

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: ____/____/____
 MM DD YYYY

Date of Admission: ____/____/____
 MM DD YYYY


Date of Day 28: ____/____/____
 MM DD YYYY

Date of Week 36: ____/____/____
 MM DD YYYY

- For inborn infants, the date of admission is the Date of Birth
- For outborn infants, the date of admission is the date the infant was admitted to your hospital

For Date of Day 28 use the *Day 28 Calculation Charts*:
<https://vtoxford.zendesk.com/hc/en-us/articles/9877129338515-2023-Calculation-Charts-Date-of-Day-28>
For Date of Week 36 use the *Week 36 Calculator*:
<https://public.vtoxford.org/week-36-calculator/>

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

General Data Items - For Infants Born in 2023 at Expanded Centers 

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: ____/____/____ <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: _____
Previously Discharged Home: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete Date of Admission and Reason for Transfer In below)	
For Outborn infants, or for Inborn infants where Previously Discharged Home is Yes	Date of Admission: ____/____/____ <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"/> .	
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: _____

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:

General Data Items - For Infants Born in 2023 at Expanded Centers 

Center Number: _____ Patient ID Number: MRN: _____

Respiratory Distress Syndrome:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumothorax:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Pneumothorax, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Patent Ductus Arteriosus:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Necrotizing Enterocolitis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, NEC, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:	
<input type="checkbox"/> Surgically Confirmed <input type="checkbox"/> Clinically Diagnosed <input type="checkbox"/> No	
Sepsis and/or Meningitis, Late (after day 3 of life):	
Bacterial Sepsis and/or Meningitis after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If Yes, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
Bacterial Sepsis and/or Meningitis after Day 3, Pathogen(s): _____	
<small>(If Bacterial Sepsis and/or Meningitis is Yes, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2, Appendix B)</small>	
Coagulase Negative Staph Infection after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
Fungal Infection after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Fungal Infection after Day 3, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
Cystic Periventricular Leukomalacia:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual of Operations, Part 2 for N/A criteria)
ROP, Retinal Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Worst Stage of ROP (0-5):	_____
Congenital Anomaly:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, enter up to 5 Congenital Anomaly Codes: _____	
<small>See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.</small>	
If Yes, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, & 907:	

ECMO at your Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Hypothermic Therapy Performed at Your Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Level of Consciousness Before Hypothermic Therapy:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
If Yes, Hypothermic Therapy Cooling Method:	<input type="checkbox"/> Selective Head <input type="checkbox"/> Whole Body <input type="checkbox"/> Both
Hypoxic-Ischemic Encephalopathy:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Center Number: _____ Patient ID Number: MRN: _____

Meconium Aspiration Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Tracheal Suction for Meconium Attempted during Initial Resuscitation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No
Neonatal Abstinence Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A when Gestational Age, Weeks is less than or equal to 33) If Yes, Pharmacological Treatment for Neonatal Abstinence Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Pharmacological Treatment for Neonatal Abstinence Syndrome, Where Given: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Is this infant still hospitalized at your center? <input type="checkbox"/> Yes <input type="checkbox"/> No
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
Duration of Assisted Ventilation (initial hospital stay): <input type="checkbox"/> None <input type="checkbox"/> <4 hours <input type="checkbox"/> 4-24 hours <input type="checkbox"/> > 24 hours If > 24 hours, Total Days of Assisted Ventilation (initial hospital stay): _____
Initial Disposition (check only one): (When <i>Transferred</i> is chosen, also complete Transfer/Readmission data below & on page 7) <input type="checkbox"/> Home <input type="checkbox"/> Died <input type="checkbox"/> Transferred to another Hospital <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>) <div style="text-align: center; font-size: small;">MM DD YYYY</div>
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: _____ (List available at https://public.vtoxford.org/transfer-codes/)

Center Number: _____ Patient ID Number: MRN: _____

Is This Infant Still Hospitalized at Another Center? Yes No

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

Post Transfer Disposition:

1. Home

Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY

2. Died

Date of Final Discharge: / / (infant record is now complete)
MM DD YYYY

3. 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)

4. 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.

Also continue to update Data Items *ECMO at your Hospital, Hypothermic Therapy at Your Hospital, Cooling Method, Hypoxic-Ischemic Encephalopathy, HIE Severity, Seizures, Neonatal Abstinence Syndrome, Pharmacological Treatment for Neonatal Abstinence Syndrome, and Pharmacological Treatment for Neonatal Abstinence Syndrome, Where Given* based on events that occur following transfer and 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

5. Still Hospitalized as of First Birthday (infant record is now complete)