Patient's Name: ______________________________ Medical Record:______________________________

(Please do not transmit information in this box)

VERMONT OXFORD NETWORK – ELBW Infant Follow-Up: 2021 Birth Year Cohort - *HEALTH STATUS REPORT*

Center Number: __________ Center Name: ______________________________

Network ID Number: __________ Year of Birth (YYYY): __________

Status at 16 – 26 Months Corrected Age: ☐ Alive ☐ Expired ☐ Unknown

VON does not require parental consent for submitting data to the ELBW Follow up Project.

Does your Center require parental consent? ☐ Yes ☐ No Consent obtained? ☐ Yes ☐ No

Was there a follow-up visit completed between 18 and 24 months corrected age? ☐ Yes ☐ No

IF no, was there a follow-up visit completed between 16 and 26 months corrected age? ☐ Yes ☐ No

Form Completed: *Check (✓) any that apply* ☐ In Person Visit ☐ Virtual / Video Visit ☐ Health Record

SECTION A: HEALTH STATUS

1. Corrected Age at the follow-up visit (months/days): ___ ___ months ___ ___ days

SECTION B: LIVING SITUATION

2. Maternal Age at Infant Birth: ___ ___years ☐ Unknown
3. Home Child Resides: ☐ Parent/Family member ☐ Foster care ☐ Institutional ☐ Unknown
4. Caregivers: ☐ Single parent ☐ Two parent ☐ Institutional ☐ Unknown
   Check (✓) only one ☐ Single parent extended family ☐ Two parent extended family
5. Primary Caregiver Education: ☐ Some High School or less ☐ Some college/university
   Check (✓) only one ☐ High School degree/GED ☐ College/university degree
   ☐ Not applicable ☐ Unknown
6. Caregiver(s) Primary Language: ☐ English ☐ Spanish ☐ Other
7. Health Related Social Needs Screen: ☐ Completed ☐ Not completed ☐ Unsure

IF completed, check (√) all that were assessed

☐ Food insecurity ☐ Housing instability ☐ Transportation needs ☐ Utility needs

☐ Financial strain ☐ Interpersonal safety ☐ Employment/unemployment

SECTION C: SUPPORT AFTER DISCHARGE

8. Any Outpatient Support: ☐ Yes ☐ No ☐ Unsure

If yes, *complete the following*	Any time *after discharge*			At present *clinic visit*		
a. Tracheostomy:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
b. Ventilator:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
c. Oxygen:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
d. Gastrostomy:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
e. Nasogastric or Post-pyloric Feeds:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
f. Apnea or CP monitor:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
g. Pulse Oximetry:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
h. Respiratory Medications:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
i. Oral Feeding Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
j. Speech Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
k. Motor Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure

Complete form on reverse side

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SECTION D: MEDICAL RE-HOSPITALIZATIONS AFTER DISCHARGE

9. Any Medical Readmissions (after ultimate discharge): ☐ Yes ☐ No ☐ Unsure

***If yes,** complete the following*

				# Admissions
a. Respiratory Illness:	☐ Yes	☐ No	☐ Unsure	____ ____
b. Nutrition/ Failure to Thrive:	☐ Yes	☐ No	☐ Unsure	____ ____
c. Seizure Disorder:	☐ Yes	☐ No	☐ Unsure	____ ____
d. Shunt Complication:	☐ Yes	☐ No	☐ Unsure	____ ____
e. *Infections (not respiratory or shunt infections)*				
i. Meningitis:	☐ Yes	☐ No	☐ Unsure	____ ____
ii. Urinary Tract Infection:	☐ Yes	☐ No	☐ Unsure	____ ____
iii. Gastrointestinal Infection:	☐ Yes	☐ No	☐ Unsure	____ ____
iv. Other infection:	☐ Yes	☐ No	☐ Unsure	
***If yes**, specify: ________________________*				____ ____
f. Other Medical Readmissions:	☐ Yes	☐ No	☐ Unsure	
***If yes**, specify: ________________________*				____ ____

SECTION E: SURGERIES

10. Surgical procedures (after ultimate discharge): ☐ Yes ☐ No ☐ Unsure

***If Yes,** put all that apply*

	# Procedures
a. *(P-Code)* ______________________	____ ____
b. *(P-Code)* ______________________	____ ____
c. *(P-Code)* ______________________	____ ____
d. *(P-Code)* ______________________	____ ____
e. *(P-Code)* ______________________	____ ____

SURGICAL PROCEDURE CODES (P-CODES)

P-Code	Procedure	P-Code	Procedure
	Central Nervous System Surgery		Otolaryngology Surgery
P-101	Shunt or shunt revision for hydrocephalus	P-501	Tracheostomy
P-102	Other neurosurgical procedure	P-502	Tympanostomy tubes
	Congenital Heart Defect Surgery	P-503	Other ENT surgical procedure
P-201	Cardiac surgery		Ophthalmologic Surgery
	Gastrointestinal Surgery	P-601	Retinal cryosurgery or laser surgery: single eye
P-301	Gastrostomy tube placement	P-602	Retinal cryosurgery or laser surgery: both eyes
P-302	Inguinal hernia repair	P-603	Strabismus surgery
P-303	Other gastrointestinal surgical procedure	P-604	Other ophthalmologic surgical procedure
	Genitourinary Surgery		
P-401	Circumcision	P-900	Other Surgical Procedure
P-402	Other genitourinary surgical procedure		

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Patient's Name: ______________________________ Medical Record:______________________________
(Please do not transmit information in this box)

VERMONT OXFORD NETWORK - Infant Follow-up: 2021 Birth Year Cohort - *DEVELOPMENTAL STATUS REPORT*

Center Number: __________ Center Name: ______________________________

Network ID Number: __________ Year of Birth (YYYY): __________

VON does not require parental consent for submitting data to the ELBW Follow up Project.

Form Completed: ☐ In Person ☐ Virtual /video Visit ☐ Health Record

SECTION A: GROWTH

1. Weight: ___ ___.___ kg **2.** Head Circumference: ___ ___.___ cm **3.** Length: ___ ___.___ cm

4. Corrected Age growth measurement (months/days): ___ ___ months ___ ___ days

SECTION B: VISION & HEARING

5. Post Discharge Eye Treatment:	☐ Laser	☐ Anti-VEGF	☐ Both	☐ Neither	☐ Unsure
6. Blindness:	☐ One eye	☐ Both eyes	☐ Neither	☐ Unsure	
7. Prescription Glasses:	☐ Yes	☐ No	☐ Unsure		
8. Hearing Impairment:	☐ One ear	☐ Both ears	☐ Neither	☐ Unsure	
9. Amplification:	☐ Yes	☐ No	☐ Unsure		

SECTION C: CEREBRAL PALSY

10. Cerebral Palsy:	☐ Yes	☐ No	☐ Unsure		
If Yes, impairment:	☐ Diplegia	☐ Hemiplegia	☐ Quadriplegia	☐ Unsure	
If No, muscle tone:	☐ Hypotonia	☐ Hypertonia	☐ Both	☐ Normal	☐ Unsure

SECTION D: GROSS MOTOR MILESTONES

11. Sits independently:	☐ Yes	☐ No	☐ Unsure
If No, sits with support:	☐ Yes	☐ No	☐ Unsure
12. Walks ten (10) steps independently:	☐ Yes	☐ No	☐ Unsure
If No, walks ten (10) steps with support:	☐ Yes	☐ No	☐ Unsure

SECTION E: CLINICAL APPRAISAL

13. Cognitive Function:	☐ Normal	☐ Suspect	☐ Impaired	☐ Unsure
Appraisal by: check (✓) any that apply:	☐ Clinical Assessment	☐ Caregiver questionnaire	☐ Both	☐ Neither
14. Language Function:	☐ Normal	☐ Suspect	☐ Impaired	☐ Unsure
Appraisal by: check (✓) any that apply:	☐ Clinical Assessment	☐ Caregiver questionnaire	☐ Both	☐ Neither
15. Motor Function:	☐ Normal	☐ Suspect	☐ Impaired	☐ Unsure
Appraisal by: check (✓) any that apply:	☐ Clinical Assessment	☐ Caregiver questionnaire	☐ Both	☐ Neither

Complete form on reverse side

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SECTION F: DEVELOPMENT

16. SCREEN completed by CAREGIVER? ☐ Yes ☐ No ☐ Unsure

a. If No (not completed), why? Check (✓) one:
☐ Too severely delayed ☐ Uncooperative ☐ Not available ☐ Other

b. If Yes (completed), check (✓) one: ☐ Ages and Stages Questionnaire ☐ Other ☐ Unsure

17. Ages & Stages Form (Reference: [ASQ Calculator - Ages and Stages]()):
Check (✓) one: ☐ 16 - month ☐ 18 - month ☐ 20 - month ☐ 22 - month
☐ 24- month ☐ 27- month ☐ 30 - month

18. Results (ASQ): Check (✓) one for each category

Communication	☐ Concern	☐ Possible concern	☐ No concern	☐ Unsure
Gross Motor	☐ Concern	☐ Possible concern	☐ No concern	☐ Unsure
Fine Motor	☐ Concern	☐ Possible concern	☐ No concern	☐ Unsure
Problem solving	☐ Concern	☐ Possible concern	☐ No concern	☐ Unsure
Personal - Social	☐ Concern	☐ Possible concern	☐ No concern	☐ Unsure

19. EVALUATION completed by PROVIDER? ☐ Yes ☐ No

a. If No (not completed), why? Check (✓) one:
☐ Neurosensory impairment ☐ Too severely delayed ☐ Uncooperative ☐ Other

b. If Yes, check (✓) one*:* ☐ Bayley – 3rd Edition ☐ Bayley – 4th Edition ☐ Other

c. *If Bayley-3rd or 4th Edition , check (✓) one:* ☐ Completed ☐ Partially completed ☐ Not done

20. Corrected Age Used In Scoring Bayley (months/days): _____months _____days

Reference: [NICHD Neonatal Research Network (rti.org)]()

21. Results Bayley (BSID):

				Scaled Score	Composite Score
☐ BSID Cognitive:	☐ Not done	☐ Done		___ ___	___ ___
☐ BSID Language:	☐ Not done	☐ Done	(Sum)	___ ___	___ ___
Expressive Communication:				___ ___	Not applicable
Receptive Communication:				___ ___	Not applicable
☐ BSID Motor:	☐ Not done	☐ Done	(Sum)	___ ___	___ ___
Gross Motor:				___ ___	Not applicable
Fine Motor:				___ ___	Not applicable

22. AUTISM SCREEN completed? ☐ Yes ☐ No ☐ Unsure

a. If Yes, check (✓) one: ☐ M-CHAT-R/F™ ☐ Other ☐ Unsure

23. Results M-CHAT-R/F: ___ ___

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