

Center Number: _____

Network ID Number:

LENGTH OF STAY CALCULATION WORKSHEET FOR INFANTS BORN IN 2019

Protected Health Care Information. **DO NOT SUBMIT** this Worksheet to Vermont Oxford Network.

Use items *Date of Admission*, *Date of Initial Disposition*, and *Date of Transfer/Discharge Home/Death/First Birthday* from the Patient Identification Worksheet when completing this form.

Find day numbers corresponding to dates using the Day Number Chart for 2019-20 (www.vtoxford.org/downloads).

Part A. Initial Length Of Stay

Enter Date of Initial Discharge, Transfer, or Death (Date of Initial Disposition): ____/____/____ Day #

Subtract Date of Admission to Your Hospital (Date of Admission): ____/____/____ - Day #

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.

Add 1: + 1
INITIAL LENGTH OF STAY = Days

Note: the maximum value of Initial Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

Part B. Total Length Of Stay

Only For Infants Transferred From Your Hospital to Another Hospital.

Enter Date of Final Discharge or Death (Transferred/Home/Died/1st Birthday): ____/____/____ Day #

Subtract Date of Admission (Date of Admission): ____/____/____ - Day #

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.

Add 1: + 1
TOTAL LENGTH OF STAY = Days

Note: the maximum value of Total Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

SAMPLE CALCULATION OF INITIAL LENGTH OF STAY

Enter Date of Initial Discharge, Transfer, or Death: 02 / 26 / 2019 Day #

Subtract Date of Admission: 01 / 13 / 2019 - Day #

Add 1: _____ + 1
INITIAL LENGTH OF STAY = Days

Explanation: Date of 02/26/2019 is Day Number 57. Date of 01/13/2019 is Day Number 13. The day numbers for each date are found in the 2019-2020 Day Number Chart on the Network web site, www.vtoxford.org/downloads.

PLEASE DO NOT SUBMIT THIS WORKSHEET

Protected Health Care Information



General Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: Year of Birth: _____

Birth Weight: _____ grams	
Gestational Age Weeks: _____ Gestational Age Days (0-6): _____	
Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, complete Delivery Room Death Data Items)</i>	
Location of Birth: <input type="checkbox"/> Inborn <input type="checkbox"/> Outborn	
If Outborn, Day of Admission to Your NICU (Range: 1 to 28. Date of Birth is Day 1): _____	
If Outborn, Transfer Code of Center from which Infant Transferred: _____ <small>(List available at http://www.vtoxford.org/transfers)</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 <i>If Yes, Number of Infants Delivered: _____</i>	
Congenital Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Congenital Infection, Organism(s): _____ <small>(If <i>Congenital Infection</i> is Yes, enter up to three Congenital Infection codes from Manual of Operations, Part 2 – Appendix E)</small>	
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	
<i>If Yes, Temperature Within the First Hour after Admission to Your NICU:</i> <input type="text"/> <input type="text"/> . <input type="text"/> <small>(In degrees <i>centigrade</i> to nearest 10th)</small>	
Died Within 12 Hours of Admission to Your NICU: <input type="checkbox"/> Yes <input type="checkbox"/> No	

General Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: Year of Birth: _____

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 three Bacterial Pathogen codes from Manual of Operations, Part 2 – Appendix B)</small>	
Oxygen on Day 28: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual of Operations, Part 2 for N/A criteria)	
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 High Flow Nasal Cannula 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 Nasal CPAP or Nasal Vent before or without ever having received ETT Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
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>(<i>Surfactant at Any Time</i> must be Yes if <i>Surfactant During Initial Resuscitation</i> 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	
Respiratory Support at 36 Weeks (See Manual of Operations, Part 2 for N/A criteria): Oxygen at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Conventional Ventilation at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A High Frequency Ventilation at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A High Flow Nasal Cannula at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Nasal Ventilation at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Nasal CPAP at 36 Weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Steroids for CLD: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Steroids for CLD, Where Given: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both	
Indomethacin for Any Reason: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ibuprofen for PDA: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acetaminophen (Paracetamol) for PDA: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Probiotics: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment of ROP with Anti-VEGF Drug: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine for Any Reason: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intramuscular Vitamin A for Any Reason: <input type="checkbox"/> Yes <input type="checkbox"/> No	

General Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: Year of Birth: _____

ROP Surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, ROP Surgery, Where Done:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Surgery or Interventional Catheterization for Closure of PDA:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</i>	
Surgery for NEC, Suspected NEC, or Bowel Perforation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</i>	
Other Surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</i>	
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:	
<i>See Manual of Operations, Part 2 – Appendix D for Surgery Codes.</i>	
<i>If Surgery for NEC is Yes, one or more of the following codes is required: S302, S303, S307, S308, S309, S333.</i>	
<i>Indicate Location of Surgery for each surgery code.</i>	
<i>If a surgical site infection is present, indicate “Yes” for the one surgical code that resulted in the surgical site infection.</i>	
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:	

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
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
Focal Intestinal Perforation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Focal Intestinal Perforation, Where Occurred:	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Sepsis and/or Meningitis, Late (after day 3 of life) (See Manual of Operations, Part 2 for N/A criteria):	
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):	_____
<i>(If Bacterial Sepsis and/or Meningitis is Yes, enter up to three Bacterial Pathogen codes from Manual of Operations, Part 2 – Appendix B)</i>	

General Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: Year of Birth: _____

Coagulase Negative Staph Infection after Day 3: Yes No N/A
If Yes, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:
 Your Hospital Outside Your Hospital Both

Fungal Infection after Day 3: Yes No N/A
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 five 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, and 907:

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
- High Flow Nasal Cannula 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 this Disposition is chosen, also complete Transfer & Readmission Data Items)
- Still Hospitalized as of First Birthday

Weight at Initial Disposition: _____ grams

Head Circumference at Initial Disposition (in cm to nearest 10th): .

Initial Length of Stay: _____ day(s) (Data Item *Initial Length of Stay* on Length of Stay Calculation Worksheet)

Transfer & Readmission Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: Year of Birth: _____

Part A. Complete for ALL Transferred Infants

If an infant is transferred to another hospital, complete Data Items *Reason for Transfer*, *Transfer Code of Center to which Infant Transferred*, and *Post Transfer Disposition* (below). Post Transfer Disposition refers to the infant's disposition upon leaving the "transferred to" hospital.

Reason for Transfer: (Check Only One) Growth/Discharge Planning Medical/Diagnostic Services Surgery ECMO Chronic Care Other

Transfer Code of Center to which Infant Transferred: _____ (List available at <https://www.vtoxford.org/tools/transferlist.aspx>)

Post Transfer Disposition (check only one):

- | | |
|---|--|
| <input type="checkbox"/> Home | <i>Skip Parts B and C. Complete Part D.</i> |
| <input type="checkbox"/> Transferred Again to Another Hospital (2 nd Transfer) | <i>Skip Part B. Complete Parts C and D when data are available.</i> |
| <input type="checkbox"/> Died | <i>Skip Parts B and C. Complete Part D.</i> |
| <input type="checkbox"/> Readmitted to Any Location in Your Hospital | <i>Complete Parts B and D (and C if applicable) when data are available.</i> |
| <input type="checkbox"/> Still Hospitalized as of First Birthday | <i>Skip Parts B and C. Complete Part D.</i> |

Part B. Complete ONLY for Readmitted Infants

If a patient is readmitted to your center after transferring once to another hospital without having been home, answer Data Items *Disposition after Readmission* and *Weight at Disposition after Readmission* (below).

When infants are readmitted to your center, continue to update Items *Bacterial Sepsis and/or Meningitis on or before Day 3 through PIH, Where First Occurred* and Items *Oxygen after Initial Resuscitation through Monitor at Discharge* based on all events at both hospitals until the date of Disposition after Readmission.

If your hospital participates in the Expanded Database and definition criteria are met, update Data Items *ECMO at your Hospital*, *Hypothermic Therapy at Your Hospital*, *Cooling Method*, *Hypoxic-Ischemic Encephalopathy*, *HIE Severity*, and *Seizures* based on events that occur following transfer and readmission.

Disposition after Readmission (check only one):

- | | |
|--|--|
| <input type="checkbox"/> Home | <i>Skip Part C. Complete Part D.</i> |
| <input type="checkbox"/> Died | <i>Skip Part C. Complete Part D.</i> |
| <input type="checkbox"/> Transferred Again to Another Hospital | <i>Complete Parts C and D when data are available.</i> |
| <input type="checkbox"/> Still Hospitalized as of First Birthday | <i>Skip Part C. Complete Part D.</i> |

Weight at Disposition after Readmission: _____ grams

Part C. Complete ONLY for Infants Who Transferred More Than Once

Answer *Ultimate Disposition* if an infant transferred from your center to another hospital and was then either (1) transferred again to another hospital, or (2) readmitted to your center and then transferred again to another hospital.

Ultimate Disposition (check only one):

- | | |
|--|-------------------------|
| <input type="checkbox"/> Home | <i>Complete Part D.</i> |
| <input type="checkbox"/> Died | <i>Complete Part D.</i> |
| <input type="checkbox"/> Still Hospitalized as of First Birthday | <i>Complete Part D.</i> |

Part D. Complete for ALL Transferred Infants

Complete *Total Length of Stay* when the infant has been discharged Home, Died, or is Still Hospitalized as of First Birthday, whichever comes first.

Total Length of Stay: _____ day(s) (Data Item *Total Length of Stay* on Length of Stay Calculation Worksheet)

Supplemental Data Items - For Infants Born in 2019
(For Expanded Data Submitting Centers)

Center Number: _____ Network ID Number: Year of Birth: _____

Previously Discharged Home: Yes No Unknown

Duration of Assisted Ventilation:

None <4 hours 4-24 hours > 24 hours N/A

If > 24 hours, Total Days of Assisted Ventilation: _____

ECMO at your Hospital: Yes No N/A

Hypothermic Therapy at Your Hospital:

Was Hypothermic Therapy Performed at Your Hospital: Yes No

If Yes, Hypothermic Therapy Cooling Method: Selective Head Whole Body Both

Hypoxic-Ischemic Encephalopathy: Yes No N/A

HIE Severity (check one): Mild Moderate Severe N/A

Meconium Aspiration Syndrome: Yes No

Tracheal Suction for Meconium Attempted during Initial Resuscitation: Yes No N/A

Seizures: Yes No N/A