





Baby ID	Baby DOB	Today's Date
AZ	M M I Y Y Y	

Baby Outcomes post 36 weeks PMA

Form is to be completed at transfer, discharge home or death post 36 weeks PMA. Only data and events occurring since admission to this hospital, and occurring after 36 weeks PMA should be recorded.

Details about baby
1. Date baby was admitted to this unit?
2. Post menstrual age at time of completing this form weeks days
3. What is the baby's status on completion of this form?
Transfer to another hospital
Discharged home
Baby died
Transfer to another hospital a. Date of transfer D Image: I
Discharge a. Date of discharge D D M M Y Y Y







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Baby Died

a. Date of death

D D / M M / Y Y Y	Υ	Y	Y	Y	1	M	M	1	D	D
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(Please send a copy of the discharge summary and if available, the post-mortem report to the CTR)

b. What were the main causes leading to death (tick all that apply)

		5	•	11 11		
	Respiratory failure					
	Infection/sepsis					
	NEC					
	Other gut pathology					
	Brain injury					
	Decision to withdraw	al of intensive support				
c.	Has a copy of the dis	charge summary been se	nt?Yes 🗌	No 🗌		
				—	-	

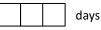
d. Is a post-mortem report available ? Yes 🗌 No 🗌 Not planned 🗌 Not performed 🗌

Summary of respiratory support

4. Please confirm the form of oxygen support at the time of form completion (select one)

Invasive support	
Non-invasive respiratory support	
Low flow oxygen	
Receiving no mechanical support and in room air	Γ

5. Since admission to your hospital, post-36 weeks PMA how many days has the baby received invasive ventilation by endotracheal tube?



6. Since admission to your hospital, post-36 weeks PMA how many days has the baby received noninvasive respiratory support?



7. Since admission to your hospital, post-36 weeks PMA how many days has the baby been on oxygen?









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Other outcomes

Central nervous system

8. While in this hospital post-36 weeks PMA, did the baby have any cerebral ultrasound scans? Yes No (if no go to question 9)

8b. Date of last scan



8c. What was the worst abnormality identified in this hospital (left and/or right hemispheres)?

None of the abnormalities listed below	
Intraventricular haemorrhage, Grade I or II without ventricular dilation	Left 🗌 Right 🗌
Severe intraventricular haemorrhage (IVH) with ventricular dilation (Grade III)	Left 🗌 Right 🗌
Severe intraventricular haemorrhage (IVH) with intraparenchymal abnormality (Grade IV)	Left Right
Hydrocephalus (ventricular index greater than 4mm above 97 th centile)	Left 🗌 Right 🗌
Cystic Periventricular Leukomalacia (PVL)	Left 🗌 Right 🗌
Non-cystic PVL	Left Right
Other white matter injury (specific, free text)	Left 🗌 Right 🗌

9. While in this hospital, post 36 weeks PMA, did the baby have Retinopathy of Prematurity (ROP)?

Yes		No		(if no go to question 1	10)
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9a. If yes, what was the worst state of ROP in either eye

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Stage 5







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9b. Please confirm any of the following

AP-ROP Yes 🗌 No 🗌]	
Has the ROP been treated	l in left eye?	Yes No
Has the ROP been treated	l in right eye?	Yes No
9c. If treated, which treat	ment have th	ey had (tick all that apply)?
Laser therapy 🗌 Yes [No	
Anti-VEGF Yes	No	
Other Yes [No	
Please specify		
10. Has the baby had a weeks PMA?	patent ductu	is arteriosus (PDA) detected since admission to your hospital, post-36
Yes 📄 No 📄 (if	no please go	to question 11)
10a. If yes, and the bab Drug treatment	y received tre	eatment please indicate (Tick all that apply)
Specify drug: Ibuprofen	Yes	No 🗌
Paracetamol	Yes	No 🗌
Indomethacin,	Yes	No 🗌
Furosemide	Yes	No 🗌

Surgical treatment

Yes No Date of surgery D D / M M / Y Y Y







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Measurements

11. Most recent weight measurement g	
12. Date of most recent weight measurement D D / M / Y Y Y	
 13. Most recent head circumference cms 14. Date of head circumference measurement/ Y Y Y Y 	tick here if not recorded
15. Most recent Length of baby cms 16. Date of measurement D D / M M / Y Y Y	tick here if not recorded
Summary of neonatal care	

- 17. Post 36 weeks PMA, whilst in your hospital, how many days has the baby received
 - a. Level 3 (intensive) care

	days	

- b. Level 2 (high dependency) care days
- c. Level 1 (special) care

Form completion

Name of person completing this CRF:	
Date of completion:	
Signature:	