yes ○ No Antenatal Steroids: ○ Yes ○ No Dose: ❒ Incomplete ❒ Complete

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

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 ≥400grams ○ Yes ○ No Transport Death include all ≥400grams ○ Yes ○ No

If DR Death or Transport Death, respond to Care Deemed Futile under NICU Disposition Data.

Positive Pressure: ○ Yes ○ No

MAP/PEEP _____ FiO2: _ . _ _ **(must be no greater than 1.00)**

Assessment date: _____ Assessment Time: _____

Initial Blood pH: ○ Yes ○ No Value: _____ Base Excess/Deficit: _____

Draw Date: _____ Draw Time: _____ Draw Type: ❒ Arterial ❒ Capillary ❒ Venous

Pressor support: Volume Expansion: ○ Yes ○ No Pharmacologic: ○ Yes ○ No

First Measured Temperature in Nursery (^{o} C.): ___ Date: ____/____/_____ Time: ___:___

NUTRITION DATA

Enteral Feeding: ○ Yes ○ No

Date of FIRST Enteral Feeding: ___/___/_____ Type: ❒ Breast ❒ Formula ❒ Both

FIRST Date Without IV Nutrition: ___/___/_____ Type: ❒ Breast ❒ Formula ❒ Both

FIRST Date Birth Weight Regained: ___ /___ / _____

OPHTHALMOLOGY DATA

Retinopathy of Prematurity: ○ Yes ○ No ○ Not Assessed

If Yes, 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 ○ Yes ○ No If Yes, Type: ❒ Unilateral ❒ Bilateral

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

NICU DISPOSITION DATA

NICU Disposition:
❒ Discharged Home ❒ Transferred ❒ Expired ❒ In House Transfer **(see below)**
Date: ___/____/_____ Time: _____:_____

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-
❒ Progressive failure despite support logical prognosis

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
Disposition Head Circumference (to nearest 10th cm) __ __ . _
Disposition Length (to nearest 10th cm) __ __ . __

O2 Support: ○ Yes ○ No Cardiac-Apnea Monitor: ○ Yes ○ No

Hearing Screen: ○ Passed ○ Didn't Pass ○ Not Done Date Rescreen Scheduled: __/__/____

Primary Care Physician/Group: _____

Feeding Type at Disposition: ❒ Breast ❒ Formula ❒ Both ❒ None

In House Transfer Disposition:
❒ Discharged Home ❒ Transferred ❒ Expired ❒ Readmit to NICU
Date: ___/___/_____ Time: _____:_____

REFERRAL DATA

County Public Health Nurse: ○ Yes ○ No
Early Intervention: ○ Yes ○ No
Developmental Testing: ○ 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):_____