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: _____

Time of Birth: _____

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

Sex:

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

Delivery Mode:

- ○ Vaginal
- ○ Cesarean
- ○ Unknown

Birth Weight: _____

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

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.

Mother's Date of Birth: _____

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

Maternal Race/Ethnicity:

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Middle Eastern or North African
- ○ Native Hawaiian or Pacific Islander
- ○ White
- ○ Other
- ○ Declined
- ○ Unknown

Check all that apply

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

[optional] Check reasons for this admission.

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/home
- ○ Acute transport-out [optional]
- ○ Non-acute transport-out [optional]
- ○ Died

Additional Discharge Notes:

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

CARE COLLABORATIVE – SECTION 1 (for participating NICUs only)

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CARE Eligibility: Check any exclusions

- ☐ Infant received palliative or comfort care only
- ☐ Family declined screening due to privacy reasons
- ☐ Family declined screening due to another reason (describe)
- ☐ Infant discharged to foster care or with no family involved during NICU stay
- ☐ Infant in NICU less than 72 hours
- ☐ Other exclusion reason (describe)

NICU patients who meet any of the exclusion criteria have all CARE fields set to ***Not applicable***.

Note that NICU patients with NICU stays shorter than 72 hours are still eligible for the CARE data collection. The inclusion decision is up to the NICU.

Description _____

Was an HRSN screening documented during the NICU stay?

- ○ Yes, completed within 1 week of NICU admission
- ○ Yes, completed after 1 week
- ○ No, screening never done
- ○ No, screening started but not completed
- ○ Not applicable
- ○ Unknown

The last day of week 1 is [Date].

Check all issues/needs identified by the HRSN screening

- ☐ Living conditions
- ☐ Sufficient and nutritious food
- ☐ Transportation
- ☐ Education
- ☐ Childcare
- ☐ Medical visits
- ☐ Employment
- ☐ Personal safety
- ☐ Other issue

Was a referral placed after a positive HRSN screening for at least 1 need?

- ○ Yes
- ○ Family denied referral
- ○ No
- ○ Not applicable
- ○ Unknown

Check all criteria the HRSN referral met

- ☐ Appropriate: Matched HRSN identified needs
- ☐ Responsive: Considered language and culture
- ☐ Access: Accounted for transportation and easy of use
- ☐ Timely: Was made before discharge
- ☐ Consent: Developed with informed family consent
- ☐ Employment
- ☐ Personal safety
- ☐ Other issue

Were any HRSN referrals denied?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

Check all denial reasons

- ☐ Insufficient capacity
- ☐ Out of scope
- ☐ No response received in a timely manner
- ☐ Other denial reason (describe)

Description _____

CARE COLLABORATIVE – SECTION 2 (for participating NICUs only)

CBO that accepted the HRSN referral _____

After home discharge, did a designated NICU team member contact the patient family and confirm that the connection to the CBO was successful?

- ○ Yes, patient family and CBO connected within 30 days of home discharge

- ○ Yes, patient family and CBO connected after 30 days
- ○ No, reached out to family but unable to ascertain connection to CBO
- ○ No, never reached out
- ○ Not applicable
- ○ Unknown

Following HRSN screening, did family have a CPS report filed?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

Is the infant ECM eligible?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

If infant meets ECM eligibility criteria except for enrollment in MediCal Managed Care, is enrollment in MediCal Managed Care planned?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

Was there any follow-up by a designated NICU team member after home discharge?

- ○ Yes, within 30 days of home discharge
- ○ Yes, after 30 days of home discharge
- ○ No, attempted follow-up but never reached anyone
- ○ No, never followed-up
- ○ Not applicable
- ○ Unknown

Following HRSN screening, did family have a hospital security call initiated involving them?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

For infants enrolled in Medicaid Managed Care, was a documented ECM referral made before home discharge?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

If enrollment in MediCal Managed Care is planned, will infant be referred to ECM?

- ○ Yes
- ○ No
- ○ Not applicable
- ○ Unknown

CARE Notes