

Center Number: \_\_\_\_\_ Patient ID Number:  MRN: \_\_\_\_\_

## VERMONT OXFORD NETWORK eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2019

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.

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### PATIENT IDENTIFICATION WORKSHEET

Patient's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Date of Birth:     /     /      
MM DD YYYY

Date of Admission:     /     /      
MM DD YYYY

Date of Day 28:     /     /      
MM DD YYYY


Date of Week 36:     /     /      
MM DD YYYY

- 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

For Date of Day 28 use the *Day 28 Calculation Charts*:  
<https://vtoxford.zendesk.com/hc/en-us/articles/360013115753-2019-Calculation-Charts-Date-of-Day-28>

For Date of Week 36 use the *Week 36 Calculator*:  
<https://public.vtoxford.org/week-36-calculator/>

**PLEASE DO NOT SUBMIT THIS WORKSHEET**  
*Protected Health Care Information*

**General Data Items - For Infants Born in 2019 at Expanded Centers** 

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> MM DD YYYY	
Died in Delivery Room: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete Delivery Room Death data booklet, not this booklet)	
Location of Birth: <input type="checkbox"/> Inborn <input type="checkbox"/> Outborn (If <i>Outborn</i> , complete <i>Date of Admission</i> below)	
Patient's First Name: _____	Mother's First Name: _____
Patient's Last Name: _____	Mother's Last Name: _____
Previously Discharged Home: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete <i>Date of Admission</i> below)	
Date of Admission: <u>    </u> / <u>    </u> / <u>    </u> (For <i>Outborn</i> infants, or for <i>Inborn</i> infants where <i>Previously Discharged Home</i> is Yes) MM DD YYYY	
Birth Weight: _____ grams	
Gestational Age, Weeks: _____	Gestational Age, Days (0-6): _____
If Location of Birth is Outborn, Transfer Code of Center from which Infant Transferred: _____ <small>(List available at <a href="https://public.vtoxford.org/transfer-codes/">https://public.vtoxford.org/transfer-codes/</a>)</small>	
Head Circumference at Birth (in cm to nearest 10 <sup>th</sup> ): <input type="text"/> <input type="text"/> <input type="text"/> .	
<b>Maternal Ethnicity/Race (Answer both Ethnicity and Race):</b>	
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 <b>If Yes, Number of Infants Delivered:</b> _____
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 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)</small>	

Center Number: \_\_\_\_\_ Patient ID Number:  MRN: \_\_\_\_\_

<b>APGAR Scores:</b>	1 minute _____	5 minutes _____
<b>Initial Resuscitation:</b>	<b>Oxygen:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Face Mask Vent:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Laryngeal Mask Airway:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Endotracheal Tube Vent:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Epinephrine:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Cardiac Compression:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Nasal Vent:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Nasal CPAP:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Temperature Measured within the First Hour after Admission to <u>Your</u> NICU:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If Yes, Temperature Within the First Hour after Admission to Your NICU: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <small>(In degrees centigrade to nearest 10<sup>th</sup>)</small>		
<b>Died within 12 Hours of Admission to Your NICU:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Bacterial Sepsis and/or Meningitis on or before Day 3:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Bacterial Sepsis and/or Meningitis on or before Day 3, Pathogen(s):</b> _____ <small>(If Bacterial Sepsis and/or Meningitis is Yes, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2 – Appendix B)</small>		
<b>Oxygen on Day 28:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual of Operations, Part 2 for N/A criteria)		
<b>Periventricular-Intraventricular Hemorrhage (PIH):</b>		
<b>Cranial Imaging (US/CT/MRI) on or before Day 28:</b> <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		
<b>Respiratory Support</b> (at any time after leaving the delivery room/initial resuscitation area):		
<b>Oxygen after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Conventional Ventilation after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>High Frequency Ventilation after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>High Flow Nasal Cannula after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Nasal Ventilation after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Nasal CPAP after Initial Resuscitation:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Nasal CPAP or Nasal Vent before or without ever having received ETT Vent:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
<b>Surfactant during Initial Resuscitation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Surfactant at Any Time:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Surfactant at Any Time must be Yes if Surfactant During Initial Resuscitation is Yes)</small>		
If Yes, Age at First Dose of Surfactant: Hours _____ Minutes (0-59) _____		
<b>Inhaled Nitric Oxide:</b> <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		

Center Number: \_\_\_\_\_ Patient ID Number:  MRN: \_\_\_\_\_

**Respiratory Support at 36 Weeks** (See Manual of Operations, Part 2 for N/A criteria):

Oxygen at 36 Weeks:  Yes  No  N/A

Conventional Ventilation at 36 Weeks:  Yes  No  N/A

High Frequency Ventilation at 36 Weeks:  Yes  No  N/A

High Flow Nasal Cannula at 36 Weeks:  Yes  No  N/A

Nasal Ventilation at 36 Weeks:  Yes  No  N/A

Nasal CPAP at 36 Weeks:  Yes  No  N/A

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**Steroids for CLD:**  Yes  No

If Yes, Steroids for CLD, Where Given:  Your Hospital  Other Hospital  Both

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**Indomethacin for Any Reason:**  Yes  No

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**Ibuprofen for PDA:**  Yes  No

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**Acetaminophen (Paracetamol) for PDA:**  Yes  No

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**Probiotics:**  Yes  No

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**Treatment of ROP with Anti-VEGF Drug:**  Yes  No

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**Caffeine for Any Reason:**  Yes  No

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**Intramuscular Vitamin A for Any Reason:**  Yes  No

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**ROP Surgery:**  Yes  No

If Yes, ROP Surgery, Where Done:  Your Hospital  Other Hospital  Both

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**Surgery or Interventional Catheterization for Closure of PDA:**  Yes  No  
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

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**Surgery for NEC, Suspected NEC, or Bowel Perforation:**  Yes  No  
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

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**Other Surgery:**  Yes  No  
(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)


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**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:**  
 See Manual of Operations, Part 2 – Appendix D for Surgery Codes.  
 If Surgery for NEC is Yes, one or more of the following codes is required: S302, S303, S307, S308, S309, S333. Indicate *Location of Surgery* for each surgery code. If a surgical site infection is present, indicate “Yes” for the one surgical code that resulted in the surgical site infection.

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:**

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**General Data Items - For Infants Born in 2019 at Expanded Centers** 

Center Number: \_\_\_\_\_ Patient ID Number:  MRN: \_\_\_\_\_

<b>Respiratory Distress Syndrome:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pneumothorax:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Pneumothorax, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
<b>Patent Ductus Arteriosus:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Necrotizing Enterocolitis:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, NEC, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
<b>Focal Intestinal Perforation:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Focal Intestinal Perforation, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
<b>Sepsis and/or Meningitis, Late (after day 3 of life)</b> (See Manual of Operations, Part 2 for N/A criteria):	
<b>Bacterial Sepsis and/or Meningitis after Day 3:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>If Yes, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
<b>Bacterial Sepsis and/or Meningitis after Day 3, Pathogen(s):</b> _____	
<small>(If Bacterial Sepsis and/or Meningitis is Yes, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2, Appendix B)</small>	
<b>Coagulase Negative Staph Infection after Day 3:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>If Yes, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
<b>Fungal Infection after Day 3:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>Fungal Infection after Day 3, Where Occurred:</b>	<input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both
<b>Cystic Periventricular Leukomalacia:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual of Operations, Part 2 for N/A criteria)
<b>ROP, Retinal Examination</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Worst Stage of ROP (0-5):</b>	_____
<b>Congenital Anomaly:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, enter up to 5 Congenital Anomaly Codes:</b> _____	
<small>See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.</small>	
<b>If Yes, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, &amp; 907:</b>	
_____	
_____	
<b>ECMO at your Hospital:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>Was Hypothermic Therapy Performed at Your Hospital:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Hypothermic Therapy Cooling Method:</b>	<input type="checkbox"/> Selective Head <input type="checkbox"/> Whole Body <input type="checkbox"/> Both
<b>Hypoxic-Ischemic Encephalopathy:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>If Yes, HIE Severity:</b>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

**General Data Items - For Infants Born in 2019 at Expanded Centers** 

Center Number: \_\_\_\_\_ Patient ID Number:  MRN: \_\_\_\_\_

<b>Meconium Aspiration Syndrome:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Tracheal Suction for Meconium Attempted during Initial Resuscitation: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Seizures:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is this infant still hospitalized at your center?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Enteral Feeding at Discharge:</b> <input type="checkbox"/> None <input type="checkbox"/> Human Milk Only <input type="checkbox"/> Formula Only <input type="checkbox"/> Human milk in combination with either fortifier or formula
<b>Oxygen, Respiratory Support, and Monitor at Discharge:</b> Oxygen at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No Conventional Ventilation at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No High Frequency Ventilation at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No High Flow Nasal Cannula at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Ventilation at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal CPAP at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No Monitor at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Duration of Assisted Ventilation:</b> <input type="checkbox"/> None <input type="checkbox"/> <4 hours <input type="checkbox"/> 4-24 hours <input type="checkbox"/> > 24 hours <input type="checkbox"/> N/A If > 24 hours, Total Days of Assisted Ventilation: _____
<b>Initial Disposition (check only one):</b> <input type="checkbox"/> Home <input type="checkbox"/> Died <input type="checkbox"/> Transferred to another Hospital (When <i>Transferred</i> is chosen, also complete Transfer/Readmission data below & on page 7) <input type="checkbox"/> Still Hospitalized as of First Birthday
<b>Date of Initial Disposition:</b> ____/____/____ (Not required when Initial Disposition is <i>Still Hospitalized as of First Birthday</i> ) <div style="text-align: center; font-size: small;">MM DD YYYY</div>
<b>Weight at Initial Disposition:</b> _____ grams
<b>Head Circumference at Initial Disposition</b> (in cm to nearest 10 <sup>th</sup> ): <input type="text"/> <input type="text"/> <input type="text"/> .____ (For infants which have not transferred, infant record is now complete)
If an infant is transferred to another hospital, complete Data Items <i>Reason for Transfer, Transfer Code of Center to which Infant Transferred, Post Transfer Disposition, and the Data Items that follow your Post Transfer Disposition choice</i> . <i>Post Transfer Disposition</i> refers to the infant's disposition upon leaving the "transferred to" hospital.
<b>If Transferred, Reason for Transfer:</b> <input type="checkbox"/> Growth/Discharge Planning <input type="checkbox"/> Medical/Diagnostic Services <input type="checkbox"/> Surgery <input type="checkbox"/> ECMO <input type="checkbox"/> Chronic Care <input type="checkbox"/> Other
<b>Transfer Code of Center to which Infant Transferred:</b> _____ (List available at <a href="https://public.vtoxford.org/transfer-codes/">https://public.vtoxford.org/transfer-codes/</a> )

Center Number: \_\_\_\_\_ Patient ID Number:      MRN: \_\_\_\_\_

Is This Infant Still Hospitalized at Another Center?  Yes  No

Choose one of the five Post Transfer Disposition options below and complete the Data Item(s) that follow your choice:

**Post Transfer Disposition:**

1.  Home

Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)

2.  Died

Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

3.  Transferred Again to Another Hospital (2<sup>nd</sup> Transfer)

**Ultimate Disposition:**

Home

Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

Died

Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

Still Hospitalized as of First Birthday (infant record is now complete)

4.  Readmitted to Any Location in Your Hospital

When infants are readmitted to your center, continue to update Data Items *Bacterial Sepsis and/or Meningitis on or before Day 3* through *Nasal CPAP or Nasal Ventilation before or without ever having received ETT Ventilation* and Data Items *Surfactant at Any Time* through *Monitor at Discharge* based on all events at both hospitals until the date of Disposition after Readmission.

Also 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:**

Home

Weight at Disposition after Readmission: \_\_\_\_ grams  
Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

Died

Weight at Disposition after Readmission: \_\_\_\_ grams  
Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

Still Hospitalized as of First Birthday  
Weight at Disposition after Readmission: \_\_\_\_ grams (infant record is now complete)

Transferred Again to Another Hospital  
Weight at Disposition after Readmission: \_\_\_\_ grams

**Ultimate Disposition:**

Still Hospitalized as of First Birthday (infant record is now complete)

Home  
Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

Died  
Date of Final Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_ (infant record is now complete)  
MM DD YYYY

5.  Still Hospitalized as of First Birthday (infant record is now complete)