DC STEP: Healthy Infants and Mothers Program

Infant Delivery and Hospital Abstraction Form

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THIS FORM IS TO BE COMPLETED BY THE RECORDS ABSTRACTOR USING INFORMATION FROM THE INFANT'S MEDICAL RECORD.

Site: _____ Today's Date: |___ ___|___ ___|___ ___ ___ ___|
Site Code (If "Other," **SPECIFY**) mm dd yyyy

Infant Number: |____| * Infant Medical Record Number**: _____

Maternal Medical Record Number: _____

(*IF MULTIPLE BIRTHS, FILL OUT A SEPARATE INFANT DELIVERY AND HOSPITALIZATION FORMS FOR EACH INFANT. THE OLDEST INFANT IS INFANT #1, THE SECOND OLDEST IS INFANT #2, ETC. ** ALSO, BE SURE TO BLACK OUT THE MEDICAL RECORD NUMBER BEFORE SENDING THE DATA FORM FOR DATA ENTRY.)

1. Date of Birth: |___ ___|___ ___|___ ___ ___ ___| ☐ -1 DNR
mm dd yyyy

2. Singleton Birth? ☐ -1 DNR

Yes **(GO TO 3)**..... 1

No 2

2a. If NO in question 2, how many? |___ ___| births ☐ -1 DNR

3. Gender of Infant: ☐ -1 DNR

Male 1

Female..... 2

4. Gestational age at birth:

   4a. by exam: |___ ___| weeks ☐ -1 DNR

   4b. by ultrasound: |___ ___| weeks ☐ -1 DNR

   4c. by dates: |___ ___| weeks ☐ -1 DNR

   4d. method unknown: |___ ___| weeks

5. Birthweight of child: ☐ -1 DNR

   |___ ___| pounds and |___ ___ **.** ___ ___| ounces

   …*or*… |___ ___ **.** ___ ___| pounds

   …*or*… |___ ___ ___ **.** ___ ___| ounces

   …*or*… |___ **.** ___ ___| kilograms

   …*or*… |___ ___ ___ ___ **.** ___ ___| grams

6. Length at birth: ☐ -1 DNR

   |___| feet and |___ ___ . ___ ___| inches

   …*or*… |___ ___ **.** ___ ___| inches

   …*or*… |___ ___ **.** ___ ___| centimeters

7. Head circumference at birth: ☐ -1 DNR

   |___ ___ **.** ___ ___| inches

   …*or*… |___ ___ **.** ___ ___| centimeters

8. Apgar 1 min. |___ ___| ☐ -1 DNR

9. Apgar 5 min. |___ ___| ☐ -1 DNR

10. Apgar 10 min. |___ ___| ☐ -1 DNR

11. Baby admitted to: ☐ -1 DNR

a. Type of Care	**b. Date/Time Admitted**	**c. Date/Time Discharged**	**d. Reason (CHECK ALL THAT APPLY.)**
Term Nursery Yes .....1 No 2	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	(not applicable)
Neonatal Intensive Care Yes .....1 No 2	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	☐ -1 DNR Prematurity ..... 1 Low apgars ..... 2 Congenital heart disease ..... 3 Other congenital abnormalities.. 4 Large for gestational age ..... 5 Small for gestational age..... 6 Neonatal asphyxia ..... 7 Respiratory disease ..... 8 Rule out/presumed sepsis..... 9 Other (**SPECIFY**) ..... 10 _____ _____
Other Yes .....1 No .....2 (Specify) _____ _____	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	Date: ☐ -1 DNR |__|__|-|__|__|-|__|__| mo day yr Time: ☐ -1 DNR |__|__|: |__|__| am pm |__|__|: |__|__| military	☐ -1 DNR Prematurity ..... 1 Low apgars ..... 2 Congenital heart disease ..... 3 Other congenital abnormalities.. 4 Large for gestational age ..... 5 Small for gestational age..... 6 Neonatal asphyxia ..... 7 Respiratory disease ..... 8 Rule out/presumed sepsis..... 9 Other (**SPECIFY**) ..... 10 _____ _____ Improved status 11

12. Was infant admitted to NICU or NICU step down unit for longer than 12 hours?

a. NICU 12+ hours? ..... □ 1 Yes □ 2 No □ -1 DNR
b. NICU Step Down Unit 12+ hours? ..... □ 1 Yes □ 2 No □ -1 DNR
c. NICU + Step Down Unit 12+ hours? ..... □ 1 Yes □ 2 No □ -1 DNR

13. Did the infant have to be resuscitated during or after delivery? □ -1 DNR

Yes.....1
No 2

14. Was Mechanical Ventilation used for the infant? □ -1 DNR

Yes 1
No 2

15. Was CPAP (Continuous Positive Airway Pressure) used for the infant? □ -1 DNR

Yes.....1
No 2

16. Other Treatments for the child:

a) Phototherapy □ 1 Yes □ 2 No □ -1 DNR
b) Eye ointment □ 1 Yes □ 2 No □ -1 DNR
(e.g., Erythromycin or silver nitrate drops)

c) Multi-vitamin drops (other than Vit K) □ 1 Yes □ 2 No □ -1 DNR
d) Hepatitis B vaccine □ 1 Yes □ 2 No □ -1 DNR
e) Vitamin K □ 1 Yes □ 2 No □ -1 DNR
d) Blood transfusion □ 1 Yes □ 2 No □ -1 DNR
SPECIFY VOLUME: _____

e) Fluids given . □ 1 Yes □ 2 No □ -1 DNR
SPECIFY TYPE/VOLUME: _____/_____

f) Pressors used to treat symptoms of shock.. ☐ 1 Yes ☐ 2 No ☐ -1 DNR

g) Withdrawal from addictive substances requiring either of the following:

(1) Methadone treatment. ☐ 1 Yes ☐ 2 No ☐ -1 DNR

(2) Hospitalization. ☐ 1 Yes ☐ 2 No ☐ -1 DNR

h) Other medications ☐ 1 Yes ☐ 2 No ☐ -1 DNR

(SPECIFY)

_____

i) Other treatments ☐ 1 Yes ☐ 2 No ☐ -1 DNR

(SPECIFY)

_____

15. Medical complications of the child? ☐ -1 DNR

Prematurity	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Low apgars	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Congenital heart disease	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Other congenital abnormalities	☐ 1 Yes	☐ 2 No	☐ -1 DNR

(SPECIFY)

_____

Large for gestational age	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Small for gestational age	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Neonatal asphyxia	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Respiratory disease	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Confirmed sepsis (culture proven)	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Sepsis (Leading to shock symptoms/pressors)	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Cardiac disease/abnormalities	☐ 1 Yes	☐ 2 No	☐ -1 DNR
HIV/AIDS	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Anemia	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Jaundice	☐ 1 Yes	☐ 2 No	☐ -1 DNR
Addictive Substances Detected	☐ 1 Yes	☐ 2 No	☐ -1 DNR

Surgical conditions **(SPECIFY)** ☐ 1 Yes ☐ 2 No ☐ -1 DNR

_____

Other diagnosis **(SPECIFY)** ☐ 1 Yes ☐ 2 No ☐ -1 DNR

_____

16. Was the infant breastfed while in the hospital? ☐ -1 DNR

Yes.....1
No 2

17. Does the mother intend to breastfeed following discharge? ☐ -1 DNR

Yes.....1
No 2

18. Does the chart indicate that the child has been referred to a clinic or physician for outpatient care? ☐ -1 DNR

Yes.....1
No 2

If YES, **SPECIFY** _____

19. Does the chart indicate the name of the pediatrician, pediatric clinic, or provider group where the mother intends to take the infant for pediatric care? ☐ -1 DNR

Yes.....1
No 2

If YES, **SPECIFY** _____

20. Date of INFANT discharge or transfer:

|___ ___|___ ___|___ ___ ___ ___| ☐ -1 DNR
mm dd yyyy

Status: ☐ -1 DNR

Alive discharged home 1
Deceased 2
Transferred to **(SPECIFY)** 3

_____

21. Was there a serious maternal illness postpartum that required any of the following for the mother?

a) Hospitalization **(SPECIFY)** ☐ 1 Yes ☐ 2 No ☐ -1 DNR

If YES, SPECIFY LENGTH IN DAYS OR WEEKS:

DAYS |____|____| WEEKS |____|____|

b) Surgery After Delivery ☐ 1 Yes ☐ 2 No ☐ -1 DNR

c) Home IV Antibiotics ☐ 1 Yes ☐ 2 No ☐ -1 DNR

d) Other (SPECIFY) ☐ 1 Yes ☐ 2 No ☐ -1 DNR

_____

22. In general, how easy or difficult was it to decipher the information contained in the medical record(s)?

Very easy 1
Somewhat easy 2
Some information easy/some difficult 3
Somewhat difficult 4
Very difficult 5

23. Describe any special problems in completing the abstraction:

_____

_____

_____

_____

_____

ABSTRACTED BY: _____ |___ ___|___ ___|___ ___ ___ ___|
Abstractor Code mm dd yyyy

EDITED BY: _____ |___ ___|___ ___|___ ___ ___ ___|
mm dd yyyy

INFANT ABSTRACTION SUMMARY SHEET:

1. Did the infant experience any of the following exclusionary criteria? **CIRCLE ALL THAT APPLY.**

Multiple birth	□ 1 Yes	□ 2 No	□ -1 DNR
Prematurity less than 34 weeks	□ 1 Yes	□ 2 No	□ -1 DNR
Birth weight less than 1800gm	□ 1 Yes	□ 2 No	□ -1 DNR
Admission to NICU for $\geq$ 12 hours	□ 1 Yes	□ 2 No	□ -1 DNR
Withdrawal from addictive substance requiring hospitalization or methadone treatment	□ 1 Yes	□ 2 No	□ -1 DNR
Maternal loss custody of infant	□ 1 Yes	□ 2 No	□ -1 DNR

2. Other infant health conditions that may need review for decision to exclude:

Significant cardiac disease or cardiac abnormalities	□ 1 Yes	□ 2 No	□ -1 DNR
Mechanical ventilation, including CPAP	□ 1 Yes	□ 2 No	□ -1 DNR
Serious congenital abnormalities, including organ abnormalities, but not including minor limb abnormalities	□ 1 Yes	□ 2 No	□ -1 DNR
Culture-proven sepsis or sepsis resulting in symptoms of shock, as defined as need for pressors	□ 1 Yes	□ 2 No	□ -1 DNR
High volume transfusions or fluids	□ 1 Yes	□ 2 No	□ -1 DNR
Delivery complications requiring resuscitation of infant	□ 1 Yes	□ 2 No	□ -1 DNR
Other (SPECIFY) ___________________________________	□ 1 Yes	□ 2 No	□ -1 DNR

IF YES TO ANY OF ABOVE→ CONTACT DR. SUSAN BLAKE AND DR. DANA BEST FOR POSSIBLE EXCLUSION FROM STUDY.

>>

FINAL INFANT DISPOSITION:

ELIGIBLE □ 1 INELIGIBLE □ 2

SIGNATURE: ___________________________**DATE OF DECISION:** ___________________