

# MALAYSIAN NATIONAL NEONATAL REGISTRY (CRF 2014)

|                                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Centre Name:<br><br>Date of Admission: <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> (dd/mm/yy) | <input type="radio"/> New Case<br><input type="radio"/> Readmission<br><input type="radio"/> Transfer from another SDP Hospital or IJN | MNNR No. (Office use): <span style="border: 1px solid black; padding: 2px 20px;"> </span> <span style="border: 1px solid black; padding: 2px 20px;"> </span><br>Centre: <span style="border: 1px solid black; padding: 2px 50px;"> </span> |
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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

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>*1. Name of mother:</b>                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>2. Name of baby (Optional):</b>                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*3. RN of baby:</b>                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*4a. Mother's I/C number:</b>                                     | MyKad: <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> - <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> - <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span>                                                              |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
|                                                                      | Other ID document No: <span style="border: 1px solid black; padding: 2px 50px;"> </span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
|                                                                      | Specify document type (if others): <input type="radio"/> Passport <input type="radio"/> Armed Force ID <input type="radio"/> Driver's License <input type="radio"/> Old IC <input type="radio"/> Hospital RN<br><input type="radio"/> Father's I/C <input type="radio"/> Work Permit number <input type="radio"/> Police ID Card <input type="radio"/> Immigration permit <input type="radio"/> Other, specify:.....                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>4b. Baby's MyKid number:</b>                                      | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> - <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> - <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*5a. Date of birth of baby:</b><br>(dd/mm/yy)                     | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> / <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> / <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span>                                                                                                                                                                                                                                                                                 | <b>5b. Time of birth:</b> (24-hour format) (enter the best estimated time of birth if the exact time unknown)                           | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> |                   |                                                                                                                                         |
| <b>*6. Ethnic group of Mother:</b>                                   | <input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Bumiputra Sabah, specify:..... <input type="radio"/> Other, Malaysian<br><input type="radio"/> Chinese <input type="radio"/> Orang Asli <input type="radio"/> Bumiputra Sarawak, specify:..... <input type="radio"/> Non-citizen, specify country:.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*7. Maternal age:</b>                                             | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*8. GPA:</b><br>(current pregnancy before delivery of this child) | <b>*Gravida:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> | <b>*Parity:</b> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span>                                                                                                                         | <b>*Abortion:</b> | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> |
| <b>*9. Maternal diabetes (including gestational diabetes):</b>       | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*10. Maternal hypertension, chronic pregnancy included:</b>       | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*11. Maternal Eclampsia:</b>                                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*12. Maternal Chorioamnionitis:</b>                               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*13. Maternal Anaemia:</b>                                        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*14. Maternal abruption placenta:</b>                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*15. Maternal Bleeding placenta praevia:</b>                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |
| <b>*16. Cord prolapse:</b>                                           | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                                                                                                                                                 |                   |                                                                                                                                         |

## SECTION 2 : BIRTH HISTORY

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          |                                                                                                                                       |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <b>*17. Antenatal steroid:</b>      | <input type="radio"/> Yes → <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <input type="radio"/> 1 dose <input type="radio"/> 2 doses <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          |                                                                                                                                       |
| <b>*18. Intrapartum antibiotic:</b> | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          |                                                                                                                                       |
| <b>*19. Birth weight:</b>           | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> (grams)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                          |                                                                                                                                       |
| <b>*20a. Gestation:</b>             | <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> ( weeks)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>*20b. Gestational age based on: (if patient died)</b> | <input type="radio"/> LMP <input type="radio"/> Ultrasound<br><input type="radio"/> Neonatal assessment <input type="radio"/> Unknown |
| <b>*21. Growth status:</b>          | <input type="radio"/> SGA <input type="radio"/> AGA <input type="radio"/> LGA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          |                                                                                                                                       |
| <b>*22. Gender:</b>                 | <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Ambiguous/ Indeterminate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                                                                                                                                       |
| <b>*23. Place of birth:</b>         | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="radio"/> Inborn<br/> <input type="radio"/> Outborn → <span style="border: 1px solid black; padding: 2px 10px;">  </span><span style="border: 1px solid black; padding: 2px 10px;">  </span><span style="border: 1px solid black; padding: 2px 10px;">  </span><span style="border: 1px solid black; padding: 2px 10px;">  </span><br/> <input type="radio"/> Home <input type="radio"/> Health Clinic <input type="radio"/> Unknown <input type="radio"/> Private Hospital<br/> <input type="radio"/> District <input type="radio"/> General <input type="radio"/> Government hospital with specialist                             </div> <div style="width: 45%;"> <input type="radio"/> University hospital <input type="radio"/> Others/specify .....<br/> <input type="radio"/> Enroute/ during transport <input type="radio"/> Unknown<br/> <input type="radio"/> Maternity home with specialist <input type="radio"/> Maternity home without specialist<br/> <input type="radio"/> Alternative Birthing centre (ABC)<br/> <input type="radio"/> Urban <input type="radio"/> Rural                             </div> </div> |                                                          |                                                                                                                                       |
| <b>*24. Multiplicity:</b>           | <input type="radio"/> Singleton <input type="radio"/> Twin <input type="radio"/> Triplet <input type="radio"/> Other, specify: ..... <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> <span style="border: 1px solid black; padding: 2px 10px;">  </span> Specify birth order if not a singleton:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                          |                                                                                                                                       |
| <b>*25. Final Mode of delivery:</b> | <input type="radio"/> Vaginal delivery → <input type="radio"/> SVD <input type="radio"/> Breech <input type="radio"/> Caesarean section → <input type="radio"/> Elective <input type="radio"/> Emergency<br><input type="radio"/> Instrumental → <input type="checkbox"/> Vacuum <input type="checkbox"/> Forceps <input type="radio"/> Others, specify:..... <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                          |                                                                                                                                       |

## SECTION 2 : BIRTH HISTORY (continue)

|                                                                         |                                                                       |                           |                                  |                                                                    |                           |                                  |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------|----------------------------------|--------------------------------------------------------------------|---------------------------|----------------------------------|
| *26. Apgar score at 1 min and 5 min (0-10)                              | a) Score at 1 min:                                                    | <input type="text"/>      | <input type="checkbox"/> Unknown | b) Score at 5 min:<br>(Please score even if the baby is intubated) | <input type="text"/>      | <input type="checkbox"/> Unknown |
| 27. Initial resuscitation:<br>(applicable for inborn only)              | a) Oxygen:                                                            | <input type="radio"/> Yes | <input type="radio"/> No         | d) Endotracheal tube vent:                                         | <input type="radio"/> Yes | <input type="radio"/> No         |
|                                                                         | b) CPAP :                                                             | <input type="radio"/> Yes | <input type="radio"/> No         | e) Cardiac compression:                                            | <input type="radio"/> Yes | <input type="radio"/> No         |
|                                                                         | c) Bag and mask ventilation:                                          | <input type="radio"/> Yes | <input type="radio"/> No         | f) Adrenaline:                                                     | <input type="radio"/> Yes | <input type="radio"/> No         |
| *28. Admission temperature:<br>(mandatory if admitted to Neonatal ward) | <input type="text"/> <input type="text"/> . <input type="text"/> (°C) |                           |                                  |                                                                    |                           |                                  |

## SECTION 3: NEONATAL EVENT

|                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|-----------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|-----------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|------------------|-----------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|
| <p><b>*29. Respiratory support:</b></p> <p>If &lt; 12 hours = state 0.5 days</p> <p>If &gt; 12 to 24 hours = state 1 day</p> <p>If &gt; 24 hours = state to next completed days</p> <p>Complete entry a) to d) for each type of respiratory support given</p> | <div> <input type="radio"/> Yes →         <input type="radio"/> No       </div> <table border="1"> <tr> <td rowspan="2">a) CPAP done?</td> <td> <input type="radio"/> Yes →         </td> <td> <input type="radio"/> No         </td> </tr> <tr> <td colspan="2"> <div> i) Early CPAP within 1 hour from birth: <input type="radio"/> Yes <input type="radio"/> No </div> <div> ii) Total duration of CPAP at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> </td> </tr> <tr> <td rowspan="2">b) Conventional ventilation:</td> <td> <input type="radio"/> Yes →         </td> <td> <input type="radio"/> No         </td> </tr> <tr> <td colspan="2"> <div> i) Total duration of Conventional ventilation at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> </td> </tr> <tr> <td rowspan="2">c) HFJV/HFOV:</td> <td> <input type="radio"/> Yes →         </td> <td> <input type="radio"/> No         </td> </tr> <tr> <td colspan="2"> <div> i) Total duration of HFJV//HFOV at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> </td> </tr> <tr> <td rowspan="2">d) Nitric Oxide:</td> <td> <input type="radio"/> Yes →         </td> <td> <input type="radio"/> No         </td> </tr> <tr> <td colspan="2"> <div> i) Total duration of Nitric Oxide at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> </td> </tr> </table> | a) CPAP done?            | <input type="radio"/> Yes → | <input type="radio"/> No | <div> i) Early CPAP within 1 hour from birth: <input type="radio"/> Yes <input type="radio"/> No </div> <div> ii) Total duration of CPAP at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> |  | b) Conventional ventilation: | <input type="radio"/> Yes → | <input type="radio"/> No | <div> i) Total duration of Conventional ventilation at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> |  | c) HFJV/HFOV: | <input type="radio"/> Yes → | <input type="radio"/> No | <div> i) Total duration of HFJV//HFOV at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> |  | d) Nitric Oxide: | <input type="radio"/> Yes → | <input type="radio"/> No | <div> i) Total duration of Nitric Oxide at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div> |  |
| a) CPAP done?                                                                                                                                                                                                                                                 | <input type="radio"/> Yes →                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          | <input type="radio"/> No    |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                               | <div> i) Early CPAP within 1 hour from birth: <input type="radio"/> Yes <input type="radio"/> No </div> <div> ii) Total duration of CPAP at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| b) Conventional ventilation:                                                                                                                                                                                                                                  | <input type="radio"/> Yes →                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> No |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                               | <div> i) Total duration of Conventional ventilation at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| c) HFJV/HFOV:                                                                                                                                                                                                                                                 | <input type="radio"/> Yes →                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> No |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                               | <div> i) Total duration of HFJV//HFOV at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| d) Nitric Oxide:                                                                                                                                                                                                                                              | <input type="radio"/> Yes →                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> No |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                               | <div> i) Total duration of Nitric Oxide at your centre: <div> <input type="text"/> . <input type="text"/> Day (s) </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| <p><b>*30.Total number of days on ventilation support at your centre:</b></p>                                                                                                                                                                                 | <div> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (autocalculate)     </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| <p><b>*31. Surfactant:</b></p>                                                                                                                                                                                                                                | <div> <input type="radio"/> Yes →         <div> <input type="radio"/> &lt; 1 hr           <input type="radio"/> 1-2 hrs           <input type="radio"/> &gt; 2 hrs         </div> </div> <div> <input type="radio"/> No     </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |
| <p><b>*32. Parenteral nutrition:</b></p>                                                                                                                                                                                                                      | <div> <input type="radio"/> Yes         <input type="radio"/> No     </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                             |                          |                                                                                                                                                                                                                                  |  |                              |                             |                          |                                                                                                                                             |  |               |                             |                          |                                                                                                                               |  |                  |                             |                          |                                                                                                                                 |  |

## SECTION 4: PROBLEMS/ DIAGNOSES

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| *33. Respiratory:                                                          | <input type="checkbox"/> Meconium aspiration syndrome <input type="checkbox"/> Pulmonary haemorrhage <input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Transient tachypnoea of newborn <input type="checkbox"/> Pulmonary interstitial emphysema                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *34. RDS:                                                                  | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *35. Pneumothorax:                                                         | <input type="radio"/> Yes → <b>Pneumothorax developed during:</b> <input type="radio"/> Spontaneous <input type="radio"/> CPAP <input type="radio"/> CMV <input type="radio"/> HFV<br><input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *36. Supplemental oxygen and BPD:                                          | a) Is baby on > 21% oxygen continuously for 28 days or more? <input type="radio"/> Yes <input type="radio"/> No<br>b) If Yes    (i) for < 32 weeks GA, baby still on oxygen / CPAP / ventilator support at 36 weeks corrected age? <input type="radio"/> Yes <input type="radio"/> No<br>(ii) for ≥ 32 weeks GA, baby still on oxygen / CPAP / ventilator support at day 56 of life? <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *37. Cardiovascular                                                        | PPHN: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *38. PDA:                                                                  | <input type="radio"/> Yes → <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>a) ECHO done:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> <tr> <td>b) Indomethacin/Ibuprofen:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> <tr> <td>c) Ligation:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> </table><br><input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  | a) ECHO done:               | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                        | b) Indomethacin/Ibuprofen:                                                 | <input type="radio"/> Yes <input type="radio"/> No                                                                                                              | c) Ligation: | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                  |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| a) ECHO done:                                                              | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| b) Indomethacin/Ibuprofen:                                                 | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| c) Ligation:                                                               | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *39. NEC (stage 2 and above):                                              | <input type="radio"/> Yes → <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>a) surgical treatment:</td><td><input type="radio"/> Yes        <input checked="" type="radio"/> No</td></tr> <tr> <td>b) NEC present before admission to your centre:<br/>(for outborn baby only)</td><td><input type="radio"/> Yes        <input checked="" type="radio"/> No</td></tr> </table><br><input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  | a) surgical treatment:      | <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                             | b) NEC present before admission to your centre:<br>(for outborn baby only) | <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                   |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| a) surgical treatment:                                                     | <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| b) NEC present before admission to your centre:<br>(for outborn baby only) | <input type="radio"/> Yes <input checked="" type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| *40. ROP Retinal Exam Done                                                 | <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input checked="" type="radio"/> Yes<br/><i>(If yes, worst stage of ROP):</i> </div> <div style="width: 65%;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>a) Date of first screening:</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr> <td>b) Post conceptional age at 1st screening:</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> (autocalculate)</td></tr> <tr> <td>c)</td><td><input type="radio"/> No ROP    <input checked="" type="radio"/> Stage 1    <input type="radio"/> Stage 2    <input type="radio"/> Stage 3    <input type="radio"/> Stage 4    <input type="radio"/> Stage 5    <input type="checkbox"/> PLUS disease</td></tr> <tr> <td>d) Laser Therapy:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> <tr> <td>e) Cryotherapy:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> <tr> <td>f) Vitrectomy:</td><td><input type="radio"/> Yes        <input type="radio"/> No</td></tr> <tr> <td>g) ROP present prior to admission?<br/>(for outborn baby only)</td><td><input checked="" type="radio"/> Yes        <input type="radio"/> No</td></tr> </table> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"> <input type="radio"/> No<br/><br/> <input type="radio"/> Not Applicable         </div> <div style="width: 65%;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">Appointment given:</div> <div style="width: 65%;"> <input checked="" type="radio"/> Yes        <input type="radio"/> No<br/>           Date of appointment <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> </div> </div> |  |  |  |  |  | a) Date of first screening: | <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> | b) Post conceptional age at 1st screening:                                 | <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> (autocalculate) | c)           | <input type="radio"/> No ROP <input checked="" type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Stage 5 <input type="checkbox"/> PLUS disease | d) Laser Therapy: | <input type="radio"/> Yes <input type="radio"/> No | e) Cryotherapy: | <input type="radio"/> Yes <input type="radio"/> No | f) Vitrectomy: | <input type="radio"/> Yes <input type="radio"/> No | g) ROP present prior to admission?<br>(for outborn baby only) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| a) Date of first screening:                                                | <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| b) Post conceptional age at 1st screening:                                 | <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> (autocalculate)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| c)                                                                         | <input type="radio"/> No ROP <input checked="" type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Stage 5 <input type="checkbox"/> PLUS disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| d) Laser Therapy:                                                          | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| e) Cryotherapy:                                                            | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| f) Vitrectomy:                                                             | <input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |
| g) ROP present prior to admission?<br>(for outborn baby only)              | <input checked="" type="radio"/> Yes <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |                             |                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                 |              |                                                                                                                                                                                                                                     |                   |                                                    |                 |                                                    |                |                                                    |                                                               |                                                               |

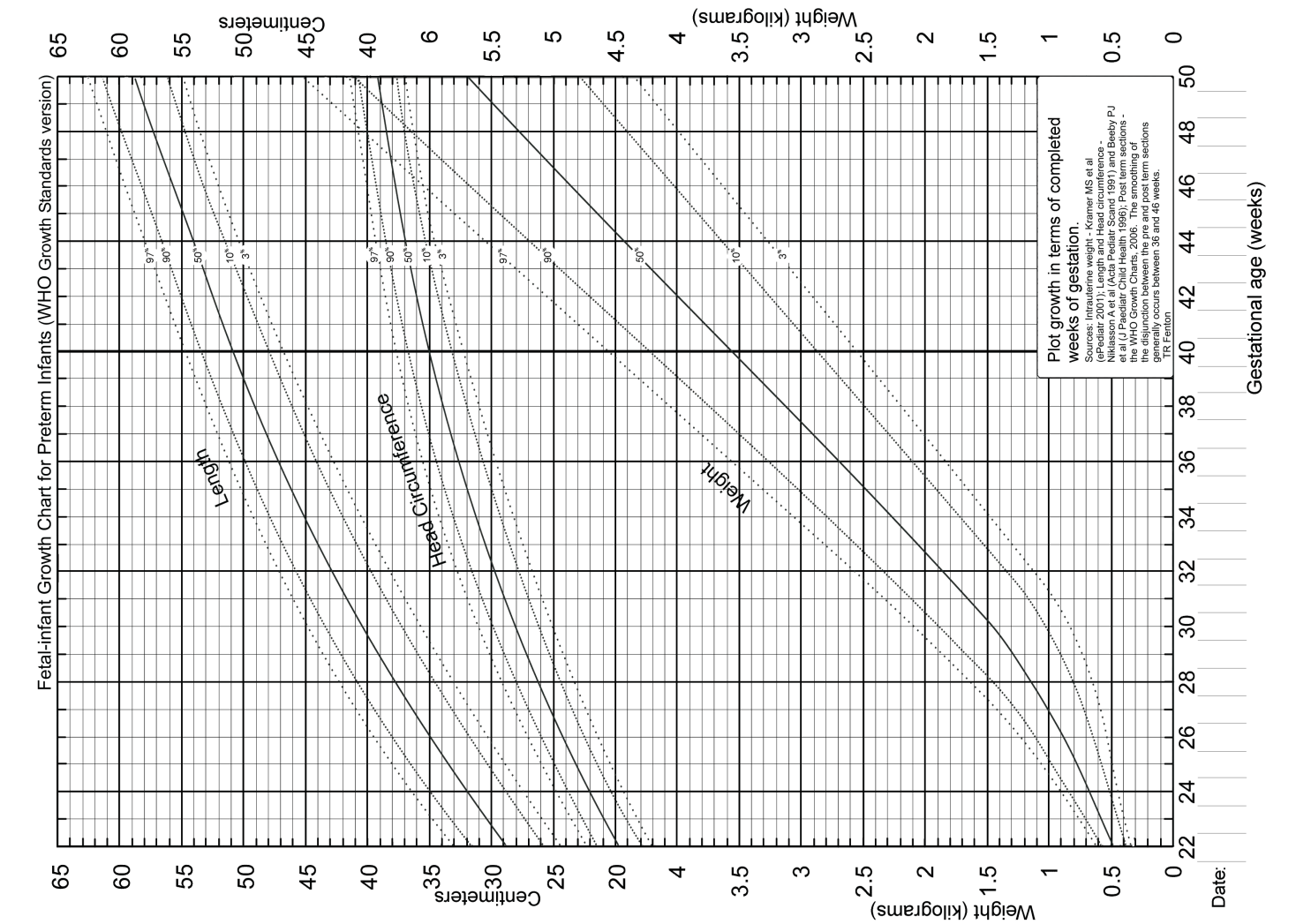
## SECTION 4: PROBLEMS/ DIAGNOSES (continue)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>*41. IVH:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Yes <i>If yes, worst grade:</i> → <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="radio"/> Grade 1</span> <span><input type="radio"/> Grade 2</span> <span><input type="radio"/> Grade 3</span> <span><input type="radio"/> Grade 4</span> </div> <div style="margin-top: 5px;"> <input type="checkbox"/> VP shunt/ reservoir insertion         </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>*42. Seizures :</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="radio"/> Yes <span style="margin-left: 150px;"><input type="radio"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>*43. Central venous line:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Yes <span style="margin-left: 150px;"><input type="radio"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>*44. Confirmed sepsis:</b><br><br><b>(Blood culture positive only)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <div style="display: flex; justify-content: space-between;"> <input type="radio"/> Yes           <input type="radio"/> No         </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> ≤ 72 hours of life           <b>II) Type of organism:</b> (can tick more than one)         </div> <div style="display: grid; grid-template-columns: repeat(4, 1fr); gap: 5px;"> <div><input type="checkbox"/> Group B Streptococcus</div> <div><input type="checkbox"/> Staphylococcus aureus</div> <div><input type="checkbox"/> Acinetobacter</div> <div><input type="checkbox"/> ESBL organisms</div> <div><input type="checkbox"/> MRSA</div> <div><input type="checkbox"/> Klebsiella</div> <div><input type="checkbox"/> Fungal</div> <div><input type="checkbox"/> E.Coli</div> <div><input type="checkbox"/> CONS</div> <div><input type="checkbox"/> Pseudomonas</div> <div><input type="checkbox"/> Others, specify: .....</div> </div> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> &gt; 72 hours of life           <b>II) Type of organism:</b> (can tick more than one)         </div> <div style="display: grid; grid-template-columns: repeat(4, 1fr); gap: 5px;"> <div><input type="checkbox"/> Group B Streptococcus</div> <div><input type="checkbox"/> Staphylococcus aureus</div> <div><input type="checkbox"/> Acinetobacter</div> <div><input type="checkbox"/> ESBL organisms</div> <div><input type="checkbox"/> MRSA</div> <div><input type="checkbox"/> Klebsiella</div> <div><input type="checkbox"/> Fungal</div> <div><input type="checkbox"/> E.Coli</div> <div><input type="checkbox"/> CONS</div> <div><input type="checkbox"/> Pseudomonas</div> <div><input type="checkbox"/> Others, specify: .....</div> </div> </div> |
| <b>*45. Neonatal meningitis:</b><br><br><input type="radio"/> Yes<br><input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>CSF Culture positive :</b><br><input type="radio"/> Yes <span style="margin-left: 100px;"><input type="radio"/> No</span><br><div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <b>If Yes, type of organism:</b> (can tick more than one)         <div style="display: grid; grid-template-columns: repeat(4, 1fr); gap: 5px;"> <div><input type="checkbox"/> Group B Streptococcus</div> <div><input type="checkbox"/> Staphylococcus aureus</div> <div><input type="checkbox"/> Acinetobacter</div> <div><input type="checkbox"/> ESBL organisms</div> <div><input type="checkbox"/> MRSA</div> <div><input type="checkbox"/> Klebsiella</div> <div><input type="checkbox"/> Fungal</div> <div><input type="checkbox"/> E.Coli</div> <div><input type="checkbox"/> CONS</div> <div><input type="checkbox"/> Pseudomonas</div> <div><input type="checkbox"/> Others, specify: .....</div> </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>*46. Hypoxic ischaemic encephalopathy (HIE):</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> None <span style="margin-left: 50px;"><input type="radio"/> Mild</span> <span style="margin-left: 50px;"><input type="radio"/> Moderate</span> <span style="margin-left: 50px;"><input type="radio"/> Severe</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>*47. Congenital anomalies:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>*47a. Major congenital anomalies:</b><br><input type="radio"/> Yes <span style="margin-left: 50px;"><input type="radio"/> No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>*47b. Types of abnormalities (check all that are present. Applies to all including 'known syndromes', 'not a recognized syndrome' or 'isolated major abnormality')</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <div style="display: flex;"> <div style="flex: 1;"> <input checked="" type="radio"/> Syndrome (known)           <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <input type="checkbox"/> Down<br/> <input type="checkbox"/> Edward<br/> <input type="checkbox"/> Patau<br/> <input type="checkbox"/> Others, specify (Refer to ICD 10):<br/> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div> </div> </div> <div style="flex: 1;"> <input type="radio"/> Not a recognized syndrome<br/> <input type="radio"/> Isolated major abnormality           </div> </div> | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <div style="margin-bottom: 10px;"> <input type="checkbox"/> CVS →            <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="radio"/> Cyanotic</span> <span><input type="radio"/> Acyanotic</span> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="checkbox"/> ECHO done           </div> </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> CNS →            <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="radio"/> Hydrocephalus<br/> <input type="radio"/> Hydrancephaly<br/> <input type="radio"/> Holoprosencephaly<br/> <input type="radio"/> Others (Refer to ICD 10): _____           </div> </div> <div> <input type="checkbox"/> Neural Tube Defect →            <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <input type="radio"/> Spina bifida<br/> <input type="radio"/> Anencephaly<br/> <input type="radio"/> Encephalocoele<br/> <input type="radio"/> Others (Refer to ICD 10): _____           </div> </div> </div> <div style="width: 35%;"> <div style="margin-bottom: 10px;"> <input type="checkbox"/> Skeletal dysplasia<br/> <input type="checkbox"/> Respiratory<br/> <input type="checkbox"/> GIT<br/> <input type="checkbox"/> Hydrops<br/> <input type="checkbox"/> Renal<br/> <input type="checkbox"/> Cleft           </div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 10px;"> <input type="radio"/> Lip <input type="radio"/> Palate <input type="radio"/> Lip and Palate           </div> <div> <input type="checkbox"/> Others, specify (Refer to ICD10):<br/> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> </div> <div> <input type="checkbox"/> None of the above           </div> </div> </div>                |

SECTION 5: OUTCOME

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

Name : \_\_\_\_\_ Signature: \_\_\_\_\_ Date:  (dd/mm/yy)



# MALAYSIAN NATIONAL NEONATAL REGISTRY

## Supplementary Form

### Instruction:

- 1) For term babies please fill in according to the most pertinent underlying cause of death.  
2) For preterm babies please fill in according to the most immediate cause of death.

|                         |                              |           |  |                                                         |
|-------------------------|------------------------------|-----------|--|---------------------------------------------------------|
| 1. Centre Name:         |                              |           |  | Office use: <input type="text"/> / <input type="text"/> |
| 2. Name:                |                              | 3. RN:    |  | Centre: <input type="text"/>                            |
| 4. Mother's I/C Number: | New IC: <input type="text"/> | Passport: |  |                                                         |

### Immediate cause of death (Modified Wigglesworth):

Tick relevant button to reach correct classification

Note: LCM = Lethal Congenital Malformation

**NEONATAL DEATH**  
(Is there any LCM?)

☐ LCM present

a) Lethal congenital malformation/defect, specify:

☐ Neural tube defects

☐ Anencephaly

☐ Encephalocele

☐ Others, specify \_\_\_\_\_  
(Refer to ICD 10):

☐ CVS

☐ Complex/ cyanotic heart disease

☐ Acyanotic

☐ CNS

☐ Hydrocephalus

☐ Hydrancephaly

☐ Holoprosencephaly

☐ Others, specify \_\_\_\_\_  
(Refer to ICD 10):

☐ Recognisable syndrome

☐ Down

☐ Edward

☐ Patau

☐ Others, specify \_\_\_\_\_  
(Refer to ICD 10):

☐ Not recognisable syndrome

☐ Skeletal dysplasia

☐ Respiratory (eg. lung hypoplasia)

☐ GIT

☐ Hydrops foetalis

☐ Renal

☐ Others, specify: \_\_\_\_\_

☐ LCM absent

b) (Is gestation <37 weeks?)

☐ Yes

c) Gestation <37 weeks conditions associated with immaturity

☐ IVH

☐ Septicaemia

☐ PDA in failure

☐ Pulmonary hemorrhage

☐ NEC

☐ Pneumonia

☐ PIE / BPD

☐ Pneumothorax

☐ Extreme prematurity

☐ Asphyxia

☐ No

Gestation ≥37 weeks  
(Did the baby have an asphyxial condition?)

☐ d) Asphyxial condition absent  
(Did the baby die from infection?)

☐ Asphyxial condition present

☐ e) Infection present

☐ Group B streptococcal septicaemia

☐ Meningitis

☐ Congenital pneumonia

☐ Congenital Infection

☐ Others, specify \_\_\_\_\_

☐ Infection absent  
(Are there any other specific causes of death?)

☐ f) Other specific causes:

☐ Kernicterus/ severe neonatal jaundice

☐ Haemorrhagic disease of newborn/ Vitamin K deficiency

☐ Intracranial bleed / SAH

☐ Pneumothorax

☐ Pulmonary hemorrhage

☐ IEM

☐ MAS

☐ Surgical, specify: \_\_\_\_\_

☐ Others, specify: \_\_\_\_\_

☐ Unknown cause

Name : \_\_\_\_\_

Signature : \_\_\_\_\_

Date:  /  /  (dd/mm/yy)

## MALAYSIAN NATIONAL NEONATAL REGISTRY (READMISSION FORM)

|                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Centre Name:</b> _____<br>_____<br>_____<br><b>Date of Admission:</b> <span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span> (dd/mm/yy) |  | <b>MNNR No.</b><br>(Office use): <span style="border: 1px solid black; padding: 0 10px;"> </span> / <span style="border: 1px solid black; padding: 0 10px;"> </span><br><b>Centre:</b> <span style="border: 1px solid black; padding: 0 20px;"> </span> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## SECTION 1 : PATIENT PARTICULARS &amp; MATERNAL HISTORY

|                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                                                                                                                         |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>*1. Name of mother:</b>                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                                                                                                                         |
| <b>2. Name of baby (Optional):</b>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                                                                                                                         |
| <b>*3. RN of baby:</b>                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |                                                                                                                                         |
| <b>*4a. Mother's I/C number:</b>                | MyKad: <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span><br>Other ID document No: <span style="border: 1px solid black; padding: 0 20px;"> </span><br>Specify document type (if others): <input type="radio"/> Passport <input type="radio"/> Armed Force ID <input type="radio"/> Driver's License <input type="radio"/> Old IC <input type="radio"/> Hospital RN<br><input type="radio"/> Father's I/C <input type="radio"/> Work Permit number <input type="radio"/> Police ID Card <input type="radio"/> Immigration permit <input type="radio"/> Other, specify:..... |                                 |                                                                                                                                         |
| <b>4b. Baby's MyKid number:</b>                 | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> - <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                 |                                                                                                                                         |
| <b>*5. Date of birth of baby:</b><br>(dd/mm/yy) | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                 |                                                                                                                                         |
| <b>*6a. Birth weight:</b>                       | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (grams)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>*6b. Gestation at birth:</b> | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (weeks) |

## SECTION 2 : PARTICULARS OF THIS ADMISSION

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <b>*7. Date of first discharge:</b><br>(dd/mm/yy) | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> |  |  |
| <b>*8. Age at readmission:</b>                    | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (days) (autocalculate)                                                                                                                                                                                                                                                                                                              |  |  |
| <b>*9. Weight at this readmission:</b>            | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (grams)                                                                                                                                                                                             |  |  |
| <b>*10. Reason for readmission:</b>               | <input type="checkbox"/> Apnoea <input type="checkbox"/> LRTI <input type="checkbox"/> Confirmed sepsis <input type="checkbox"/> Others, Specify:.....<br><input type="checkbox"/> Fever <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Jaundice<br><input type="checkbox"/> URTI <input type="checkbox"/> Cyanosis due to sucking / swallowing incoordination                                                                                                                                                  |  |  |
| <b>*11. Ventilated:</b>                           | <input type="radio"/> Yes → (fill in main CRF section 3&4) <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |

## SECTION 5: OUTCOME

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>*48a. Date of discharge / transfer/ death:</b> (dd/mm/yy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> / <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> | <b>48b. Time of Death:</b> (24 hour format) (mandatory for death cases) | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (enter the best estimated time of death if the exact time is unknown) |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>*49. Weight and growth status on discharge:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>a) Weight:</b> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> (grams)<br><b>b) Growth status:</b> <input type="radio"/> SGA <input type="radio"/> AGA <input type="radio"/> LGA |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>*50. Feeding at discharge / death:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> Never fed <input type="radio"/> Human milk only <input type="radio"/> Formula only <input type="radio"/> Human milk with formula <input type="radio"/> No data / Unknown                                                                                                                                                                                                                                                                      |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>*51. Total duration of hospital stay (neonatal/ peads care):</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> <span style="border: 1px solid black; padding: 0 5px;"> </span> ( in completed days) (autocalculate)                                                                                                                                                                                                                                |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>*52. Outcome:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <input type="radio"/> Alive → <b>Place discharged to:</b> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <input type="radio"/> Home<br/> <input type="radio"/> Social welfare home<br/> <input type="radio"/> Other non Paeds ward<br/> <input type="radio"/> Still hospitalized as of 1st birthday<br/> <input type="radio"/> Transfer to other hospitals →           <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:30%;"><b>a) Name of hospital:</b></td> <td></td> </tr> <tr> <td><b>b) Reason for transfer:</b></td> <td> <input type="radio"/> Growth/ stepdown care    <input type="radio"/> Acute medical/ diagnostic services    <input type="radio"/> Social/ Logistic reason<br/> <input type="radio"/> Lack of NICU bed    <input type="radio"/> Surgery    <input type="radio"/> Other, specify: .....<br/> <input type="radio"/> Chronic/ Palliative care               </td> </tr> <tr> <td><b>c) Post transfer disposition:</b><br/>(Please fill this section if place transferred is not part of the NNR Network)</td> <td> <input type="radio"/> Home    <input type="radio"/> Transferred again to another hospital<br/> <input type="radio"/> Death    <input type="radio"/> Readmitted to your hospital<br/> <input type="radio"/> Still in ward               </td> </tr> </table> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                                                                                                                                                                                                                                                                                                                                       | <b>a) Name of hospital:</b> |  | <b>b) Reason for transfer:</b> | <input type="radio"/> Growth/ stepdown care <input type="radio"/> Acute medical/ diagnostic services <input type="radio"/> Social/ Logistic reason<br><input type="radio"/> Lack of NICU bed <input type="radio"/> Surgery <input type="radio"/> Other, specify: .....<br><input type="radio"/> Chronic/ Palliative care | <b>c) Post transfer disposition:</b><br>(Please fill this section if place transferred is not part of the NNR Network) | <input type="radio"/> Home <input type="radio"/> Transferred again to another hospital<br><input type="radio"/> Death <input type="radio"/> Readmitted to your hospital<br><input type="radio"/> Still in ward |
| <b>a) Name of hospital:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>b) Reason for transfer:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="radio"/> Growth/ stepdown care <input type="radio"/> Acute medical/ diagnostic services <input type="radio"/> Social/ Logistic reason<br><input type="radio"/> Lack of NICU bed <input type="radio"/> Surgery <input type="radio"/> Other, specify: .....<br><input type="radio"/> Chronic/ Palliative care                                                                                                                                            |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <b>c) Post transfer disposition:</b><br>(Please fill this section if place transferred is not part of the NNR Network)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Home <input type="radio"/> Transferred again to another hospital<br><input type="radio"/> Death <input type="radio"/> Readmitted to your hospital<br><input type="radio"/> Still in ward                                                                                                                                                                                                                                                      |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |
| <input type="radio"/> Dead → <b>Place of death:</b> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <input type="radio"/> Labour room / OT    <input type="radio"/> Neonatal unit<br/> <input type="radio"/> In transit    <input type="radio"/> Others, specify: .....           </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                         |                                                                                                                                                                                                                                                                                                                                       |                             |  |                                |                                                                                                                                                                                                                                                                                                                          |                                                                                                                        |                                                                                                                                                                                                                |

Name : \_\_\_\_\_ Signature: \_\_\_\_\_

Date:      (dd/mm/yy)