

Center Number: _____ Patient ID Number: MRN: _____

VERMONT OXFORD NETWORK

eNICQ DELIVERY ROOM DEATH BOOKLET FOR INFANTS BORN IN 2020

Use the Delivery Room Death Booklet for eligible inborn infants who die in the delivery room or at any other location in your hospital within 12 hours of birth and prior to admission to the NICU.

This booklet contains protected health care information and must NOT be submitted to Vermont Oxford Network (VON). VON only accepts protected health care information in cases where members have both voluntarily elected to send this information to VON and have signed an appropriate Business Associate Agreement with VON.

This booklet is designed for you to use to collect data that will later be entered by your center into eNICQ, the VON data submission tool.

This page intentionally left blank

Contents:
Page 1: Patient Identification Worksheet
Page 2-3: Delivery Room Death Data Items For Infants Born in 2020 at VLBW Centers

**DELIVERY ROOM DEATH
PATIENT IDENTIFICATION WORKSHEET**

Patient's Name: _____

Mother's Name: _____

Patient's Medical Record Number: _____

Date of Birth: / /
 MM DD YYYY

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

Center Number: _____ Patient ID Number: MRN: _____

Patient ID number: _____ (this is the VON Network ID – it is auto-generated by eNICQ)	
Medical Record Number: _____	
Date of Birth: <u> </u> / <u> </u> / <u> </u> <small>MM DD YYYY</small>	
Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, complete General Data Items booklet, not this booklet)	
Patient's First Name: _____	
Patient's Last Name: _____	
Mother's First Name: _____	
Mother's Last Name: _____	
Birth Weight: _____ grams	
Gestational Age, Weeks: _____	Gestational Age, Days (0-6): _____
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 If Yes, Number of Infants Delivered: _____
Congenital Infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Infection, Organism(s): _____ <small>(If Congenital Infection is Yes, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)</small>	
APGAR Scores:	1 minute _____ 5 minutes _____

Center Number: _____ Patient ID Number: MRN: _____

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
Surfactant during Initial Resuscitation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Surfactant at Any Time: <input type="checkbox"/> Yes <input type="checkbox"/> No (Surfactant at Any Time must be Yes if Surfactant During Initial Resuscitation is Yes)			
If Yes, Age at First Dose of Surfactant: Hours _____ Minutes (0-59) _____			
Congenital Anomaly: <input type="checkbox"/> Yes <input type="checkbox"/> No (For infants where Congenital Anomaly is No, infant record is now complete)			
If Yes, enter up to 5 Congenital Anomaly Codes: _____ <small>See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.</small>			
If Yes, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, & 907: _____ _____			
(infant record is now complete)			