Patient's Name: ___________________________ Medical Record:_________________________

(Please do not transmit information in this box)

VERMONT OXFORD NETWORK – ELBW Infant Follow-Up: 2022 Birth Year Cohort - *HEALTH STATUS REPORT*

Center Number: __________ Center Name: ________________________________

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

Status at 18 – 24 Months Corrected Age: ☐ Alive ☐ Expired ☐ Unknown

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

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

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. Caregiver(s) Primary Language: ☐ English ☐ Spanish ☐ Other
3. 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

☐ Other

SECTION C: SUPPORT AFTER DISCHARGE

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

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

	Any time *after discharge*	At present *clinic visit*
a. Tracheotomy	☐ 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. Apnea or CP monitor	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
f. Pulse oximetry	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure
g. Respiratory medications:	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

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h. Nasogastric or post-pyloric Feeds:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
i. SLP/OT (feeding support):	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
j. SLP/OT (speech support):	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
k. OT/PT (motor support):	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
l. Developmental specialist (developmental support):	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
m. Dietician (nutritional support):	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure

SECTION D: MEDICAL READMISSIONS AFTER DISCHARGE

5. 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. Infections (not respiratory or shunt infections):	☐ Yes	☐ No	☐ Unsure	____ ____
d. Shunt complication (including infections):	☐ Yes	☐ No	☐ Unsure	____ ____
e. Other medical readmissions:	☐ Yes	☐ No	☐ Unsure	____ ____

If yes, specify: ____

SECTION E: SURGERIES

6. 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)* ______________________	____ ____

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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		Orthopedic Procedure
P-401	Circumcision	P-701	Tendon release
P-402	Other genitourinary surgical procedure	P-702	Casting
		P-703	Other Orthopedic surgical procedure
		P-900	Other 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: 2022 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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DEVELOPMENTAL STATUS REPORT: PAGE 2

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 – 4th Edition ☐ Other

c. If Bayley-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):

			Standard Score
☐ BSID Cognitive:	☐ Not done	☐ Done	___ ___
☐ BSID Language:	☐ Not done	☐ Done	___ ___
☐ BSID Motor:	☐ Not Done	☐ Done	___ ___

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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