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Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

VERMONT OXFORD NETWORK
eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2022

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:

PATIENT IDENTIFICATION WORKSHEET

Patient's Name: _____

Mother's Name: _____

Date of Birth: ____/____/____ (MM DD YYYY)

Date of Admission: ____/____/____ (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

Date of Day 28: ____/____/____ (MM DD YYYY)

Date of Week 36: ____/____/____ (MM DD YYYY)

For Date of Day 28 use the *Day 28 Calculation Charts*:
https://vtoxford.zendesk.com/hc/en-us/articles/4402663457171-2022-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

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: ☐ Yes ☐ No (If *Yes*, complete Delivery Room Death data booklet, not this booklet)

Location of Birth: ☐ Inborn ☐ Outborn (If *Outborn*, complete *Date of Admission* below)

Patient's First Name: _____ **Mother's First Name:** _____

Patient's Last Name: _____ **Mother's Last Name:** _____

Previously Discharged Home: ☐ Yes ☐ No (If *Yes*, complete *Date of Admission* and *Reason for Transfer In* below)

For *Outborn* infants, or for *Inborn* infants where *Previously Discharged Home* is *Yes*

Date of Admission: ____/____/____ (MM DD YYYY)

Reason for Transfer In: ☐ ECMO ☐ Growth/Discharge Planning ☐ Medical/Diagnostic Services ☐ Surgery ☐ Chronic Care ☐ Other ☐ Hypothermic Therapy

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: _____
(List available at https://public.vtoxford.org/transfer-codes/)

Head Circumference at Birth (in cm to nearest 10th): ☐☐.☐

Maternal Ethnicity/Race (Answer both Ethnicity and Race):

Ethnicity of Mother: ☐ Hispanic ☐ Not Hispanic

Race of Mother: ☐ Black or African American ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Prenatal Care: ☐ Yes ☐ No

Antenatal Steroids: ☐ Yes ☐ No

Antenatal Magnesium Sulfate: ☐ Yes ☐ No

Chorioamnionitis: ☐ Yes ☐ No

Maternal Hypertension, Chronic or Pregnancy-Induced: ☐ Yes ☐ No

Maternal Diabetes ☐ Yes ☐ No

Mode of Delivery: ☐ Vaginal ☐ Cesarean Section

Sex of Infant: ☐ Male ☐ Female ☐ Unknown

Multiple Gestation: ☐ Yes ☐ No **If *Yes*, Number of Infants Delivered:** ____

Congenital Infection: ☐ Yes ☐ No

Congenital Infection, Organism(s): _____ _____ _____
(If *Congenital Infection* is *Yes*, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)

General Data Items - *For Infants Born in 2022 at Expanded Centers* VON Vermont Oxford NETWORK

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: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
2. ☐ **Died**
   Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
3. ☐ **Transferred Again to Another Hospital (2nd Transfer)**
   Ultimate Disposition:
   - ☐ **Home**
     Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
   - ☐ **Died**
     Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
   - ☐ **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 *Monitor at Discharge* based on all events at both hospitals until the date of Disposition after Readmission.
   Also continue to update Data Items *ECMO at your Hospital*, *Hypothermic Therapy at Your Hospital*, *Cooling Method*, *Hypoxic-Ischemic Encephalopathy*, *HIE Severity*, *Seizures*, *Neonatal Abstinence Syndrome*, *Pharmacological Treatment for Neonatal Abstinence Syndrome*, and *Pharmacological Treatment for Neonatal Abstinence Syndrome, Where Given* based on events that occur following transfer and readmission.
   Disposition after Readmission:
   - ☐ **Home**
     Weight at Disposition after Readmission: ____ grams
     Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
   - ☐ **Died**
     Weight at Disposition after Readmission: ____ grams
     Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
   - ☐ **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: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
     - ☐ **Died**
       Date of Final Discharge: ____/____/____ (MM DD YYYY) **(infant record is now complete)**
5. ☐ **Still Hospitalized as of First Birthday** **(infant record is now complete)**

Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

Meconium Aspiration Syndrome: ☐ Yes ☐ No

If *Yes*, Tracheal Suction for Meconium Attempted during Initial Resuscitation: ☐ Yes ☐ No

Seizures: ☐ Yes ☐ No

Neonatal Abstinence Syndrome: ☐ Yes ☐ No ☐ N/A (N/A when *Gestational Age, Weeks* is less than or equal to 33)

If *Yes*, Pharmacological Treatment for Neonatal Abstinence Syndrome: ☐ Yes ☐ No

If *Yes*, Pharmacological Treatment for Neonatal Abstinence Syndrome, Where Given:
☐ Your Hospital ☐ Other Hospital ☐ Both

Is this infant still hospitalized at your center? ☐ Yes ☐ No

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
Nasal Cannula Flow (at Discharge): ☐ Yes ☐ No
If *Yes*, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (at Discharge): ☐ Yes ☐ No
Nasal Ventilation (at Discharge): ☐ Yes ☐ No
Nasal CPAP (at Discharge): ☐ Yes ☐ No
Monitor (at Discharge): ☐ Yes ☐ No

Duration of Assisted Ventilation: ☐ None ☐ <4 hours ☐ 4-24 hours ☐ > 24 hours

If > 24 hours, Total Days of Assisted Ventilation: _____

Initial Disposition (check only one): (When *Transferred* is chosen, also complete Transfer/Readmission data below & on page 7)
☐ **Home** ☐ **Died** ☐ **Transferred to another Hospital** ☐ **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 10th): ☐☐.☐ **(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 Out: ☐ ECMO ☐ Growth/Discharge Planning
☐ Medical/Diagnostic Services ☐ Surgery ☐ Chronic Care
☐ Other ☐ Hypothermic Therapy

Transfer Code of Center to which Infant Transferred: _____
(List available at https://public.vtoxford.org/transfer-codes/)

General Data Items - *For Infants Born in 2022 at Expanded Centers* VON Vermont Oxford Network

Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

APGAR Scores: **1 minute** _____ **5 minutes** _____

Initial Resuscitation:

Oxygen: ☐ Yes ☐ No
Face Mask Vent: ☐ Yes ☐ No
Laryngeal Mask Airway: ☐ Yes ☐ No
Endotracheal Tube Vent: ☐ Yes ☐ No
Epinephrine: ☐ Yes ☐ No
Cardiac Compression: ☐ Yes ☐ No
Nasal Vent: ☐ Yes ☐ No
Nasal CPAP: ☐ Yes ☐ No

Temperature Measured within the First Hour after Admission to Your NICU: ☐ Yes ☐ No ☐ N/A

If *Yes*, Temperature Within the First Hour after Admission to Your NICU: ☐☐.☐
(In degrees *centigrade* to nearest 10th)

Died within 12 Hours of Admission to Your NICU: ☐ Yes ☐ No

Bacterial Sepsis and/or Meningitis on or before Day 3: ☐ Yes ☐ No

Bacterial Sepsis and/or Meningitis on or before Day 3, Pathogen(s): _____ _____ _____
(If *Bacterial Sepsis and/or Meningitis* is *Yes*, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2 – Appendix B)

Oxygen on Day 28: ☐ Yes ☐ No

Periventricular-Intraventricular Hemorrhage (PIH):

Cranial Imaging (US/CT/MRI) on or before Day 28: ☐ Yes ☐ No

If *Yes*, Worst Grade of PIH (0-4): _____

If PIH Grade 1-4, Where PIH First Occurred: ☐ Your Hospital ☐ Other Hospital

Respiratory Support (at any time after leaving the delivery room/initial resuscitation area):

Oxygen (after Initial Resuscitation): ☐ Yes ☐ No
Conventional Ventilation (after Initial Resuscitation): ☐ Yes ☐ No
High Frequency Ventilation (after Initial Resuscitation): ☐ Yes ☐ No
Nasal Cannula Flow (after Initial Resuscitation): ☐ Yes ☐ No
If *Yes*, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (after Initial Resuscitation): ☐ Yes ☐ No
Nasal Ventilation (after Initial Resuscitation): ☐ Yes ☐ No
Nasal CPAP (after Initial Resuscitation): ☐ Yes ☐ No

Surfactant during Initial Resuscitation: ☐ Yes ☐ No

Surfactant at Any Time: ☐ Yes ☐ 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) _____

Inhaled Nitric Oxide: ☐ Yes ☐ No

If *Yes*, Inhaled Nitric Oxide, Where Given: ☐ Your Hospital ☐ Other Hospital ☐ 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
- **Nasal Cannula Flow** (at 36 Weeks): ☐ Yes ☐ No ☐ N/A
  - **If *Yes*, Flow Rate of Nasal Cannula Greater than Two Liters per Minute** (at 36 Weeks): ☐ Yes ☐ No
- **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: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 2: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 3: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 4: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 5: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 6: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 7: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 8: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 9: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 10: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No

Include description for Surgery Codes S100,S200,S300,S400,S500,S600,S700,S800,S900,S1000, and S1001:

_____

_____

General Data Items - *For Infants Born in 2022 at Expanded Centers* VON Vermont Oxford NETWORK

Center Number: _____ **Patient ID Number:** ☐☐☐☐☐ **MRN:** _____

Respiratory Distress Syndrome: ☐ Yes ☐ No

Pneumothorax: ☐ Yes ☐ No
If *Yes*, Pneumothorax, Where Occurred: ☐ Your Hospital ☐ Other Hospital ☐ Both

Patent Ductus Arteriosus: ☐ Yes ☐ No ☐ N/A

Necrotizing Enterocolitis: ☐ Yes ☐ No
If *Yes*, NEC, Where Occurred: ☐ Your Hospital ☐ Other Hospital ☐ Both

Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:
☐ Surgically Confirmed ☐ Clinically Diagnosed ☐ No

Sepsis and/or Meningitis, Late (after day 3 of life):

Bacterial Sepsis and/or Meningitis after Day 3: ☐ Yes ☐ No
If *Yes*, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred:
☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Bacterial Sepsis and/or Meningitis after Day 3, Pathogen(s): _____ _____ _____
(If *Bacterial Sepsis and/or Meningitis* is *Yes*, enter up to 3 Bacterial Pathogen descriptions from Manual of Operations, Part 2, Appendix B)

Coagulase Negative Staph Infection after Day 3: ☐ Yes ☐ No
If *Yes*, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:
☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Fungal Infection after Day 3: ☐ Yes ☐ No
If *Yes*, Fungal Infection after Day 3, Where Occurred: ☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Cystic Periventricular Leukomalacia: ☐ Yes ☐ No ☐ N/A (See Manual of Operations, Part 2 for N/A criteria)

ROP, Retinal Examination ☐ Yes ☐ No
If *Yes*, Worst Stage of ROP (0-5): _____

Congenital Anomaly: ☐ Yes ☐ No
If *Yes*, enter up to 5 Congenital Anomaly Codes: _____ _____ _____ _____ _____
See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.

If *Yes*, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, & 907:

_____

_____

ECMO at your Hospital: ☐ Yes ☐ No

Was Hypothermic Therapy Performed at Your Hospital: ☐ Yes ☐ No
If *Yes*, Level of Consciousness Before Hypothermic Therapy: ☐ Mild ☐ Moderate ☐ Severe
If *Yes*, Hypothermic Therapy Cooling Method: ☐ Selective Head ☐ Whole Body ☐ Both

Hypoxic-Ischemic Encephalopathy: ☐ Yes ☐ No