ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

Do not use this form if this infant qualifies as a delivery room death (DRD). If this infant is a DRD please fill out the DRD form.

- The **"Identification and Demographics"**, **"Maternal History"** and **"Delivery Room and First Hour After Birth"** sections **must** be filled out when an eligible infant is admitted to your NICU.
- The "**Post-Delivery Diagnoses and Interventions-Respiratory"** (respiratory, infections, other diagnoses, surgeries, and surgical complications, neurological, and congenital malformations) and the "**Initial Disposition"** sections must be filled out when the baby is discharged for the first time from your center.
- The **"Transport Information"** section only needs to be filled out if the infant was transported after its initial stay.

SELECTION CRITERIA

To be eligible, you MUST answer YES to at least one of the possible criteria (A-C)

A. **≤ 1500 grams** ☐ **Yes** (If Yes go to item #1) ☐ **No** (If No go to Part B)

B. **GA ≤ 31 6/7 weeks** ☐ **Yes** (If Yes go to item #1) ☐ **No** (If No go to Part C)

C. **If > 1500 grams** ☐ **Yes** (If Yes select criteria below) ☐ **No**

MUST check at least one to be eligible.

NOTE: **Any infant that was previously discharged home and re-admitted to any location in our hospital (On or before Day 28) for Total Serum Bilirubin=>25mg/dl (427 Micromoles/Liter) and/or exchange transfusion is CPQCC NICU eligible.**

- ☐ Death
- ☐ Major Surgery with general anesthesia or equivalent
- ☐ Intubated Vent > 4hrs
- ☐ Non-Intubated Vent > 4hrs
- ☐ Suspected Encephalopathy or Suspected Perinatal Asphyxia
- ☐ Acute Transport-In
- ☐ Acute Transport-Out
- ☐ Early Bacterial Sepsis
- ☐ Hyperbilirubinemia
- ☐ Active Therapeutic Hypothermia
- ☐ Seizures

IDENTIFICATION AND DEMOGRAPHICS

1. **Birth Weight:** ___ ___ ___ ___ grams

2. **Head Circumference at Birth:** ___ ___ . ___ cm ☐ Unknown ☐ Not Done

3. **Best Estimate of Gestational Age:** ___ ___ a) Weeks (15-46) ___ ___ b) Days (0-6) ☐ Unknown

4. **a. Birth Date:** (MM-DD) ___ ___ - ___ ___ -2025

b. Birth Time: (00:00) ___ ___ : ___ ___ (use 24-hour clock)

5. **Infant Sex:** ☐ Male ☐ Female ☐ Undetermined ☐ Unknown

6. **Died in Delivery Room:** ☐ Yes (If Yes, Use DRD Form) ☐ No

7. **a. Location of Birth:** ☐ Inborn ☐ Outborn ☐ Born at Co-Located Hospital (Satellite NICUs Only)

NOTE: **For infants who were previously home, always check Outborn, even if the infant was born at your hospital or at a Co-Located Hospital (for Satellite NICUs only.)**

b. Age in Days at Admission to your NICU: ___ ___ Date of Birth is Day 1

c. Hospital of Birth for Outborn Infants: ___ ___ ___ ___ ___ ___ (Enter HCAI Code (Formerly OSHPD) ☐ Unknown ☐ NA

d. Reason for Transport – In (If Location of Birth is "Outborn", select only one response indicating the primary reason for transport in):

- ☐ ECMO
- ☐ Hypothermic Therapy
- ☐ Surgery
- ☐ Other Medical/Diagnostic Services
- ☐ Growth/Discharge Planning
- ☐ Chronic Care
- ☐ Insurance
- ☐ Other
- ☐ Not Applicable
- ☐ Unknown

8. **Hospital Admission History** (answer parts a. and b. only for Outborn infants)

NOTE: **The Hyperbilirubinemia items 53 to 55 are activated ONLY if the infant was home after birth (item 8a). A home birth does NOT qualify for checking "Was Previously Discharged Home from a Hospital after Birth."**

a. Discharged Home after Birth:

☐ Never Discharged Home from a Hospital after Birth ☐ Was Previously Discharged Home after Birth ☐ NA

b. NICU Re-Admission Status after PDH:

☐ First Admission to this NICU ☐ Readmission to this NICU ☐ NA

MATERNAL HISTORY

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

9. **a. Maternal Date of Birth:** (MM/DD/YY) ___ ___ / ___ ___ / ___ ___ **b. Maternal Age:** ☐☐ years ☐ Unknown

10. **Maternal Race/Ethnicity:** (select all that apply)

☐ American Indian/Native American ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Declined ☐ Unknown

11. **Prenatal Care:** ☐ Yes ☐ No ☐ Unknown

12. **Group B Strep Positive:** ☐ Yes ☐ No ☐ Not Done ☐ Unknown

13. **a. Is there documentation that Antenatal Steroids therapy was initiated before delivery?** ☐ Yes ☐ No ☐ Unknown

b. Is there documentation in the medical record of reason for NOT initiating antenatal steroid therapy before delivery? (This item is only applicable and optional for inborn infants who are <34 weeks GA) ☐ Yes ☐ No ☐ Unknown

c. If Yes, what was the documented reason for NOT administering antenatal steroids? (This item is only applicable and optional for inborn infants who are <34 weeks GA)

☐ Chorioamnionitis
☐ Other active infection
☐ Immediate delivery
☐ Fetus has anomalies incompatible with life
☐ History of adverse reaction to corticosteroids
☐ Comfort Care
☐ Other
☐ Unknown

14. **Spontaneous Labor** ☐ Yes ☐ No ☐ Unknown

15. **a. Multiple Gestation** ☐ Yes ☐ No ☐ Unknown

b. If Yes, to multiple gestation enter number of infants delivered including stillborn _____ ☐ Unknown ☐ NA

c. Birth Order: _____ ☐ Unknown ☐ NA

16. **Delivery Mode** (check only one) ☐ Spontaneous Vaginal ☐ Operative Vaginal ☐ Cesarean ☐ Unknown

17. **Antenatal Conditions** (select ALL conditions occurring in this pregnancy)

a. Maternal Antenatal Conditions

☐ None ☐ Other Infection ☐ Antenatal Magnesium Sulfate
☐ Hypertension ☐ Diabetes ☐ Other (describe): _____
☐ Chorioamnionitis ☐ Previous Cesarean ☐ Unknown

b. Fetal Antenatal Conditions

☐ None ☐ Non-Reassuring Fetal Status ☐ Other Fetal (describe):
☐ IUGR ☐ Anomaly ☐ Unknown

c. Obstetrical Conditions

☐ None
☐ Preterm (<37 wks) Labor
☐ Preterm (<37 wks) Premature ROM before onset of labor
☐ Term Premature ROM (≥37 wks) before onset of labor, not premature gestation)
☐ Prolonged ROM (>18hrs)
☐ Malpresentation/Breech
☐ Bleeding/Abruption/Previa
☐ Anhydramnios/Oligohydramnios
☐ Polyhydramnios
☐ Other Obstetrical (describe): _____

18. **Indications for Cesarean Section** (select at least one)

☐ Not Applicable (No C/S)
☐ Elective
☐ Malpresentation/Breech
☐ Dystocia/Failed to Progress
☐ Multiple Gestation
☐ Placental Problems
☐ Non-Reassuring Fetal Status
☐ Hypertension
☐ Other (describe): _____
☐ Unknown

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

19. Delayed Cord Clamping

NOTE: For outborn babies it is acceptable that these variables are 'unknown', if this information is unavailable)

a. Was delayed umbilical cord clamping performed?	☐ Yes	☐ No	☐ Unknown		
b. How long was umbilical cord clamping delayed?	☐ 30-60 secs	☐ 61-120 secs	☐ >120 secs	☐ NA	☐ Unknown
c. If DCC was not done, reason why (optional)?	☐ Maternal Bleeding	☐ Neonatal Causes	☐ Other (specify) _____		
d. Was umbilical cord milking performed?	☐ Yes	☐ No	☐ Unknown		
e. Did breathing begin before umbilical cord clamping?	☐ Yes	☐ No	☐ Unknown		

20. Apgar Scores:

☐☐ 1min	☐ Unknown ☐ Not Done	☐☐ 5min	☐ Unknown ☐ Not Done	☐☐ 10min	☐ Unknown ☐ Not Done

21. Perinatal Asphyxia

NOTE: **Items 21a – 21e apply only to infants >1,500 grams AND items 21b – 21e apply if infant meets at least one of the following criteria:**

1. **Admitted with suspected encephalopathy or suspected perinatal asphyxia [Yes to item 21a]**
2. **5-min Apgar ≤ 3 or 10-min Apgar ≤ 4 [item 20]**
3. **Received active hypothermia [Selective or Whole Body to item 24d]**
4. **Diagnosis with HIE [Mild/Moderate or Severe to item 51]**

a. Suspected Encephalopathy of Suspected Perinatal Asphyxia Low 5-min and/or 10-min Apgar Score?	☐ Yes ☐ No	☐ Unknown ☐ NA	
b. In there an umbilical cord blood gas or a baby blood gas in the first hour of life available?	☐ Yes ☐ No	☐ Unknown ☐ NA	
c. Source of blood gas:	☐ Cord Umbilical Arterial (UA) ☐ Cord Umbilical Venous (UV) ☐ Arterial Baby Gas	☐ Venous Baby Gas ☐ Capillary Baby Gas	☐ Unknown ☐ NA
d. pH within one hour of life:	___ . ___ ___	☐ Unknown	☐ NA
e. Base deficit:	___ ___ . ___	☐ Unknown	☐ NA ☐ Too Low to Register

22. Delivery Room Resuscitation

a. Supplemental Oxygen:	☐ Yes	☐ No	☐ Unknown	e. Epinephrine:	☐ Yes	☐ No	☐ Unknown
b. Nasal CPAP:	☐ Yes	☐ No	☐ Unknown	f. Cardiac Compressions:	☐ Yes	☐ No	☐ Unknown
c. PPV via Bag/Mask:	☐ Yes	☐ No	☐ Unknown	g. Noninvasive Ventilation	☐ Yes	☐ No	☐ Unknown
d. ETT Ventilation	☐ Yes	☐ No	☐ Unknown	h. Supraglottic Airway Device	☐ Yes	☐ No	☐ Unknown

23. Surfactant Treatment

a. Was Surfactant given in the Delivery Room?	☐ Yes	☐ No	☐ Unknown
b. Was Surfactant given at any time?	☐ Yes	☐ No	☐ Unknown
c. Enter age at first dose:	___ ___ hours ___ ___ mins ☐ Unknown ☐ NA or Date/time of First Surfactant Dose (MM-DD-YYYY HH:MM) ___ ___ - ___ ___ -___ ___ ___ ___ ___ ___ : ___ ___		

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

POST-DELIVERY DIAGNOSES AND INTERVENTIONS - RESPIRATORY

24. Temperature and Cooling for HIE

a. Was the temperature measured within one hour of the NICU admission? ☐ Yes ☐ No ☐ Unknown

b. Enter first temperature either in Centigrade or Fahrenheit Degrees: ___ ___ . ___ °C ___ ☐ Too Low ☐ Unknown
NOTE: The temperature has to be entered even if the infant continued cooling in your NICU or started cooling in your NICU prior to the first temperature. ___ . ___ °F

c. Infant cooling status during stay at your NICU ☐ No Cooling ☐ Cooling Started ☐ Cooling Continued ☐ Unknown

d. Last Cooling Method Used for HIE ☐ Passive ☐ Whole Body ☐ Other ☐ Unknown

25. Respiratory Support after Initial Resuscitation

a. Supplemental Oxygen ☐ Yes ☐ No ☐ Unknown

b. Intubated Conventional Ventilation ☐ Yes ☐ No ☐ Unknown

c. Intubated HiFi Ventilation ☐ Yes ☐ No ☐ Unknown

d. Nasal Cannula ☐ Yes, flow rate >2l/min ☐ Yes, flow rate ≤ 2l/min ☐ Yes, flow rate unknown ☐ No ☐ Unknown

e. Noninvasive Ventilation (or any other form of non-intubated assisted ventilation) ☐ ≤4 hours ☐ >4 hours ☐ No ☐ Unknown

f. Nasal CPAP ☐ Yes (Always if 25e. is "Yes") ☐ No ☐ Unknown

27. Use of Intubated Assisted Ventilation

a. Length of Intubated Assisted Ventilation ☐ ≤ 4 hours ☐ > 4 hours ☐ No ☐ Unknown

b. If 1st episode of intubated Assisted Ventilation > 4 hours, enter duration of 1st episode in days: ☐☐☐ days ☐ Unknown

c. If > 1 Episode of Intubated Assisted Ventilation, enter total duration of all episodes in days: (optional for both SB and BB) _____

28. Infant Death within 12 Hours of NICU Admission ☐ Yes ☐ No ☐ Unknown

29. Respiratory Distress Syndrome ☐ Yes ☐ No ☐ Unknown

30. Pneumothorax ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown

31. Meconium Aspiration Syndrome ☐ Yes ☐ No ☐ Unknown

32. Caffeine for any Reason ☐ Yes ☐ No ☐ Unknown

33. Intramuscular Vitamin A for any Reason ☐ Yes ☐ No ☐ Unknown

34. Inhaled Nitric Oxide > 4 hours ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown

35. ECMO ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown

36. Postnatal Steroids

a. Were postnatal steroids used? ☐ Yes ☐ No ☐ Unknown

b. If postnatal steroids were used, select all reasons that applied

- Chronic Lung Disease: ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown
- Extubation: ☐ Yes ☐ No ☐ Unknown
- Hypotension/Blood Pressure: ☐ Yes ☐ No ☐ Unknown
- Other Reason: ☐ Yes ☐ No ☐ Unknown

37. Supplemental Oxygen on Day 28 ☐ Continuous ☐ Intermittent ☐ None ☐ Unknown ☐ NA

38. Respiratory Support at 36 weeks

a. Supplemental Oxygen: ☐ Continuous ☐ Intermittent ☐ None ☐ Unknown ☐ NA

b. Intubated Conventional Ventilation ☐ Yes ☐ No ☐ Unknown ☐ NA

c. Intubated High Frequency Ventilation ☐ Yes ☐ No ☐ Unknown ☐ NA

d. Nasal Cannula ☐ Yes, flow rate >2l/min ☐ Yes, flow rate ≤ 2l/min ☐ Yes, flow rate unknown ☐ No ☐ Unknown

e. Noninvasive Ventilation ☐ Yes ☐ No ☐ Unknown ☐ NA

f. Nasal CPAP ☐ Yes ☐ No ☐ Unknown ☐ NA

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – RESPIRATORY (continued)

39. Respiratory Monitoring and Support Devices at Discharge

NOTE: **Responses to this item will be ignored if you do not answer item 57, Initial disposition from your Center!**

If the infant had a tracheostomy in place at discharge, make sure to enter the surgery code S101 as a major surgery under item 47b.

a. Apnea/Cardio-Respiratory Monitor	☐ Yes	☐ No	☐ Unknown	
b. Supplemental Oxygen:	☐ Yes	☐ No	☐ Unknown	
c. Intubated Conventional Ventilation	☐ Yes	☐ No	☐ Unknown	
d. Intubated High Frequency Ventilation	☐ Yes	☐ No	☐ Unknown	
e. Nasal Cannula	☐ Yes, flow rate >2l/min	☐ Yes, flow rate ≤ 2l/min	☐ Yes, flow rate unknown	
	☐ No	☐ Unknown		
f. Noninvasive Ventilation	☐ Yes	☐ No	☐ Unknown	
g. Nasal CPAP	☐ Yes	☐ No	☐ Unknown	

POST-DELIVERY DIAGNOSES AND INTERVENTIONS - INFECTIONS

40. Early Bacterial Sepsis and/or Meningitis on or before Day 3 ☐ Yes ☐ No ☐ Unknown

NOTE: **Please refer to Appendix B for the Bacterial Infection Pathogen codes**

If Yes, specify up to 3 pathogen codes: 1. _____ 2. _____ 3. _____

Enter a description for pathogen code 8888 (other): _____

41. Late Infection after Day 3:

NOTE: **Please refer to Appendix B for the Bacterial Infection Pathogen codes**

a. Late Bacterial Sepsis and/or Meningitis	☐ Yes, here	☐ Yes, here and elsewhere	☐ NA
	☐ Yes, elsewhere	☐ No	☐ Unknown
If Yes, select up to 3 pathogens:	1. _____	2. _____	3. _____
Enter a description for pathogen code 8888 (other):	_____		
b. Coagulase Negative Staphylococci	☐ Yes, here	☐ Yes, here and elsewhere	☐ NA
	☐ Yes, elsewhere	☐ No	☐ Unknown
c. Fungal	☐ Yes, here	☐ Yes, here and elsewhere	☐ NA
	☐ Yes, elsewhere	☐ No	☐ Unknown

42. Congenital Infection ☐ Yes ☐ No ☐ Unknown

If Yes, select up to 3 pathogens: 1. _____ 2. _____ 3. _____

Enter a description for pathogen code 8888 (other): _____

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES

43.

a. Patent Ductus Arteriosus	☐ PDA meeting revised 2011 VON definition			☐ No
	☐ PDA Diagnosis based on echo and/or clinical evidence or was treated for PDA, but not meeting all 2011 VON criteria.			☐ Unknown
b. Indomethacin for any Reason	☐ Yes	☐ No	☐ Unknown	
c. Ibuprofen for Prevention and Treatment of PDA	☐ Yes	☐ No	☐ Unknown	
d. Acetaminophen (Paracetamol) for Prevention and Treatment for PDA	☐ Yes	☐ No	☐ Unknown	
e. Infant received prostaglandin medication to maintain ductal patency	☐ Yes (Applicable only if PDA is diagnosed)	☐ No	☐ Unknown	
	☐ NA (If infant is not diagnosed with PDA)			
f. PDA Ligation or PDA Closure by Catheterization	☐ Yes		☐ NA (If infant is not diagnosed with PDA)	
	☐ No			
	☐ Unknown			
g. Was PDA Surgery done in conjunction with Repair or Palliation of Congenital Heart Disease (S501, S502, S504, S507, S508, S509, S510, S511,	☐ Yes (Applicable only if 43f. is Yes)	☐ No	☐ Unknown	
	☐ NA If no PDA Ligation or Closure by Catheterization			

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

	S512, S513, S514)	
44.	**a. Probiotics**	☐ Yes ☐ No ☐ Unknown
	b. Necrotizing Enterocolitis	☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown
	c. NEC Surgery	☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown ☐ NA
45.	**Focal Intestinal Perforation**	**a. Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:** ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ Unknown **b. Surgically Confirmed or Clinically Diagnosed** ☐ Surgically Confirmed ☐ Clinically Diagnosed ☐ NA ☐ Unknown

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES (continue)

46. Retinopathy of Prematurity

NOTE: This section is only applicable to infants ≤1,500 grams or ≤ 31 completed weeks GA unless your NICU participates in the VON expanded data collection.

a. Was a retinal exam performed? ☐ Yes ☐ No ☐ Unknown ☐ NA

b. If retinal exam was performed, enter worst stage of ROP ☐ 0, No ROP ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Unknown ☐ NA

c. Treatment of ROP with Anti-VEGF Drug ☐ Yes ☐ No ☐ Unknown ☐ NA

d. ROP Surgery (for infants with ROP stage 1 or higher) ☐ Yes, here ☐ Yes, here and elsewhere ☐ Unknown ☐ Yes, elsewhere ☐ No ☐ NA

47. a. Major Surgery (Not NEC, ROP, PDA) ☐ Yes ☐ No ☐ Unknown

b. If Yes, Enter up to 10 surgery codes:

Specify the location of the surgery, and – for surgeries that were performed at <u>your hospital</u> only (never elsewhere) – whether or not a surgical site infection (SSI) occurred at your hospital.

Code 1. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 2. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 3. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 4. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 5. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 6. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 7. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 8. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 9. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here
Code 10. _____	**Location:** ☐ Here	☐ Elsewhere	☐ Both	☐ SSI Here

NOTE: If infant had NEC surgery, one of the following surgeries should be listed: S302, S303, S308, S309 or S333

NOTE: If infant had a PDA Ligation or a PDA Closure by Catheterization, one of the following surgeries should be listed: S515, S516 or S605

Provide description for surgery codes S100, S200, S300, S500, S600, S700, S800, S900 AND S1000:

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ HOSPITAL ID: ☐☐☐☐

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSIS / SURGERIES

48. Intracranial Hemorrhage

a. Neural Imaging done on or before Day 28	☐ Yes	☐ No	☐ Unknown					
b. If neural imaging was done on or before Day 28, enter worst grade of peri-intraventricular hemorrhage:	☐ 0, No Hemorrhage	☐ 1	☐ 2	☐ 3	☐ 4	☐ Unknown	☐ NA	
c. If peri-intraventricular hemorrhage was present, where was it first diagnosed?	☐ Here	☐ Elsewhere	☐ Unknown	☐ NA				
d. If peri-intraventricular hemorrhage was present, was shunt placed for bleed?	☐ Yes	☐ No	☐ Unknown					
e. If neural imaging was done on or before Day 28, was any other intracranial hemorrhage found?	☐ Yes	☐ No	☐ Unknown					

Describe Other: _____

49. Cystic Periventricular Leukomalacia (CPVL) & Cerebellar Hemorrhage

a. Was a neural image done?	☐ Yes	☐ No	☐ Unknown
b. If neural image done, evidence of Cystic PVL?	☐ Yes	☐ No	☐ Unknown
c. Cerebellar Hemorrhage	☐ Yes	☐ No	☐ Unknown

50. Seizures, EEG or Clinical ☐ Yes ☐ No ☐ Unknown

51. Hypoxic-Ischemic Encephalopathy ☐ Mild ☐ Moderate ☐ Severe ☐ None ☐ Unknown ☐ NA

CONGENITAL MALFORMATIONS / HYPERBILIRUBINEMIA

52. a. Congenital Anomalies ☐ Yes ☐ No ☐ Unknown

b. If Yes, enter up to 5 congenital anomaly codes:

Code 1. _____ **Code 2.** _____ **Code 3.** _____ **Code 4.** _____ **Code 5.** _____

Enter a congenital anomaly description for codes 100, 150, 200, 300, 400, 504, 601, 605, 800 and 900:

53. NOTE: **The following items 53-55 pertain to ANY infant that was previously discharged home and re-admitted before day 28.**

a. Maximum Level of Bilirubin (mg/dl) found On THIS Re Admission

☐ < 25 mg/dl ☐ ≥ 30 mg/dl ☐ 25 - < 30 mg/dl ☐ Unknown/Not Done ☐ NA

b. Exchange Transfusion on THIS Re-Admission ☐ Yes ☐ No ☐ Unknown

c. Hospital that Discharged Infant Home Prior to THIS Admission:

_____

54. Primary Caregiver's Preferred Language: Please select the primary caregiver's preferred language.

☐ Arabic	☐ Hmong/Miao	☐ Spanish
☐ Armenian	☐ Japanese	☐ Tagalog
☐ Cambodian/Khmer	☐ Korean	☐ Thai
☐ Cantonese	☐ Mandarin	☐ Vietnamese
☐ English	☐ Mixteco	☐ Sign Language
☐ Farsi/Persian	☐ Punjabi	☐ Other, Describe: _____
☐ Hindi	☐ Russian	☐ Unknown

55. Did the primary caregiver require interpreter services (either in-person or remote) during this hospitalization? ☐ Yes ☐ No ☐ Not Applicable (If primary language is English) ☐ Unknown

ADMISSION/DISCHARGE FORM FOR INFANTS BORN IN 2026

DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

NETWORK ID: ☐☐☐☐☐ **HOSPITAL ID:** ☐☐☐☐

INITIAL DISPOSITION

56. Enteral Feeding at Discharge
☐ None ☐ Human Milk with Fortifier or Formula ☐ Unknown
☐ Human Milk Only ☐ Formula Only

57. Initial Disposition from your Center
☐ Home ☐ Transported ☐ Unknown
☐ Died ☐ Still Hospitalized as of 1st Birthday

58. Weight at Initial Disposition ____ ____ ____ ____ ____ grams ☐ Unknown

59. Head Circumference at Initial Disposition ____ ____ . ____cm ☐ Unknown ☐ Not Done

60. Initial Discharge Date: (MM-DD-YYYY) ____ ____ - ____ ____ - ____ ____ ____ ____ ☐ Unknown

POST-TRANSPORT STATUS

NOTE: If infant was transported to another hospital, complete items 61 – 63.

61. Reason for Transport
☐ ECMO ☐ Growth/Discharge Planning ☐ Unknown
☐ Hypothermic Therapy ☐ Chronic Care ☐ Other Reason
☐ Surgery ☐ Insurance ☐ Not Applicable
☐ Other Medical/Diagnostic Services

62. Hospital the infant was transported to: _____

63. Post-Transport Disposition
☐ Home (skip to item 67)
☐ Transport again to another hospital (skip to item 66)
☐ Died (skip to item 67)
☐ Re-Admitted to your hospital (continue with item 64)
☐ Still Hospitalized as of 1st Birthday (skip to item 67)
☐ Unknown

NOTE: Complete items 64 – 65 for infants who were initially transported from or center and then transported back to your center without every going home. For these infants, it is necessary to update items 23, 25 – 27, and 29 – 56 with information that should be obtained from the episode of care at the hospital the infant was transported to and the care upon re-admission at your center. The intention is to capture the cumulative interventions received by the infant while the infant was in your NICU before and after transport and while the infant was at the transport-out NICU.

NOTE: That these items do not need to be tracked for subsequent transports and re-admissions.

64. Weight after Re-Admission _____ _____ _____ _____ _____ grams ☐ Unknown

65. Disposition after Re-Admission
☐ Home (skip to item 67)
☐ Transport again to another hospital
☐ Died (skip to item 67)
☐ Still Hospitalized as of 1st Birthday (skip to item 67)
☐ Unknown

NOTE: Complete item 66 for infants who were initially transported from your center and then a) either transported again to another hospital, or b) re-admitted to your center and then transported from your hospital to another hospital.

66. Ultimate Disposition ☐ Home ☐ Died ☐ Still Hospitalized as of 1st Birthday ☐ Unknown

67. Final Discharged Date: (MM-DD-YYYY) ____ ____ - ____ ____ - ____ ____ ____ ____