

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

VERMONT OXFORD NETWORK
eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2021

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.

Contents:

- Page 1: Patient Identification Worksheet
Page 2-7: General Data Items For Infants Born in 2021 at VLBW Centers

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/360055252333-2021-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 2021 at VLBW 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: ____/____/____ 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	
Patient's First Name: _____	
Patient's Last Name: _____	
Mother's First Name: _____	
Mother's Last Name: _____	
If Location of Birth is Outborn, Date of Admission: ____/____/____ 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 Congenital Infection is Yes, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)</small>	

**General Data Items - For Infants Born in 2021 at VLBW Centers**

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		

**General Data Items - For Infants Born in 2021 at VLBW Centers**

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

**Steroids for CLD:**  Yes  No  
**If Yes, Steroids for CLD, Where Given:**  Your Hospital  Other Hospital  Both

**Indomethacin for Any Reason:**  Yes  No

**Ibuprofen for PDA:**  Yes  No

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

**Probiotics:**  Yes  No

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

**Caffeine for Any Reason:**  Yes  No

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

**ROP Surgery:**  Yes  No  
**If Yes, ROP Surgery, Where Done:**  Your Hospital  Other Hospital  Both

**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)*

**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)*

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

**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 2021 at VLBW 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>Is this infant still hospitalized at your center?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

# General Data Items - For Infants Born in 2021 at VLBW Centers

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

- 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**

**Date of Initial Disposition:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Not required when Initial Disposition is *Still Hospitalized as of First Birthday*)  
MM DD YYYY

**Weight at Initial Disposition:** \_\_\_\_\_ grams

**Head Circumference at Initial Disposition** (in cm to nearest 10<sup>th</sup>):  (For infants which have not transferred, infant record is now complete)

If an infant is transferred to another hospital, complete Data Items *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*. *Post Transfer Disposition* refers to the infant's disposition upon leaving the "transferred to" hospital.

- If Transferred, Reason for Transfer:**
- Growth/Discharge Planning
  - Medical/Diagnostic Services
  - Surgery
  - ECMO
  - Chronic Care
  - Other

**Transfer Code of Center to which Infant Transferred:** \_\_\_\_\_  
(List available at <https://public.vtoxford.org/transfer-codes/>)

**Is This Infant Still Hospitalized at Another Center?**  Yes  No

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

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.

**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)