**SECTION C: SUPPORT AFTER DISCHARGE**

8. Any Outpatient Support: ☐ Yes ☐ No ☐ Unsure
   
   *If yes, complete the following*

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

   At present *clinic visit*

   ☐ Yes ☐ No ☐ Unsure

---

**VERMONT OXFORD NETWORK - Infant Follow-Up - HEALTH STATUS REPORT**

Center Number: __________

Network ID Number: __________

Center Name: __________

Year of Birth (YYYY): __________

Follow-up Category: ☐ ELBW 2017 ☐ Clinical study (specify): __________

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

Form Completed: ☐ During Visit ☐ From Chart ☐ Both

---

**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:
   
   *Check (✓) only one*
   
   ☐ Single parent ☐ Two parent ☐ Institutional ☐ Unknown
   
   ☐ Single parent extended family ☐ Two parent extended family

5. Primary Caregiver Education:
   
   *Check (✓) only one*
   
   ☐ Some High School or less ☐ Some college/university
   
   ☐ High School degree/GED ☐ College/university degree
   
   ☐ Not applicable ☐ Unknown

**USA CENTERS ONLY**

6. Income Below 2017 HHS Poverty Guideline: ☐ Yes ☐ No ☐ Unknown

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

---

**Income 2017 HHS Poverty Guidelines**

(48 contiguous states and District of Columbia)

<table>
<thead>
<tr>
<th>Persons</th>
<th>Income</th>
<th>Persons</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$16,240</td>
<td>6</td>
<td>$32,960</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
<td>7</td>
<td>$37,140</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
<td>8</td>
<td>$41,320</td>
</tr>
<tr>
<td>5</td>
<td>$28,780</td>
<td>Additional</td>
<td>$4,180</td>
</tr>
</tbody>
</table>


---

Complete form on reverse side

©2018 Vermont Oxford Network, Inc
SECTION D: MEDICAL RE-HOSPITALIZATIONS AFTER DISCHARGE

9. Any Medical Readmissions (after ultimate discharge):  
   □ Yes  □ No  □ Unsure  
   *If yes, complete the following*  
   □ Yes  □ No  □ Unsure  
   # 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*  
    □ Yes  □ No  □ Unsure  
    # Procedures

    a. (P-Code) ________________________  
       ________  

    b. (P-Code) ________________________  
       ________  

    c. (P-Code) ________________________  
       ________  

    d. (P-Code) ________________________  
       ________  

    e. (P-Code) ________________________  
       ________

SURGICAL PROCEDURE CODES (P-CODES)

<table>
<thead>
<tr>
<th>P-Code</th>
<th>Procedure</th>
<th>P-Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-101</td>
<td>Central Nervous System Surgery</td>
<td>P-501</td>
<td>Otolaryngology Surgery</td>
</tr>
<tr>
<td>P-102</td>
<td>Shunt or shunt revision for hydrocephalus</td>
<td>P-502</td>
<td>Tracheostomy</td>
</tr>
<tr>
<td></td>
<td>Other neurosurgical procedure</td>
<td>P-503</td>
<td>Tymanostomy tubes</td>
</tr>
<tr>
<td>P-201</td>
<td>Congenital Heart Defect Surgery</td>
<td></td>
<td>Other ENT surgical procedure</td>
</tr>
<tr>
<td>P-301</td>
<td>Cardiac surgery</td>
<td>P-601</td>
<td>Retinal cryosurgery or laser surgery: single eye</td>
</tr>
<tr>
<td>P-302</td>
<td>Gastrointestinal Surgery</td>
<td>P-602</td>
<td>Retinal cryosurgery or laser surgery: both eyes</td>
</tr>
<tr>
<td>P-303</td>
<td>Gastrostomy tube placement</td>
<td>P-603</td>
<td>Strabismus surgery</td>
</tr>
<tr>
<td>P-401</td>
<td>Inguinal hernia repair</td>
<td>P-604</td>
<td>Other ophthalmologic surgical procedure</td>
</tr>
<tr>
<td></td>
<td>Other gastrointestinal surgical procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-402</td>
<td>Circumcision</td>
<td>P-900</td>
<td>Other Surgical Procedure</td>
</tr>
</tbody>
</table>
Patient’s Name: _____________________________ Medical Record: __________________

(Please do not transmit information in this box)

VERMONT OXFORD NETWORK - Infant Follow-up - DEVELOPMENTAL STATUS REPORT

Center Number: _____________ Center Name: _____________________________
Network ID Number: _____________ Year of Birth (YYYY): _____________

Follow-up Category: □ ELBW Birth Year 2017 □ Clinical trial (specify): _____________________________

Form Completed: □ During Visit □ From Chart □ Both

SECTION A: GROWTH PARAMETERS
10. Corrected Age Growth Parameters Were Obtained (months/days): ________months ________days
11. Weight: ________.____ kg
12. Head Circumference: ________.____ cm

SECTION B: VISION & HEARING
13. Post Discharge Eye Treatment: □ Laser □ Anti-VEGF □ Both □ Neither □ Unsure
14. Blindness: □ One eye □ Both eyes □ Neither □ Unsure
15. Prescription Glasses: □ Yes □ No □ Unsure
16. Hearing Impairment: □ One ear □ Both ears □ Neither □ Unsure
17. Amplification: □ Yes □ No □ Unsure

SECTION C: CEREBRAL PALSY
18. 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
19. Sits independently: □ Yes □ No □ Unsure
   If No, sits with support: □ Yes □ No □ Unsure
20. Walks ten (10) steps independently: □ Yes □ No □ Unsure
   If No, walks ten (10) steps with support: □ Yes □ No □ Unsure

SECTION E: DEVELOPMENTAL TESTING
21. Developmental Evaluation: □ Completed □ Partially completed □ Not done
   a. If partially completed or not done, check (✓) why:
      ■ Neurosensory impairment □ Too severely delayed □ Uncooperative □ Other
   b. If completed or partially completed, check (✓) which test:
      □ Bayley Scales of Infant Development-III □ Other
22. Corrected Age Used In Scoring (months/days): ________months ________days

23. Results (BSID-III):
   □ BSID-III Cognitive: □ Not Done □ Done Scaled Score Composite Score
   □ BSID-III Language: □ Not Done □ Done (Sum) ________ ________
   ■ Expressive Communication: ________ Not applicable
   ■ Receptive Communication: ________ Not applicable
   □ BSID-III Motor: □ Not Done □ Done (Sum) ________ ________
   Gross Motor: ________ Not applicable
   Fine Motor: ________ Not applicable

SECTION F: OVERALL CLINICAL APPRAISAL
24. Clinical Appraisal:
   Cognitive function: □ Normal □ Suspect □ Impaired □ Unsure
   Language: □ Normal □ Suspect □ Impaired □ Unsure
   Motor function: □ Normal □ Suspect □ Impaired □ Unsure

Form Completed: _____________________________
Network ID Number: _____________
Center Number: _____________________________
Patient’s Name: _____________________________
Corrected Age Used In Scoring (months/days): ________months ________days

VERMONT OXFORD NETWORK - Infant Follow-up - DEVELOPMENTAL STATUS REPORT

Center Number: _____________ Center Name: _____________________________
Network ID Number: _____________ Year of Birth (YYYY): _____________

Follow-up Category: □ ELBW Birth Year 2017 □ Clinical trial (specify): _____________________________

Form Completed: □ During Visit □ From Chart □ Both

SECTION A: GROWTH PARAMETERS
10. Corrected Age Growth Parameters Were Obtained (months/days): ________months ________days
11. Weight: ________.____ kg
12. Head Circumference: ________.____ cm

SECTION B: VISION & HEARING
13. Post Discharge Eye Treatment: □ Laser □ Anti-VEGF □ Both □ Neither □ Unsure
14. Blindness: □ One eye □ Both eyes □ Neither □ Unsure
15. Prescription Glasses: □ Yes □ No □ Unsure
16. Hearing Impairment: □ One ear □ Both ears □ Neither □ Unsure
17. Amplification: □ Yes □ No □ Unsure

SECTION C: CEREBRAL PALSY
18. 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
19. Sits independently: □ Yes □ No □ Unsure
   If No, sits with support: □ Yes □ No □ Unsure
20. Walks ten (10) steps independently: □ Yes □ No □ Unsure
   If No, walks ten (10) steps with support: □ Yes □ No □ Unsure

SECTION E: DEVELOPMENTAL TESTING
21. Developmental Evaluation: □ Completed □ Partially completed □ Not done
   a. If partially completed or not done, check (✓) why:
      ■ Neurosensory impairment □ Too severely delayed □ Uncooperative □ Other
   b. If completed or partially completed, check (✓) which test:
      □ Bayley Scales of Infant Development-III □ Other
22. Corrected Age Used In Scoring (months/days): ________months ________days

23. Results (BSID-III):
   □ BSID-III Cognitive: □ Not Done □ Done Scaled Score Composite Score
   □ BSID-III Language: □ Not Done □ Done (Sum) ________ ________
   ■ Expressive Communication: ________ Not applicable
   ■ Receptive Communication: ________ Not applicable
   □ BSID-III Motor: □ Not Done □ Done (Sum) ________ ________
   Gross Motor: ________ Not applicable
   Fine Motor: ________ Not applicable

SECTION F: OVERALL CLINICAL APPRAISAL
24. Clinical Appraisal:
   Cognitive function: □ Normal □ Suspect □ Impaired □ Unsure
   Language: □ Normal □ Suspect □ Impaired □ Unsure
   Motor function: □ Normal □ Suspect □ Impaired □ Unsure

Form Completed: _____________________________
Network ID Number: _____________
Center Number: _____________________________
Patient’s Name: _____________________________
Corrected Age Used In Scoring (months/days): ________months ________days