

MALAYSIAN NATIONAL NEONATAL REGISTRY (CRF 2013)

Centre Name: 	☐ New Case ☐ Readmission ☐ Previously admitted to other SDP hospital:	MNNR No. (Office use): / Centre:
Date of Admission: / / (dd/mm/yy)		

Admitted to neonatal ward: ☐ Yes → Proceed to complete all sections in this CRF ☐ No → Proceed to complete [Sections 1,2,4(No.47) and 5]
☐ Abandoned baby → (if box is ticked, item # 1,4a, 6 - 16 not mandatory)

Instruction: Where check boxes ☐ are provided, check (✓) one or more boxes. Where radio buttons ☐ are provided (✓) one box only.

SECTION 1 : PATIENT PARTICULARS & MATERNAL HISTORY

*1. Name of mother:			
*2. Name of baby (Optional):			
*3. RN of baby:			
*4a. Mother's I/C number:	MyKad: - -		
	Other ID document No:		
	Specify document ☐ Passport ☐ Armed Force ID ☐ Driver's License ☐ Old IC ☐ Hospital RN Type (if others): ☐ Father's I/C ☐ Work Permit number ☐ Police ID Card ☐ Immigration permit ☐ Other, specify:.....		
*4b. Baby's MyKid number:	- -		
*5a. Date of birth of baby: (dd/mm/yy)	/ /	*5b. Time of birth: (24 - hour format) (enter the best estimated time of birth if the exact time unknown)	
*6. Ethnic group of Mother:	☐ Malay ☐ Indian ☐ Bumiputra Sabah, specify..... ☐ Other, Malaysian ☐ Chinese ☐ Orang Asli ☐ Bumiputra Sarawak, specify..... ☐ Non - citizen, specify country		
*7. Maternal age:	(years)		
*8. GPA: (current pregnancy before delivery of this child)	*Gravida:	*Parity:	*Abortion:
*9. Maternal diabetes (including gestational diabetes):	☐ Yes ☐ No ☐ Unknown		
*10. Maternal hypertension, chronic pregnancy included:	☐ Yes ☐ No ☐ Unknown		
*11. Maternal Eclampsia:	☐ Yes ☐ No ☐ Unknown		
*12. Maternal Chorioamnionitis:	☐ Yes ☐ No ☐ Unknown		
*13. Maternal Anaemia:	☐ Yes ☐ No ☐ Unknown		
*14. Maternal abruption placenta:	☐ Yes ☐ No ☐ Unknown		
*15. Maternal Bleeding placenta praevia:	☐ Yes ☐ No ☐ Unknown		
*16. Cord prolapse:	☐ Yes ☐ No ☐ Unknown		

SECTION 2 : BIRTH HISTORY

*17. Antenatal steroid:	☐ Yes → ☐ 1 dose ☐ 2 doses ☐ No ☐ Unknown		
*18. Intrapartum antibiotic:	☐ Yes ☐ No ☐ Unknown		
*19. Birth weight:	(grams)		
*20a. Gestation:	(weeks)	*20b. Gestational age based on: (if patinet died) ☐ LMP ☐ Ultrasound ☐ Neonatal assessment ☐ Unknown	
*21. Growth status:	☐ SGA ☐ AGA ☐ LGA		
*22. Gender:	☐ Male ☐ Female ☐ Ambiguous/Indeterminate		
*23. Place of birth:	☐ Inborn ☐ Outborn → ☐ Home ☐ Health Clinic ☐ Private Hospital ☐ Government hospital with specialist ☐ District ☐ General ☐ Government hospital without specialist ☐ University hospital ☐ University hospital ☐ Unknown ☐ Others, specify ☐ Maternity home with specialist ☐ Maternity home without specialist ☐ Alternative Birthing centre (ABC) ☐ Urban ☐ Rural		
*24. Multiplicity:	☐ Singleton ☐ Twin ☐ Triplet ☐ Other, specify:		Specify birth order if not a singleton:
*25. Final Mode of delivery:	☐ Vaginal delivery → ☐ SVD ☐ Breech ☐ Caesarean section → ☐ Elective ☐ Emergency ☐ Instrumental → ☐ Vacuum ☐ Forceps ☐ Others, specify: ☐ Unknown		

SECTION 2 : BIRTH HISTORY (continue)

*26. Apgar score at 1 min and 5 min (1 - 10)	a) Score at 1 min:	☐ Unknown	b) Score at 5 min: (Please score even if the baby is intubated)	☐ Unknown
27. Initial resuscitation: (applicable for inborn only)	a) Oxygen:	☐ Yes ☐ No	d) Endotracheal tube vent:	☐ Yes ☐ No
	b) CPAP :	☐ Yes ☐ No	e) Cardiac compression:	☐ Yes ☐ No
	c) PPV:	☐ Yes ☐ No	f) Adrenaline:	☐ Yes ☐ No
*28. Admission temperature: (mandatory if admitted to Neonatal ward)		. (°C)		

SECTION 3: NEONATAL EVENT

*29. Respiratory support:	☐ Yes →	a) CPAP done?	☐ Yes ☐ No
	☐ No		
		i) Early CPAP within 1 hour from birth:	☐ Yes ☐ No
		ii) Total duration of CPAP at your centre:	. day(s)
		b) Conventional ventilation:	☐ Yes ☐ No
		i) Total duration of Conventional ventilation at your centre:	. day(s)
		c) HFJV/HFOV:	☐ Yes ☐ No
		i) Total duration of HFJV//HFOV at your centre:	. day(s)
		d) Nitric Oxide:	☐ Yes ☐ No
		i) Total duration of Nitric Oxide at your centre:	. day(s)
*30. Total number of days on ventilation support at your centre:		. (autocalculate)	
*31. Surfactant:	☐ Yes → ☐ < 1 hr ☐ 1-2 hrs ☐ > 2 hrs ☐ No		
*32. Parenteral nutrition:	☐ Yes ☐ No		

SECTION 4: PROBLEMS/ DIAGNOSES

*33. Respiratory:	☐ Meconium aspiration syndrome ☐ Transient tachypnoea of newborn	☐ Pulmonary haemorrhage ☐ Pulmonary interstitial emphysema	☐ Pneumonia
*34. RDS:	☐ Yes ☐ No		
*35. Pneumothorax:	☐ Yes → Pneumothorax developed during: ☐ Spontaneous ☐ CPAP ☐ CMV ☐ HFV ☐ No		
*36. Supplemental oxygen and BPD:	a) Is baby on > 21% oxygen continuously for 28 days or more? ☐ Yes ☐ No		
	b) If Yes		
	(i) for < 32 weeks GA, baby still on oxygen / CPAP / ventilator support at 36 weeks corrected age? ☐ Yes ☐ No (ii) for >= 32 weeks GA, baby still on oxygen / CPAP / ventilator support at day 56 of life? ☐ Yes ☐ No		
*37. Cardiovascular	PPHN: ☐ Yes ☐ No ☐ Unknown		
*38. PDA:	☐ Yes → ☐ No a) ECHO done: ☐ Yes ☐ No b) Indomethacin/Ibuprofen: ☐ Yes ☐ No c) Ligation: ☐ Yes ☐ No		
*39. NEC (stage 2 and above):	☐ Yes → ☐ No a) surgical treatment: ☐ Yes ☐ No b) NEC present before admission to your centre: (for outborn baby only) ☐ Yes ☐ No		
*40. ROP Retinal Exam Done	☐ Yes (If yes, worst stage of ROP): ☐ No ☐ Not Applicable	a) Date of first screening:	/ /
		b) Post conceptional age at 1st screening:	(autocalculate)
		c) ☐ No ROP ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5 ☐ PLUS disease	
		d) Laser Therapy:	☐ Yes ☐ No
		e) Cryotherapy:	☐ Yes ☐ No
		f) Vitrectomy:	☐ Yes ☐ No
		g) ROP present prior to admission? (for outborn baby only)	☐ Yes ☐ No
		Appointment given:	☐ Yes ☐ No
		Date of appointment	/ /

SECTION 4 : PROBLEMS / DIAGNOSES (continue)

*41. IVH:	☐ Yes <i>If yes, worst grade :</i> → ☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ No ☐ Not applicable (term infant) ☐ Ultrasound not done
*42. Seizures :	☐ Yes ☐ No
*43. Central venous line:	☐ Yes ☐ No
*44. Confirmed sepsis:	☐ Yes → I) For first episode: ☐ ≤ 72 hours of life ☐ > 72 hours of life II) Type of organism: (can tick more than one) ☐ Group B Streptococcus ☐ Staphylococcus aureus ☐ Acinetobacter ☐ ESBL organisms ☐ MRSA ☐ Klebsiella ☐ Fungal ☐ CONS ☐ Pseudomonas ☐ Others, specify: ☐ No
45. Neonatal meningitis:	☐ Yes ☐ No
*46. Hypoxic ischaemic encephalopathy (HIE):	☐ None ☐ Mild ☐ Moderate ☐ Severe
*47. Congenital anomalies:	
*47a. Major congenital anomalies: ☐ Yes → ☐ Syndrome (known) ☐ Down ☐ Edward ☐ Patau ☐ Others, specify (Refer to ICD 10): ☐ Not a recognized syndrome ☐ Isolated major abnormality	*47b. Types of abnormalities (check all that are present. Applies to all including 'known syndromes', 'not a recognized syndrome' or 'isolated major abnormality') ☐ CVS → ☐ Cyanotic ☐ Acyanotic ☐ ECHO done ☐ CNS → ☐ Hydrocephalus ☐ Hydrancephaly ☐ Holoprosencephaly ☐ Others (Refer to ICD 10): ☐ Neural Tube Defect → ☐ Spina bifida ☐ Anencephaly ☐ Encephalocele ☐ Others (Refer to ICD 10): ☐ Skeletal dysplasia ☐ Respiratory ☐ GIT ☐ Hydrops ☐ Renal ☐ Cleft ☐ Lip ☐ Palate ☐ Lip and Palate ☐ Others, specify (Refer to ICD 10): ☐ None of the above

SECTION 5: OUTCOME

*48a. Date of discharge / transfer/ death:(dd/mm/yy)		/ /		48b. Time of Death:(24 hour format) (mandatory for death cases)		(enter the best estimated time of death if the exact time is unknown)	
*49. Weight and growth status on discharge:		a) Weight:		(grams)			
		b) Growth status:		☐ SGA ☐ AGA ☐ LGA			
*50. Feeding at discharge / death:		☐ Never fed ☐ Human milk only ☐ Formula only ☐ Human milk with Formula ☐ No data/ Unknown					
*51. Total duration of hospital stay (neonatal/ peads care):		(in completed days) (autocalculate)					
*52. Outcome:							
☐ Alive →							
Place discharged to: ☐ Home ☐ Social welfare home ☐ Other non Paeds ward ☐ Still hospitalized as of 1st birthday ☐ Transfer to other hospitals a) Name of hospital: b) Reason for transfer: ☐ Growth/ stepdown care ☐ Acute medical/ ☐ Social/ Logistic reason ☐ Lack of NICU bed ☐ Diagnostic services ☐ Other, specify: ☐ Chronic/ Palliative care ☐ Surgery c) Post transfer disposition: (Please fill this section if place transferred is not part of the NNR Network) ☐ Home ☐ Transferred again to another hospital ☐ Death ☐ Readmitted to your hospital ☐ Still in ward							
☐ Dead →							
Place of death: ☐ Labour room/OT ☐ Neonatal unit ☐ In transit ☐ Others, specify :							

Name : _____ Signature: _____

Date:

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 (dd/mm/yy)

Fetal-infant Growth Chart for Preterm Infants (WHO Growth Standards version)

