

Center Number: _____ Patient ID Number: MRN: _____

VERMONT OXFORD NETWORK eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2022

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/4402663457171-2022-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 2022 at VLBW 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: <u> </u> / <u> </u> / <u> </u> MM DD YYYY
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> MM DD YYYY	
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>	

General Data Items - For Infants Born in 2022 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"/> . <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 Bacterial Sepsis and/or Meningitis 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 <small>(Surfactant at Any Time must be Yes if Surfactant During Initial Resuscitation is Yes)</small>		
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		

General Data Items - For Infants Born in 2022 at VLBW Centers

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 2022 at VLBW 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
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:	

Is this infant still hospitalized at your center? <input type="checkbox"/> Yes <input type="checkbox"/> No	

General Data Items - For Infants Born in 2022 at VLBW Centers

Center Number: _____ Patient ID Number: MRN: _____

- Enteral Feeding at Discharge:**
- None
 - Human Milk Only
 - Formula Only
 - Human milk in combination with either fortifier or formula

Oxygen, Respiratory Support, and Monitor at Discharge:

- Oxygen** (at Discharge): Yes No
- Conventional Ventilation** (at Discharge): Yes No
- High Frequency Ventilation** (at Discharge): Yes No
- Nasal Cannula Flow** (at Discharge): Yes No
- If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute** (at Discharge): Yes No
- Nasal Ventilation** (at Discharge): Yes No
- Nasal CPAP** (at Discharge): Yes No
- Monitor** (at Discharge): Yes No

Initial Disposition (check only one):

- Home
- Died
- Transferred to another Hospital
(When *Transferred* is chosen, also complete Transfer/Readmission data below & on page 7)
- Still Hospitalized as of First Birthday

Date of Initial Disposition: ____/____/____ (Not required when Initial Disposition is *Still Hospitalized as of First Birthday*)
MM DD YYYY

Weight at Initial Disposition: _____ grams

Head Circumference at Initial Disposition (in cm to nearest 10th): . (For infants which have not transferred, infant record is now complete)

If an infant is transferred to another hospital, complete Data Items *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*. *Post Transfer Disposition* refers to the infant's disposition upon leaving the "transferred to" hospital.

- If Transferred, Reason for Transfer Out:**
- ECMO
 - Growth/Discharge Planning
 - Medical/Diagnostic Services
 - Surgery
 - Chronic Care
 - Other
 - Hypothermic Therapy

Transfer Code of Center to which Infant Transferred: _____
(List available at <https://public.vtoxford.org/transfer-codes/>)

Is This Infant Still Hospitalized at Another Center? Yes No

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:

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.

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)