

VERMONT OXFORD NETWORK

NER Booklet for Infants Born in 2012



Center Number: _____

Network ID Number:

--	--	--	--	--

The Neonatal Encephalopathy Registry (NER) forms are provided to aid Registry participants in collecting and organizing NER patient data. **Do not submit this booklet or any of the paper forms to the Vermont Oxford Network.** **Submit all NER data to the Vermont Oxford Network as electronic files using the Network's eNICQ software.** Data files submitted using the eNICQ software do not include any protected health care information, as defined by the U.S. Health Insurance Portability and Accountability Act of 1996. No dates or times will be exported to the Vermont Oxford Network. The Vermont Oxford Network does not accept protected health care information.

Contents:

- I: Eligibility Form
- II: OB/Initial Status Form
- III: Neurological Form
- IV. Diagnoses and Discharge Form
- V. Hypothermic Therapy Form (only for infants who received hypothermic therapy.)

I. ELIGIBILITY FORM

EL1. Hypothermic Therapy Received?

Yes No

Only infants who are actively cooled are eligible for the Registry; do not complete this form or other forms in this booklet if EL1 is answered "No".

EL2. Gestational Age \geq 36 Weeks 0 Days or More?

Yes No Unknown

EL3. Major CNS Congenital Malformation?

Yes No Unknown

EL4. Stupor or Coma within 72 Hours?

Yes No Unknown

EL5. Seizures within 72 Hours?

Yes No Unknown

EL6. Paralysis Induced for First 72 Hours?

Yes No Unknown

EL7. APGAR Score at 5 Minutes of 3 or Less?

Yes No Unknown

VERMONT OXFORD NETWORK NER Booklet for Infants Born in 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

II. OB/INITIAL STATUS FORM

Part A, Obstetric-Perinatal History

OB1. Mode of Delivery (select one):

- Vaginal without Vacuum or Forceps
- Vacuum and/or Forceps Assisted Vaginal
- C Section before Labor Started
- C Section after Labor Started
- C Section after Failed Vacuum or Forceps Delivery
- Unknown

OB2. Presentation (select one):

- Vertex
- Breech
- Transverse
- Other
- Unknown

OB3. Ruptured Membranes 24 Hours or More Prior to Delivery?

- Yes
- No
- Unknown

OB4. Cord Prolapse?

- Yes
- No
- Unknown

OB5. Uterine Rupture?

- Yes
- No
- Unknown

OB6. Antepartum Hemorrhage?

- Yes
- No
- Unknown

OB7. Chorioamnionitis?

- Yes
- No
- Unknown

OB8. Maternal Temperature during Labor and Delivery:

a. Maternal Temperature Recorded?

- Yes
- No
- Unknown

b. Temperature of Mother: Range: 30.0-44.0 for C, 86.0-111.0 for F, 777.7=N/A, 999.9=Unknown

Record the highest intrapartum maternal temperature and the units in which it was recorded.

Use a single decimal place, e.g. 36.7° C or 98.2° F: . ° C ° F

OB9. Antenatal Magnesium Exposure:

- Yes
- No
- Unknown

VERMONT OXFORD NETWORK NER Booklet for Infants Born in 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

OB10. Maternal Hypertension, Pre-eclampsia, or Eclampsia?

Yes No Unknown

OB11. Maternal Diabetes?

Yes No Unknown

OB12. Maternal Hypothyroidism?

Yes No Unknown

OB13. Non-Reassuring Fetal Assessment:

a. Bradycardia Prior to Delivery?

Yes No Unknown

b. Tachycardia Prior to Delivery?

Yes No Unknown

c. Decreased FHR Variability Prior to Delivery?

Yes No Unknown

d. Prolonged or Recurrent Decelerations Prior to Delivery?

Yes No Unknown

OB14. Umbilical Cord Blood Sampling:

a. Cord Blood Sampling Performed?

Yes No Unknown

If "Yes" to a, answer questions b and c below.

b. pH from Cord Blood Sample: Range: 5.00-8.00, 77.77=N/A, 99.9=Unknown

Record the lowest cord blood pH to 2 decimal places: .

c. Base Deficit from Cord Blood Sample: Range: -20.0 to 40.0, 77.7=N/A, 99.9=Unknown

Record the worst cord blood base deficit (mmoles/liter) to the nearest tenth (base deficit is normally a positive number): +/- .

OB15. Assisted Reproduction?

Yes No Unknown

OB16. Placenta Sent for Pathology?

Yes No Unknown

VERMONT OXFORD NETWORK NER Booklet for Infants Born in 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

II. OB/INITIAL STATUS FORM

Part B, Infant's Initial Clinical Status

OB17 Age at Admission to Your NICU:

a. Infant Admitted to your NICU?

Yes

No

If Yes to a, enter **Age at Admission:**

b. Age, Days: _____

c. Age, Hours: _____

d. Age, Minutes: _____

OB18. APGAR Score at 10 Minutes: Range: 0-10, 99=Unknown _____

OB19. Assisted Ventilation at 10 Minutes?

Yes

No

Unknown

OB20. Infant Arterial, Venous, or Capillary Blood Gas:

a. Arterial, Venous, or Capillary Blood Gas Obtained During First Hour of Life?

Yes

No

Unknown

If "Yes" to a, answer questions b and c below.

b. pH from Arterial, Venous, or Capillary Blood Gas: Range: 5.00-8.00, 77.77=N/A, 99.99=Unknown

Record the lowest arterial, venous, or capillary pH obtained within the first hour of life to 2 decimal places: .

c. Base Deficit from Arterial, Venous, or Capillary Blood Gas:

Range: -20.0 to 40.0, 77.7=N/A, 99.9=Unknown

Record the worst arterial, venous, or capillary base deficit obtained within the first hour of life to the nearest tenth (base deficit is normally a positive number):

+ / - .

VERMONT OXFORD NETWORK NER Booklet for Infants Born in 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

OB21. Temperature of Infant:

a. Infant Temperature Recorded within 72 Hours of Birth?

Yes No Unknown

If "Yes" to a, answer questions b and c below.

b. Highest Temperature of Infant:

Range: 30.0-44.0 for C, 86.0-111.0 for F, 777.7=N/A, 999.9=Unknown

Record the highest temperature within 72 hours of birth and the units in which it was recorded. Use a single decimal place, e.g. 36.7° C or 98.2° F: .

. ° C ° F

c. Lowest Temperature of Infant:

Range: 30.0-44.0 for C, 86.0-111.0 for F, 777.7=N/A, 999.9=Unknown

Record the lowest temperature within 72 hours of birth and the units in which it was recorded. Use a single decimal place, e.g. 36.7° C or 98.2° F:

. ° C ° F

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

III. NEUROLOGICAL FORM

Part A, Neurological Indicators on Day 1 (≤ 6 hours and 6 to 24 hours)

	A Neuro Status Day 1 (≤ 6 Hours)	B Neuro Status Day 1 (>6-24 Hours)
NU1. Infant Alive During Examination Period? <small>See Manual of Operations</small>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes <input type="checkbox"/> No
NU2. Paralysis for the Entire Examination Period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If infant was alive and not paralyzed during the examination period, complete item NU3 through NU11 below based on the <u>worst</u> state during the examination period.		
NU3. Conscious State: <small>(Select the worst)</small>	<input type="checkbox"/> Normal <input type="checkbox"/> Stupor <input type="checkbox"/> Irritability <input type="checkbox"/> Coma <input type="checkbox"/> Lethargy <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Stupor <input type="checkbox"/> Irritability <input type="checkbox"/> Coma <input type="checkbox"/> Lethargy <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU4. Brainstem Function:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU5. Movements:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU6. Posturing:	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU7. Tone:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU8. Reflexes:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU9. Feeding:	<input type="checkbox"/> No enteral feedings <input type="checkbox"/> No feedings by mouth <input type="checkbox"/> Some feedings by mouth <input type="checkbox"/> All feedings by mouth <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> No enteral feedings <input type="checkbox"/> No feedings by mouth <input type="checkbox"/> Some feedings by mouth <input type="checkbox"/> All feedings by mouth <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU10. Assisted Ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU11. Clinical Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

III. NEUROLOGICAL FORM

Part A, Neurological Indicators on Day 3 and Day 7

	C Neuro Status Day 3	D Neuro Status Day 7 (± 1 Day)
NU1. Infant Alive During Examination Period? See Manual of Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
NU2. Paralysis for the Entire Examination Period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If infant was alive and not paralyzed during the examination period, complete item NU3 through NU11 below based on the <u>worst</u> state during the examination period.		
NU3. Conscious State: (Select the worst)	<input type="checkbox"/> Normal <input type="checkbox"/> Stupor <input type="checkbox"/> Irritability <input type="checkbox"/> Coma <input type="checkbox"/> Lethargy <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Stupor <input type="checkbox"/> Irritability <input type="checkbox"/> Coma <input type="checkbox"/> Lethargy <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU4. Brainstem Function:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU5. Movements:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU6. Posturing:	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU7. Tone:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU8. Reflexes:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU9. Feeding:	<input type="checkbox"/> No enteral feedings <input type="checkbox"/> No feedings by mouth <input type="checkbox"/> Some feedings by mouth <input type="checkbox"/> All feedings by mouth <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> No enteral feedings <input type="checkbox"/> No feedings by mouth <input type="checkbox"/> Some feedings by mouth <input type="checkbox"/> All feedings by mouth <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU10. Assisted Ventilation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU11. Clinical Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

III. NEUROLOGICAL FORM

Part B, Electrophysiology, Seizures and Anticonvulsants

NU12. Full Channel EEG:

a. Full Channel EEG Performed?

Yes No Unknown

b. EEG Background Pattern:

If "Yes" to a, select worst observed background pattern (select one):

- Normal
- Excessively Discontinuous
- Depressed Amplitude
- Burst Suppression Pattern
- Background Iso-Electric
- Unknown
- N/A

NU13. Bedside aEEG:

a. Bedside aEEG Performed?

Yes No Unknown

b. Bedside aEEG Background Pattern:

If "Yes" to a, select worst observed background pattern (select one):

- Normal
- Moderately Abnormal or Discontinuous
- Severely Abnormal
- Unknown
- N/A

NU14. Seizures Prior to Discharge:

a. Seizures Occurred Prior to Discharge?

Yes No Unknown

If "Yes" to a, answer questions b through e below.

b. Evidence of Clinical Seizure?

Yes No Unknown N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

c. Full Channel EEG Evidence of Seizure?

Yes No Unknown N/A

d. Bedside aEEG Evidence of Seizure?

Yes No Unknown N/A

e. Age Seizures First Observed:

(1) Days: _____ (2) Hours: _____ (3) Minutes: _____

NU15. Anticonvulsants Prior to Discharge:

a. Anticonvulsants Received Prior to Discharge?

Yes No Unknown

If "Yes" to a, answer questions b through h below.

c. Phenobarbital Prior to Discharge?

Yes No Unknown N/A

d. Phenytoin or Fosphenytoin Prior to Discharge?

Yes No Unknown N/A

e. Lorazepam Prior to Discharge?

Yes No Unknown N/A

f. Diazepam Prior to Discharge?

Yes No Unknown N/A

g. Midazolam Prior to Discharge?

Yes No Unknown N/A

h. Topiramate Prior to Discharge?

Yes No Unknown N/A

i. Other Anticonvulsants Prior to Discharge:

(1) Were Other Anticonvulsants Given Prior to Discharge?

Yes No Unknown N/A

(2) If "Yes", specify which other anticonvulsants: _____
(See Appendix C of NER Manual of Operations)

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

NEUROLOGICAL FORM Part C, Neuroimaging

	A Cranial US Exam(s)	B CT Scan(s)	C MRI Scan(s)
NU16 Exam or Scan Performed?	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No
NU17 Day of First Exam/Scan:	_ _ _ _	_ _ _ _	_ _ _ _
NU18 Day of Last Exam/Scan:	_ _ _ _	_ _ _ _	_ _ _ _
NU19 Intraventricular Hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU20 Extra-axial, Subdural or Subarachnoid Hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU21 Intraparenchymal Hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU22 Subependymal Hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU23 Abnormality in Deep Nuclear Gray Matter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU24 Cystic White Matter Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU25 Diffuse White Matter Injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU26 Ventriculomegaly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU27 Veno-Occlusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU28 Arterial Occlusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU29 Brainstem Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU30 Cerebellar Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU31 Diffuse Cortical Signal Abnormality?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU32 Parasagittal Watershed Cortical Gray Matter Injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU33 Absence of Posterior Limb of Internal Capsule?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
NU34 Other Intracranial Abnormalities If "Yes", describe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A

Note: Shaded items indicate the item does not apply to this type of exam/scan.

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

IV. DIAGNOSES AND DISCHARGE FORM

Part A, Diagnoses

DD1. Persistent Pulmonary Hypertension of the Newborn, PPHN?

Yes No Unknown

DD2. Renal Failure?

Yes No Unknown

DD3. Syndrome of Inappropriate Secretion of Antidiuretic Hormone, SIADH?

Yes No Unknown

DD4. Disseminated Intravascular Coagulation, DIC?

Yes No Unknown

DD5. Hepatic Dysfunction?

Yes No Unknown

DD6. Hyperbilirubinemia within 7 Days of Birth?

Yes No Unknown

DD7. Cardiac Dysfunction?

Yes No Unknown

DD8. Prenatal TORCH Infection:

a. Prenatal TORCH Infection Present?

Yes No Unknown

If "Yes" to a, indicate which of the prenatal infections in b through f below were present.

b. Toxoplasmosis?

Yes No Unknown N/A

c. Rubella?

Yes No Unknown N/A

d. Syphilis?

Yes No Unknown N/A

e. Cytomegalovirus?

Yes No Unknown N/A

f. Herpes Simplex?

Yes No Unknown N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

DD9. Congenital Neuromuscular Disorder?

a. Congenital Neuromuscular Disorder Present?

Yes No Unknown

b. If "Yes", describe: _____

DD10. Birth Trauma?

a. Traumatic Birth Injury?

Yes No Unknown

If "Yes" to a, answer questions b through h below:

b. Spinal Cord Injury?

Yes No Unknown N/A

c. Brachial Plexus Injury?

Yes No Unknown N/A

d. Skull Fracture?

Yes No Unknown N/A

e. Long Bone Fracture?

Yes No Unknown N/A

f. Clavicle Fracture?

Yes No Unknown N/A

g. Cephalhematoma?

Yes No Unknown N/A

h. Other Traumatic Birth Injury?

(1) Other Traumatic Birth Injury Observed?

Yes No Unknown N/A

(2) If "Yes", describe: _____

DD11. Meningitis or Encephalitis:

a. Meningitis or Encephalitis Suspected or Proven?

Yes No Unknown

If "Yes" to a, complete the questions below.

b. Bacterial Meningitis or Encephalitis:

None Suspected Proven

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

(1) Onset of Bacterial Meningitis or Encephalitis:

Early Late Unknown N/A

(2) Name of Bacterial Meningitis or Encephalitis Organism:

c. Fungal Meningitis or Encephalitis:

None Suspected Proven Unknown N/A

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

(1) Onset of Fungal Meningitis or Encephalitis:

Early Late Unknown N/A

(2) Name of Fungal Meningitis or Encephalitis Organism:

d. Viral Meningitis or Encephalitis:

None Suspected Proven Unknown N/A

If suspected, only answer question (1) below. If proven, answer questions (1) & (2) below.

(1) Onset of Viral Meningitis or Encephalitis:

Early Late Unknown N/A

(2) Name of Viral Meningitis or Encephalitis Organism:

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

IV. DIAGNOSES AND DISCHARGE FORM Part B, Discharge Status

DD12. Hearing Screening:

a. Hearing Screen Exam Performed?

Yes No Unknown

If "Yes" to a, enter the results of the last exam before discharge.

b. Hearing Screen Passed?

Yes No Unknown N/A

DD13. Feedings at Discharge:

- No Enteral Feedings
- Enteral Feedings, No Feedings by Mouth
- Enteral Feedings, Some Feedings by Mouth
- Enteral Feedings, All Feedings by Mouth
- Unknown

DD14. Tracheotomy at Discharge?

Yes No Unknown

DD15. Discharged with Ventilator?

Yes No Unknown

DD16. Anticonvulsant Medication at Discharge?

a. Anticonvulsant Medication at Discharge?

Yes No Unknown

If "Yes" to a, complete questions b through h below:

b. Phenobarbital at Discharge?

Yes No Unknown N/A

c. Phenytoin or Fosphenytoin at Discharge?

Yes No Unknown N/A

d. Lorazepam at Discharge?

Yes No Unknown N/A

e. Diazepam at Discharge?

Yes No Unknown N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

f. Midazolam at Discharge?

Yes No Unknown N/A

g. Topiramate at Discharge?

Yes No Unknown N/A

h. Other Anticonvulsant at Discharge?

Yes No Unknown N/A

If "Yes", specify which other anticonvulsant(s) _____
(see Appendix C of NER Manual of Operations)

DD17. Autopsy Status:

- N/A
- Autopsy performed
- Autopsy Permission Requested and Denied
- Autopsy Permission Not Requested
- Unknown

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

V. HYPOTHERMIC THERAPY FORM

HT1. Cooling Location and Method:

a. Cooling at Hospital from which Infant Transferred (outborn infants only):

(1) Hypothermic Therapy at Hospital from which Transferred?

Not Outborn Yes No Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) Cooling Method at Hospital from which Transferred:

Selective Head Whole Body Unknown N/A

(3) Hospital from which Infant Transferred:

(a) Name of Hospital: _____

(b) City: _____ (c) State/Prov./Country: _____

b. Cooling During Transport to Your Hospital (outborn infants only):

(1) Hypothermic Therapy During Transport to Your Hospital?

Not Outborn Yes No Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) Cooling Method during Transport to Your Hospital:

Selective Head Whole Body Unknown N/A

(3) Hospital from which Infant Transferred:

(a) Name of Hospital: _____

(b) City : _____ (c) State/Prov./Country: _____

c. Cooling at Your Hospital:

(1) Hypothermic Therapy at Your Hospital?

Yes No Unknown

If "Yes" to (1), answer question (2) below.

(2) Cooling Method at Your Hospital:

Selective Head Whole Body Unknown N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

d. Cooling During Transport from Your Hospital (transferred infants only):

(1) Hypothermic Therapy During Transport from Your Hospital?

Not Transferred Yes No Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) Cooling Method during Transport from Your Hospital:

Selective Head Whole Body Unknown N/A

(3) Hospital to which Infant Transferred:

(a) Name of Hospital: _____

(b) City: _____ (c) State/Prov./Country: _____

e. Cooling at Hospital to which Infant Transferred (transferred infants only)

(1) Hypothermic Therapy at Hospital to which Transferred?

Not Transferred Yes No Unknown

If "Yes" to (1), answer questions (2) and (3) below.

(2) Cooling Method at Hospital to which Transferred:

Selective Head Whole Body Unknown N/A

(3) Hospital to which Infant Transferred:

(a) Name of Hospital: _____

(b) City: _____ (c) State/Prov./Country: _____

HT2. Age Hypothermic Therapy Began:

a. Age, Days: _____ b. Age, Hours: _____ c. Minutes: _____

HT3. Age Hypothermic Therapy Stopped:

a. Age, Days: _____ b. Age, Hours: _____ c. Age, Minutes: _____

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

HT4. Core Body Temperature when Hypothermic Therapy Stopped:

a. Temperature Measured when Hypothermic Therapy Stopped?

Yes No Unknown

If "Yes" to a, answer question b below.

b. Temperature when Hypothermic Therapy Stopped:

Range: 30.0-44.0 for C, 86.0-111.0 for F, 777.7 for N/A, 999.9 for Unknown

Record the temperature when hypothermic therapy stopped and the units in which it was recorded. Use a single decimal place, e.g. 36.7° C or 98.2° F

. ° C ° F

HT5. Age Re-Warming Completed:

a. Age, Days: _____ b. Age, Hours: _____ c. Age, Minutes: _____

HT6. Cooling Interruptions:

a. Was Cooling Interrupted for More than 30 Minutes?

Yes No Unknown

If "Yes" to a, answer question b below.

b. Number of Cooling Interruptions? _____

HT7. Cooling Provided as Part of a Randomized Controlled Trial?

Yes No Unknown

HT8. Adverse Events within 7 Days of Birth:

a. Cardiac Arrhythmia within 7 Days of Birth?

Yes No Unknown

If "Yes" to a, indicate in (1) through (6) below, the adverse events from Cardiac Arrhythmia:

(1) Sinus Bradycardia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
(2) Sinus Tachycardia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
(3) Ventricular Tachycardia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
(4) Ventricular Fibrillation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
(5) Conduction Block?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
(6) Prolonged QT interval?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

(7) Other Arrhythmia:

(1) Other Arrhythmia Present?

Yes

No

Unknown

N/A

(2) If Other Arrhythmia, describe: _____

b. Thrombosis within 7 Days of Birth?

Yes

No

Unknown

c. Severe Hypotension within 7 Days of Birth?

Yes

No

Unknown

d. Seizure during Re-Warming within 7 Days of Birth?

Yes

No

Unknown

e. Scalp Edema within 7 Days of Birth?

Yes

No

Unknown

f. Skin Breakdown within 7 Days of Birth?

Yes

No

Unknown

g. Sclerema Neonatorum within 7 Days of Birth?

Yes

No

Unknown

h. Thrombocytopenia within 7 Days of Birth?

Yes

No

Unknown

HT9. Seizures Prior to Cooling?

a. Were seizures noted prior to cooling?

Yes

No

Unknown

If "Yes" to a, complete question b below.

b. Diagnosis of Seizures Prior to Cooling:

(1) Clinical Diagnosis of Seizures Prior to Cooling?

Yes

No

Unknown

N/A

(2) aEEG Diagnosis of Seizures Prior to Cooling?

Yes

No

Unknown

N/A

(3) EEG Diagnosis of Seizures Prior to Cooling?

Yes

No

Unknown

N/A

HT10. Modified SARNAT Stage Prior to Cooling: _____

Range: 0 to 3, 7=N/A, 9=Unknown

VERMONT OXFORD NETWORK NER Booklet for 2012

Center Number: _____

Network ID Number:

--	--	--	--	--

HT11. Full channel EEG Prior to Cooling:

a. Full Channel EEG Performed Prior to Cooling?

- Yes No Unknown

If "Yes" to a, select worst background pattern observed prior to cooling (select one).

b. Background Pattern of Full Channel EEG Prior to Cooling:

- Normal
 Excessively Discontinuous
 Depressed Amplitude
 Burst Suppression Pattern
 Background Iso-Electric
 Unknown
 N/A

HT12. Bedside aEEG Prior to Cooling:

a. Bedside aEEG Prior to Cooling?

- Yes No Unknown

If "Yes" to a, select worst background pattern observed prior to cooling (select one).

b. Background Pattern of Bedside aEEG Prior to Cooling:

- Normal
 Moderately Abnormal or Discontinuous
 Severely Abnormal
 Unknown
 N/A