

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

**VERMONT OXFORD NETWORK  
eNICQ PATIENT DATA BOOKLET FOR INFANTS BORN IN 2026**

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
	<ul style="list-style-type: none"> <li>• For <u>inborn</u> infants, the date of admission is the Date of Birth</li> <li>• For <u>outborn</u> infants, the date of admission is the date the infant was admitted to your hospital</li> </ul>
	For Date of Day 28 use the <i>Day 28 Calculation Charts</i> : <a href="https://vtoxford.zendesk.com/hc/article_attachments/46001422006931">https://vtoxford.zendesk.com/hc/article_attachments/46001422006931</a> For Date of Week 36 use the <i>Week 36 Calculator</i> : <a href="https://public.vtoxford.org/week-36-calculator/">https://public.vtoxford.org/week-36-calculator/</a>
<p><b>PLEASE DO NOT SUBMIT THIS WORKSHEET</b> Protected Health Care Information</p>	

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 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> and <i>Reason for Transfer In</i> below)	
<small>For <i>Outborn</i> infants, or for <i>Inborn</i> infants where <i>Previously Discharged Home</i> is Yes</small>	Date of Admission: <u>    </u> / <u>    </u> / <u>    </u> <small>MM DD YYYY</small>
Reason for Transfer In: <input type="checkbox"/> ECMO <input type="checkbox"/> Growth/Discharge Planning <input type="checkbox"/> Medical/Diagnostic Services <input type="checkbox"/> Surgery <input type="checkbox"/> Chronic Care <input type="checkbox"/> Other <input type="checkbox"/> 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: _____ <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"/> <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 <i>Congenital Infection</i> is Yes, enter up to 3 Congenital Infection descriptions from Manual of Operations, Part 2 – Appendix E)</small>	

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Is This Infant Still Hospitalized at Another Center? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Choose <u>one</u> of the five Post Transfer Disposition options below and complete the Data Item(s) that follow your choice:	
Post Transfer Disposition:	
1. <input type="checkbox"/> Home	Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
2. <input type="checkbox"/> Died	Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
3. <input type="checkbox"/> Transferred Again to Another Hospital (2 <sup>nd</sup> Transfer)	Ultimate Disposition:
	<input type="checkbox"/> Home Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
	<input type="checkbox"/> Died Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
	<input type="checkbox"/> Still Hospitalized as of First Birthday (infant record is now complete)
4. <input type="checkbox"/> Readmitted to Any Location in Your Hospital	When infants are readmitted to your center, continue to update Data Items <i>Bacterial Sepsis and/or Meningitis on or before Day 3</i> through <i>Monitor at Discharge</i> based on all events at both hospitals until the date of Disposition after Readmission. <small>Also continue to update Data Items <i>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</i> based on events that occur following transfer and readmission.</small>
	Disposition after Readmission:
	<input type="checkbox"/> Home Weight at Disposition after Readmission: _____ grams Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
	<input type="checkbox"/> Died Weight at Disposition after Readmission: _____ grams Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
	<input type="checkbox"/> Still Hospitalized as of First Birthday Weight at Disposition after Readmission: _____ grams (infant record is now complete)
	<input type="checkbox"/> Transferred Again to Another Hospital Weight at Disposition after Readmission: _____ grams
	Ultimate Disposition:
	<input type="checkbox"/> Still Hospitalized as of First Birthday (infant record is now complete)
	<input type="checkbox"/> Home Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
	<input type="checkbox"/> Died Date of Final Discharge: <u>    </u> / <u>    </u> / <u>    </u> (infant record is now complete) <small>MM DD YYYY</small>
5. <input type="checkbox"/> Still Hospitalized as of First Birthday	(infant record is now complete)

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Meconium Aspiration Syndrome: <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
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No
Neonatal Abstinence Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A when Gestational Age, Weeks is less than or equal to 33) If Yes, Pharmacological Treatment for Neonatal Abstinence Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Pharmacological Treatment for Neonatal Abstinence Syndrome, Where Given: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both
Is this infant still hospitalized at your center? <input type="checkbox"/> Yes <input type="checkbox"/> No
Enteral Feeding at Discharge: <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 Nasal Cannula Flow (at Discharge): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (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
Duration of Assisted Ventilation (initial hospital stay): <input type="checkbox"/> None <input type="checkbox"/> <4 hours <input type="checkbox"/> 4-24 hours <input type="checkbox"/> > 24 hours If > 24 hours, Total Days of Assisted Ventilation (initial hospital stay): _____
<b>Initial Disposition (check only one):</b> (When Transferred is chosen, also complete Transfer/Readmission data below & on page 7) <input type="checkbox"/> Home <input type="checkbox"/> Died <input type="checkbox"/> Transferred to another Hospital <input type="checkbox"/> Still Hospitalized as of First Birthday
Date of Initial Disposition: ____/____/____ (Not required when Initial Disposition is Still Hospitalized as of First Birthday) <small style="margin-left: 40px;">MM DD YYYY</small>
Weight at Initial Disposition: _____ grams
Head Circumference at Initial Disposition (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 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: <input type="checkbox"/> ECMO <input type="checkbox"/> Growth/Discharge Planning <input type="checkbox"/> Medical/Diagnostic Services <input type="checkbox"/> Surgery <input type="checkbox"/> Chronic Care <input type="checkbox"/> Other <input type="checkbox"/> Hypothermic Therapy
Transfer Code of Center to which Infant Transferred: _____ <small>(List available at <a href="https://public.vtoxford.org/transfer-codes/">https://public.vtoxford.org/transfer-codes/</a>)</small>

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<b>APGAR Scores:</b> 1 minute _____ 5 minutes _____
Initial Resuscitation: Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No Face Mask Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No Supraglottic Airway Device: <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
Temperature Measured within the First Hour after Admission to <u>Your</u> NICU: <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"/> <input type="text"/> <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>
Died within 12 Hours of Admission to Your NICU: <input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial Sepsis and/or Meningitis on or before Day 3: <input type="checkbox"/> Yes <input type="checkbox"/> No Bacterial Sepsis and/or Meningitis on or before Day 3, Pathogen(s): _____ <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>
Oxygen on Day 28: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Periventricular-Intraventricular Hemorrhage (PIH):</b> Cranial Imaging (US/CT/MRI) on or before Day 28: <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 (at any time after leaving the delivery room/initial resuscitation area):</b> Oxygen (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Conventional Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No High Frequency Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Cannula Flow (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Ventilation (after Initial Resuscitation): <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal CPAP (after Initial Resuscitation): <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) _____
Inhaled Nitric Oxide: <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

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<b>Respiratory Support at 36 Weeks</b> (See Manual of Operations, Part 2 for N/A criteria):	
Oxygen (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Conventional Ventilation (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
High Frequency Ventilation (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Nasal Cannula Flow (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If Yes, Flow Rate of Nasal Cannula Greater than Two Liters per Minute (at 36 Weeks): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nasal Ventilation (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Nasal CPAP (at 36 Weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Steroids for CLD:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Steroids for CLD, Where Given: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both	
Indomethacin for Any Reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ibuprofen for PDA:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acetaminophen (Paracetamol) for PDA:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Probiotics:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment of ROP with Anti-VEGF Drug:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine for Any Reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intramuscular Vitamin A for Any Reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No
ROP Surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, ROP Surgery, Where Done: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both	
Surgery or Interventional Catheterization for Closure of PDA:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<small>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</small>	
Surgery for NEC, Suspected NEC, or Bowel Perforation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<small>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</small>	
Other Surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<small>(If Yes, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)</small>	
<b>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:</b>	
<small>See Manual of Operations, Part 2 – Appendix D for Surgery Codes.</small>	
<small>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.</small>	
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
<b>Include description for Surgery Codes S100,S200,S300,S400,S500,S600,S700,S800,S900,S1000, and S1001:</b>	
_____	

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Respiratory Distress Syndrome:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumothorax:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Pneumothorax, Where Occurred: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both	
Patent Ductus Arteriosus:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Necrotizing Enterocolitis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, NEC, Where Occurred: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Both	
<b>Surgically Confirmed or Clinically Diagnosed Focal Intestinal Perforation:</b>	
<input type="checkbox"/> Surgically Confirmed <input type="checkbox"/> Clinically Diagnosed <input type="checkbox"/> No	
<b>Sepsis and/or Meningitis, Late (after day 3 of life):</b>	
Bacterial Sepsis and/or Meningitis after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred: <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>	
Coagulase Negative Staph Infection after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both	
Fungal Infection after Day 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Fungal Infection after Day 3, Where Occurred: <input type="checkbox"/> Your Hospital <input type="checkbox"/> Outside Your Hospital <input type="checkbox"/> Both	
Cystic Periventricular Leukomalacia:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (See Manual of Operations, Part 2 for N/A criteria)
ROP, Retinal Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Worst Stage of ROP (0-5): _____	
Congenital Anomaly:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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:	
_____	
_____	
ECMO at your Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Hypothermic Therapy Performed at Your Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Level of Consciousness Before Hypothermic Therapy: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
If Yes, Hypothermic Therapy Cooling Method: <input type="checkbox"/> Selective Head <input type="checkbox"/> Whole Body <input type="checkbox"/> Both	
Hypoxic-Ischemic Encephalopathy:	<input type="checkbox"/> Yes <input type="checkbox"/> No