Patient's Name: _____ Medical Record:_____

(Please do not transmit information in this box)

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

Center Number: _____ Center Name: _____

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

Form Completed: ☐ During Visit ☐ From Chart ☐ Both

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

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

USA CENTERS ONLY

6. Income Below 2018 HHS Poverty Guideline: ☐ Yes ☐ No ☐ Unknown
7. Caregiver(s) Primary Language: ☐ English ☐ Spanish ☐ Other

Income 2018 HHS Poverty Guidelines (48 contiguous states and District of Columbia)			
Persons	Income	Persons	Income
2	$ 16,460	6	$ 33,740
3	$ 20,780	7	$ 38,060
4	$ 25,100	8	$ 42,380
5	$ 29,420	Additional	$ 4,320
***Source:* Federal Registrar Vol. 83, No.12, January 18, 2018, pp.2642-2643.**			

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

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		

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 2018 ☐ 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 – 3rd Edition ☐ Bayley Scales – 4th Edition ☐ Other test
22. Corrected Age Used In Scoring (months/days): _____months _____days
23. Results (BSID 3rd or 4th Edition):

			Scaled Score	Composite Score
☐ Cognitive:	☐ Not Done	☐ Done	___ ___	___ ___
☐ Language:	☐ Not Done	☐ Done	(Sum) ___ ___	___ ___
Expressive Communication:			___ ___	Not applicable
Receptive Communication:			___ ___	Not applicable
☐ 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