Baby ID A Z | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

Transfer form (up to 36 weeks PMA)

This form is to be completed each time the baby is transferred between hospitals before reaching 36 weeks PMA).

Only events occurring since admission to this hospital should be recorded

Details about baby

1. Date baby was admitted to this unit?
   D D / M M / Y Y Y Y

Summary of respiratory support

2. Whilst in this hospital, how many days has the baby received invasive ventilation by endotracheal tube?
   ☐☐☐ days

3. Whilst in this hospital, how many days has the baby received non-invasive respiratory support?
   ☐☐☐ days

4. Whilst in this hospital, how many days has the baby received oxygen?
   ☐☐☐ days

5. Whilst in this hospital, has the baby had any pneumothorax?
   Yes ☐ No ☐

6. Whilst in this hospital, has the baby had pulmonary haemorrhage?
   Yes ☐ No ☐

7. Whilst in this hospital, has the baby received treatment with corticosteroids?
   Yes ☐ No ☐ (if no please go to question 8)

If yes: Please give details in table for **each** course in the table below (or leave blank if no courses). A course is defined as a gap in treatment of >72 hours

Baby ID A Z

Baby DOB M M / Y Y Y Y

Today's Date D D / M M / Y Y Y Y

Course number	Steroid	Route	Start and end date	dose (mcg)	Indication
	☐ Hydrocortisone ☐ Dexamethasone ☐ Prednisolone ☐ Budesonide ☐ Beclomethasone ☐ Fluticasone	☐ I.V. ☐ Enteral ☐ Oral ☐ Inhaled	Start: D D / M M / Y Y Y Y End: D D / M M / Y Y Y Y	Cumulative Maximum	☐ Respiratory (parenchymal disease) ☐ Stridor ☐ Blood pressure ☐ Other
	☐ hydrocortisone ☐ Dexamethasone ☐ Prednisolone ☐ Budesonide ☐ Beclomethasone ☐ Fluticasone	☐ I.V. ☐ Enteral ☐ Oral ☐ Inhaled	Start: D D / M M / Y Y Y Y End: D D / M M / Y Y Y Y	Cumulative Maximum	☐ Respiratory (parenchymal disease) ☐ Stridor ☐ Blood pressure ☐ Other
	☐ hydrocortisone ☐ Dexamethasone ☐ Prednisolone ☐ Budesonide ☐ Beclomethasone ☐ Fluticasone	☐ I.V. ☐ Enteral ☐ Oral ☐ Inhaled	Start: D D / M M / Y Y Y Y End: D D / M M / Y Y Y Y	Cumulative Maximum	☐ Respiratory (parenchymal disease) ☐ Stridor ☐ Blood pressure ☐ Other

8. Whilst in this hospital, has any other treatment been given for respiratory complications of prematurity?
   Yes ☐ No ☐

   (if yes specify) _____

Other Outcomes at Transfer

Cardiovascular

9. Whilst in this hospital, has the baby had a patent ductus arteriosus (PDA) detected since admission to your hospital?

   Yes ☐ No ☐ (if no please go to question 11

10. If yes, and the baby received treatment please indicate (Tick all that apply)

Drug treatment

Specify drug: Ibuprofen Yes ☐ No ☐

Paracetamol Yes ☐ No ☐

Indomethacin Yes ☐ No ☐

Furosemide Yes ☐ No ☐

Baby ID A Z _ _ _ _ **Baby DOB** M M / Y Y Y Y **Today's Date** D D / M M / Y Y Y Y

Surgical treatment Yes ☐ No ☐

If yes Date of surgery D D / M M / Y Y Y Y

Microbiology

11. Whilst in your hospital, did the baby receive prophylactic antifungals?

    Yes ☐ No ☐

12. Following completion of the initial 21-day surveillance period (**recorded on daily log**), whilst at your hospital, was the baby exposed to any further antibiotics?

    Yes ☐ No ☐ Transferred prior to completing 21-day surveillance period ☐

    If yes, complete the tables below

Antibiotic use post 21 days				
Course number:	Antibiotic (record each on a separate line)	Start date	Stop date	Ongoing at transfer
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No
		D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	☐ Yes ☐ No

Baby ID A Z | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

Positive cultures post 21 days			
Number	Organism	Sample type	Date of positive culture
		☐ Blood ☐ CSF	D D / M M / Y Y Y Y
		☐ Blood ☐ CSF	D D / M M / Y Y Y Y
		☐ Blood ☐ CSF	D D / M M / Y Y Y Y
		☐ Blood ☐ CSF	D D / M M / Y Y Y Y
		☐ Blood ☐ CSF	D D / M M / Y Y Y Y

Gastrointestinal

13. Since admission to your hospital has the baby had a gastrointestinal perforation or NEC (Bell's stage II or above)? Yes ☐ No ☐

13a. if yes, date of incident

D D / M M / Y Y Y Y

13b. Was this spontaneous gastrointestinal perforation, NEC or unclear?

Spontaneous Gastrointestinal Perforation ☐

NEC (stage II or above) ☐

Unclear ☐

13c. Was this confirmed on radiography? ☐ Yes ☐ No

13d. Did the baby go to theatre? ☐ Yes ☐ No

13e. Was this confirmed on histopathology? ☐ Yes ☐ No

Bell stage	**Systemic**	**Gastro-intestinal**	**Radiographic**
Stage II A (Definite NEC:mildly ill)	Increased desaturations and/or bradycardia Temperature instability Lethargy	Increased pre-feed gastric aspirate Definite abdominal distension Possible abdominal tenderness Possibly bloody stools	Pneumotosisintestinalis
Stage II B (Definite NEC:moderately ill)	As **II A** with platelets <100 x 1012 and/or metabolic acidosis: base excess <-8 meq/l	Abdominal distension with definite tenderness Possible abdominal wall oedema and/or erythema	As **II A** with portal vein gas Possible ascites
Stage III A (Advanced NEC: bowel intact)	As **II B** plus mixed acidosis: pH <7.2 DIC neutropaenia <1x109/l Severe apnoea Hypotension requiring inotropes	Generalised peritonitis with severe tenderness withabdominal wall induration	As **II A** with definite ascites
Stage **III B** (Advanced NEC: bowel perforated)	As **IIIA**	As **III A**	As **III A** with pneumoperitoneum

Baby ID A Z | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

Central nervous system

14. While in this hospital, did the baby have any cerebral ultrasound scans? Yes ☐ No ☐ (if no go to question 15)

14a. Date of last scan

D D / M M / Y Y Y Y

14b. 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 97th centile)	Left ☐	Right ☐
Cystic Periventricular Leukomalacia (PVL)	Left ☐	Right ☐
Non-cystic PVL	Left ☐	Right ☐
Other white matter injury (specific, free text)	Left ☐	Right ☐

15. While in this hospital, did the baby have Retinopathy of Prematurity (ROP)?

Yes ☐ No ☐ (if no go to question 16)

15a. If yes, what was the worst state of ROP in either eye

Stage 1 ☐

Stage 2 ☐

Stage 3 ☐

Stage 4 ☐

Stage 5 ☐

Baby ID A Z | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

15b. Please confirm any of the following

AP-ROP Yes ☐ No ☐

Has the ROP been treated in left eye? Yes ☐ No ☐

Has the ROP been treated in right eye? Yes ☐ No ☐

15c. If treated, which treatment have they had (tick all that apply)?

Laser therapy ☐ Yes ☐ No

Anti-VEGF ☐ Yes ☐ No

Other ☐ Yes No

Please specify

16. What was the maximum creatinine value recorded during the hospital stay?

Maximum creatinine ☐☐ µmol/L

17. What were the maximum values recorded for Bilirubin, AST and ALP during the hospital stay?

17a. Max bilirubin ☐☐☐ µmol/L

17b. Max AST ☐☐☐ U/L

17c. Max ALP ☐☐☐☐ U/L

Summary of neonatal care

18. 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
☐☐ Days

Baby ID A Z | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

Measurements

19. **Most recent** weight measurement ____ g

20. Date of most recent weight measurement

D D / M M / Y Y Y Y

21. **First** head circumference (closest to birth) ____ . ____ cms tick here if not recorded ☐

22. Date of measurement

D D / M M / Y Y Y Y

23. **Most recent** length of baby ____ . ____ cms tick here if not recorded ☐

24. Date of measurement

D D / M M / Y Y Y Y

Baby's Transfer

25. Transfer

a. Date of transfer

D D / M M / Y Y Y Y

b. Receiving hospital contact information

c. Name of receiving consultant- if known

Baby ID A Z _ _ _ _ | **Baby DOB** M M / Y Y Y Y | **Today's Date** D D / M M / Y Y Y Y

Form completion

Name of person completing this CRF:

Date of completion: D D / M M / Y Y Y Y

Signature: