

Center Number: _____ Patient ID Number: MRN: _____

VERMONT OXFORD NETWORK
eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2023

This booklet contains protected health care information and must NOT be submitted to Vermont Oxford Network (VON). VON only accepts protected health care information in cases where members have both voluntarily elected to send this information to VON and have signed an appropriate Business Associate Agreement with VON.

This booklet is designed for you to use to collect data that will later be entered by your center into eNICQ, the VON data submission tool.

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PATIENT IDENTIFICATION WORKSHEET	
Patient's Name:	_____
Mother's Name:	_____
Date of Birth:	<u> </u> / <u> </u> / <u> </u> MM DD YYYY
Date of Admission:	<u> </u> / <u> </u> / <u> </u> MM DD YYYY
Date of Day 28:	<u> </u> / <u> </u> / <u> </u> MM DD YYYY
Date of Week 36:	<u> </u> / <u> </u> / <u> </u> MM DD YYYY
	<ul style="list-style-type: none"> • For <u>inborn</u> infants, the date of admission is the Date of Birth • For <u>outborn</u> infants, the date of admission is the date the infant was admitted to your hospital
	For Date of Day 28 use the <i>Day 28 Calculation Charts</i> : https://vtoxford.zendesk.com/hc/en-us/articles/9877129338515-2023-Calculation-Charts-Date-of-Day-28 For Date of Week 36 use the <i>Week 36 Calculator</i> : https://public.vtoxford.org/week-36-calculator/
<p>PLEASE DO NOT SUBMIT THIS WORKSHEET Protected Health Care Information</p>	

Center Number: _____ Patient ID Number: MRN: _____

Patient ID number: _____ (this is the VON Network ID – it is auto-generated by eNICQ)	
Medical Record Number: _____	Date of Birth: <u> </u> / <u> </u> / <u> </u> <small>MM DD YYYY</small>
Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete Delivery Room Death data booklet, not this booklet)	
Location of Birth: <input type="checkbox"/> Inborn <input type="checkbox"/> Outborn (If Outborn, complete Date of Admission below)	
Patient's First Name: _____	Mother's First Name: _____
Patient's Last Name: _____	Mother's Last Name: _____
For Outborn infants:	
Date of Admission: <u> </u> / <u> </u> / <u> </u> <small>MM DD YYYY</small>	
Reason for Transfer In: <input type="checkbox"/> ECMO <input type="checkbox"/> Growth/Discharge Planning <input type="checkbox"/> Medical/Diagnostic Services <input type="checkbox"/> Surgery <input type="checkbox"/> Chronic Care <input type="checkbox"/> Other <input type="checkbox"/> Hypothermic Therapy	
Birth Weight: _____ grams	
Gestational Age, Weeks: _____ Gestational Age, Days (0-6): _____	
If Location of Birth is Outborn, Transfer Code of Center from which Infant Transferred: _____ <small>(List available at https://public.vtoxford.org/transfer-codes/)</small>	
Head Circumference at Birth (in cm to nearest 10 th): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Maternal Ethnicity/Race (Answer both Ethnicity and Race):	
Ethnicity of Mother: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	
Race of Mother: <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	
Prenatal Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Antenatal Steroids: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Antenatal Magnesium Sulfate: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chorioamnionitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maternal Hypertension, Chronic or Pregnancy-Induced: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maternal Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mode of Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section	
Sex of Infant: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Multiple Gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Number of Infants Delivered: _____	
Congenital Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Congenital Infection, Organism(s): _____ <small>(If Congenital Infection is Yes, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)</small>	

Center Number: _____ Patient ID Number: MRN: _____

Choose one of the five Post Transfer Disposition options below and complete the Data Item(s) that follow your choice:

Post Transfer Disposition:

- Home
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
- Died
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
- Transferred Again to Another Hospital (2nd Transfer)
Ultimate Disposition:
 Home
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
 Died
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
 Still Hospitalized as of First Birthday (infant record is now complete)
- Readmitted to Any Location in Your Hospital
When infants are readmitted to your center, continue to update Data Items Bacterial Sepsis and/or Meningitis on or before Day 3 through Monitor at Discharge based on all events at both hospitals until the date of Disposition after Readmission.
Disposition after Readmission:
 Home
Weight at Disposition after Readmission: _____ grams
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
 Died
Weight at Disposition after Readmission: _____ grams
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
 Still Hospitalized as of First Birthday
Weight at Disposition after Readmission: _____ grams (infant record is now complete)
 Transferred Again to Another Hospital
Weight at Disposition after Readmission: _____ grams
Ultimate Disposition:
 Still Hospitalized as of First Birthday (infant record is now complete)
 Home
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
 Died
Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY
- Still Hospitalized as of First Birthday (infant record is now complete)

General Data Items - For Infants Born in **2023** at VLBW Centers



Center Number: _____ Patient ID Number: MRN: _____

Enteral Feeding at Discharge: <input type="checkbox"/> None <input type="checkbox"/> Human Milk Only <input type="checkbox"/> Formula Only <input type="checkbox"/> Human milk in combination with either fortifier or formula
Oxygen, Respiratory Support, and Monitor at Discharge: Oxygen (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No Conventional Ventilation (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No High Frequency Ventilation (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Cannula Flow (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Ventilation (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal CPAP (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No Monitor (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No
Initial Disposition (check only one): <input type="checkbox"/> Home <input type="checkbox"/> Died <input type="checkbox"/> Transferred to another Hospital <small>(When <i>Transferred</i> is chosen, also complete Transfer/Readmission data below & on page 7)</small> <input type="checkbox"/> Still Hospitalized as of First Birthday
Date of Initial Disposition: ____/____/____ (Not required when Initial Disposition is <i>Still Hospitalized as of First Birthday</i>) <small>MM DD YYYY</small>
Weight at Initial Disposition: _____ grams
Head Circumference at Initial Disposition (in cm to nearest 10 th): <input type="text"/> <input type="text"/> <input type="text"/> (For infants which have not transferred, infant record is now complete)
If an infant is transferred to another hospital, complete Data Items <i>Reason for Transfer, Transfer Code of Center to which Infant Transferred, Post Transfer Disposition, and the Data Items that follow your Post Transfer Disposition choice</i> . <i>Post Transfer Disposition</i> refers to the infant's disposition upon leaving the "transferred to" hospital.
If Transferred, Reason for Transfer Out: <input type="checkbox"/> ECMO <input type="checkbox"/> Growth/Discharge Planning <input type="checkbox"/> Medical/Diagnostic Services <input type="checkbox"/> Surgery <input type="checkbox"/> Chronic Care <input type="checkbox"/> Other <input type="checkbox"/> Hypothermic Therapy
Transfer Code of Center to which Infant Transferred: _____ <small>(List available at https://public.vtoxford.org/transfer-codes/)</small>
Is This Infant Still Hospitalized at Another Center? <input type="checkbox"/> Yes <input type="checkbox"/> No

General Data Items - For Infants Born in **2023** at VLBW Centers



Center Number: _____ Patient ID Number: MRN: _____

APGAR Scores: 1 minute _____ 5 minutes _____
Initial Resuscitation: Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Face Mask Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No Laryngeal Mask Airway: <input type="checkbox"/> Yes <input type="checkbox"/> No Endotracheal Tube Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No Epinephrine: <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Compression: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No
Temperature Measured within the First Hour after Admission to <u>Your</u> NICU: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If Yes, Temperature Within the First Hour after Admission to Your NICU: <input type="text"/> <input type="text"/> <input type="text"/> <small>(In degrees centigrade to nearest 10th)</small>
Died within 12 Hours of Admission to Your NICU: <input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial Sepsis and/or Meningitis on or before Day 3: <input type="checkbox"/> Yes <input type="checkbox"/> No Bacterial Sepsis and/or Meningitis on or before Day 3, Pathogen(s): _____ <small>(If <i>Bacterial Sepsis and/or Meningitis</i> is Yes, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2 – Appendix B)</small>
Oxygen on Day 28: <input type="checkbox"/> Yes <input type="checkbox"/> No
Periventricular-Intraventricular Hemorrhage (PIH): Cranial Imaging (US/CT/MRI) on or before Day 28: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Worst Grade of PIH (0-4): _____ If PIH Grade 1-4, Where PIH First Occurred: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital
Respiratory Support (at any time after leaving the delivery room/initial resuscitation area): Oxygen (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Conventional Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No High Frequency Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Cannula Flow (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal CPAP (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No
Surfactant during Initial Resuscitation: <input type="checkbox"/> Yes <input type="checkbox"/> No Surfactant at Any Time: <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Surfactant at Any Time</i> must be Yes if <i>Surfactant During Initial Resuscitation</i> is Yes) If Yes, Age at First Dose of Surfactant: Hours _____ Minutes (0-59) _____
Inhaled Nitric Oxide: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Inhaled Nitric Oxide, Where Given: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both

Center Number: _____ Patient ID Number: MRN: _____

Respiratory Support at 36 Weeks (See Manual of Operations, Part 2 for N/A criteria):

Oxygen (at 36 Weeks): Yes No N/A

Conventional Ventilation (at 36 Weeks): Yes No N/A

High Frequency Ventilation (at 36 Weeks): Yes No N/A

Nasal Cannula Flow (at 36 Weeks): Yes No N/A

If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (at 36 Weeks): Yes No

Nasal Ventilation (at 36 Weeks): Yes No N/A

Nasal CPAP (at 36 Weeks): Yes No N/A

Steroids for CLD: Yes No

If Yes, Steroids for CLD, Where Given: Your Hospital Other Hospital Both

Indomethacin for Any Reason: Yes No

Ibuprofen for PDA: Yes No

Acetaminophen (Paracetamol) for PDA: Yes No

Probiotics: Yes No

Treatment of ROP with Anti-VEGF Drug: Yes No

Caffeine for Any Reason: Yes No

Intramuscular Vitamin A for Any Reason: Yes No

ROP Surgery: Yes No

If Yes, ROP Surgery, Where Done: Your Hospital Other Hospital Both

Surgery or Interventional Catheterization for Closure of PDA: Yes No
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

Surgery for NEC, Suspected NEC, or Bowel Perforation: Yes No
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

Other Surgery: Yes No
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

If Yes to Surgery for Closure of PDA, Surgery for NEC, or Other Surgery, enter up to 10 Surgery Codes, Locations of Surgery, and check Yes or No for Surgical Site Infection following Surgery at Your Hospital:
See Manual of Operations, Part 2 – Appendix D for Surgery Codes.
If Surgery for NEC is Yes, one or more of the following codes is required: S302, S303, S307, S308, S309, S333. Indicate Location of Surgery for each surgery code. If a surgical site infection is present, indicate "Yes" for the one surgical code that resulted in the surgical site infection.

Surgery Code 1: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 2: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 3: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 4: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 5: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 6: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 7: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 8: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 9: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery Code 10: _____	<input type="checkbox"/> Your Hospital	<input type="checkbox"/> Other Hospital	<input type="checkbox"/> Both	Surgical Site Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No

Include description for Surgery Codes S100,S200,S300,S400,S500,S600,S700,S800,S900,S1000, and S1001:

Center Number: _____ Patient ID Number: MRN: _____

Respiratory Distress Syndrome: Yes No

Pneumothorax: Yes No

If Yes, Pneumothorax, Where Occurred: Your Hospital Other Hospital Both

Patent Ductus Arteriosus: Yes No N/A

Necrotizing Enterocolitis: Yes No

If Yes, NEC, Where Occurred: Your Hospital Other Hospital Both

Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:
 Surgically Confirmed Clinically Diagnosed No

Sepsis and/or Meningitis, Late (after day 3 of life):

Bacterial Sepsis and/or Meningitis after Day 3: Yes No

If Yes, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred:
 Your Hospital Outside Your Hospital Both

Bacterial Sepsis and/or Meningitis after Day 3, Pathogen(s): _____
(If Bacterial Sepsis and/or Meningitis is Yes, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2, Appendix B)

Coagulase Negative Staph Infection after Day 3: Yes No

If Yes, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:
 Your Hospital Outside Your Hospital Both

Fungal Infection after Day 3: Yes No

If Yes, Fungal Infection after Day 3, Where Occurred: Your Hospital Outside Your Hospital Both

Cystic Periventricular Leukomalacia: Yes No N/A (See Manual of Operations, Part 2 for N/A criteria)

ROP, Retinal Examination Yes No

If Yes, Worst Stage of ROP (0-5): _____

Congenital Anomaly: Yes No

If Yes, enter up to 5 Congenital Anomaly Codes: _____
See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.

If Yes, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, & 907:

Is this infant still hospitalized at your center? Yes No