

Center Number: _____ Patient ID Number: MRN: _____

VERMONT OXFORD NETWORK

eNICQ DELIVERY ROOM DEATH BOOKLET FOR INFANTS BORN IN 2022

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 be later entered by your center into eNICQ, the VON data submission tool.

Contents:

- Page 1: Patient Identification Worksheet
- Page 2-3: Delivery Room Death Data Items For Infants Born in 2022 at Expanded 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

DRD Data Items - For Infants Born in 2022 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 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): _____ (If Congenital Infection is Yes, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E) | |
| APGAR Scores: | 1 minute _____ 5 minutes _____ |

DRD Data Items - For Infants Born in 2022 at Expanded Centers



Center Number: _____ Patient ID Number: MRN: _____

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

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) _____

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:

Meconium Aspiration Syndrome: Yes No (for infants where Meconium Aspiration Syndrome is No, infant record is now complete)

If Yes, Tracheal Suction for Meconium Attempted during Initial Resuscitation: Yes No (infant record is now complete)
