ALL NICU ADMITS DATABASE FORM

This form is for internal use ONLY.

DEMOGRPAHICS

Reference Number: _____

Unique reference number for infant and/or NICU Stay

Enter a reference number (integer) that identifies unique NICU admissions OR unique infants OR leave empty and check option to have the system assign the next available sequential number.

For an infant who was previously in your NICU, has an NAD record and is readmitted, enter the infant's reference number, and use the Re-Admission Counter to indicate the re-admission incidence.

Do not use the infant's MRN as reference number.

OR, have system assign next sequential number (online only)

- ○ Without prefix
- ○ Prefixed by birth year
- ○ Prefixed by admit year
- ○ Prefixed by 2-digit birth year
- ○ Prefixed by 2-digit admit year

Readmission Counter: _____

If your reference number is unique for each infant admitted to your NICU, specify the re-admission incidence to identity unique NICU stays. In this case, date of birth, time of birth, birth weight, gestational age, multiple status, sex, delivery mode, mother's date of birth, and birth location are copied based on the Reference Number entered.

Leave empty unless the infant was previously at your NICU.

Date of Birth: _____

Birth Weight: _____

Specify the birth weight in grams. Any non-number entries are ignored.

Time of Birth: _____

Gestational Age (ww/d): _____

Specify gestational age in completed weeks and days as WW/D or WW.D or WW-D or WWD or WW (assumes 0 for days). Enter UNK if unknown.

Multiple (i.e. 1A, 1B): _____

Mother's Date of Birth: _____

Enter UNK if mother's date of birth is unknown.

Sex:

- ○ Female
- ○ Male
- ○ Undetermined
- ○ Unknown

Mother's Race:

- ○ Black
- ○ Asian
- ○ Native Hawaiian/Pacific Islander
- ○ Am Indian/Alaska Native
- ○ White
- ○ Other
- ○ Unknown

[optional]

Delivery Mode:

- ○ Vaginal
- ○ Cesarean
- ○ Unknown

Mother's Hispanic Origin:

- ○ Hispanic
- ○ Non-Hispanic
- ○ Unknown

[optional]

NICU A/D Record ID: _____

ADMISSION

Admit Date: _____

Admit Time: _____

Acute Admit: ☐

Check this box if the infant's admission was acute. Acute admissions include acute transports to the NICU, acute admissions from home or from another unit within the NICU's hospital.

Admit Type:

- ○ Inborn never home immediately admitted to the NICU after birth
- ○ Inborn never home admitted from another unit within my hospital
- ○ Outborn admitted from another hospital or non-hospital location or unit within my hospital
- ○ Admitted from home or from another unit within my hospital after previous home discharge
- ○ Re-admitted from another unit within my hospital (continuing care episode)
- ○ Re-admitted from another unit within my hospital (new care episode)
- ○ Re-admitted from another hospital (continuing care episode)
- ○ Re-admitted from another hospital (new care episode)

Admit Notes:

[optional] Provide notes regarding this admission, e.g., primary reason for admission, custom filters.

Birth Location: _____

[optional] Provide the birth location in any format you like.

Referring Location: _____

[optional] Provide the referring location in any format you like. Note that the referring location can be another NICU, hospital or a unit within your

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○ Re-admitted from home	hospital.

Admit Reason:

- ☐ Suspected Infection
- ☐ Respiratory Distress
- ☐ Hypoglycemia
- ☐ Hyperbilirubinemia
- ☐ Temperature Instability
- ☐ Feeding Difficulties
- ☐ BW/GA per policy
- ☐ Small for gestational age
- ☐ Perinatal transitional monitoring
- ☐ Neonatal abstinence syndrome
- ☐ Dysmorphic/chromosomal anomaly
- ☐ Apnea/cyanotic event
- ☐ Cardiac
- ☐ Seizure/Neurological
- ☐ Transport-In for Insurance reasons
- ☐ Transport-In for bed availability or staffing reasons
- ☐ Other Reason

ABX / CENTRAL LINES

ABX Days: _____

[optional] Number of days during this stay of IM or IV antibiotic exposure (antibacterial or antifungal agents). If admission period overlaps two years, separate days in year of admission and subsequent year by +, e.g., 5+1.

Central Line Days: _____

[optional] Number of days during this stay on which the infant had an umbilical catheter or one or more central lines in place.

CLABSI: ☐

[optional] Check this box if CLABSI occurred. Dependency on central line days intentionally not implemented!

DISPOSITION

NICU Discharge Date: _____

NICU Disposition:

- ○ Home from this NICU
- ○ Transport-Out to another hospital
- ○ Died in this NICU
- ○ Transfer to another unit within my hospital

Problems during NICU Stay:

- ☐ Suspected Infection
- ☐ Respiratory Distress
- ☐ Hypoglycemia
- ☐ Hyperbilirubinemia
- ☐ Temperature Instability
- ☐ Feeding Difficulties
- ☐ BW/GA per policy
- ☐ Small for gestational age
- ☐ Perinatal transitional monitoring
- ☐ Neonatal abstinence syndrome
- ☐ Dysmorphic/chromosomal anomaly
- ☐ Apnea/cyanotic event
- ☐ Cardiac
- ☐ Seizure/Neurological
- ☐ Other Problem

Check problems during NICU stay, i.e., problems that contributed to the infant's NICU stay and length of stay.

Acute Transport Out: ☐

Check this box if this infant was acutely transported out of your NICU to another location outside your hospital.

Transport/Transfer Location: _____

[optional] Provide the location the infant was transported or transferred to in any format you like. Note that this location can be another NICU, hospital or a unit within your hospital.

Hospital Discharge Date: _____

Hospital Disposition:

- ○ Discharged alive
- ○ Died

Additional Discharge Notes:

[optional] Provide additional discharge notes including a description for Other.