

**MODULE 5 - NEWBORN DISCHARGE MODULE**

**(TO BE FILLED OUT BY THE NURSE OR PHYSICIAN UPON DISCHARGE/TRANSFER/DEATH OF THE INFANT)**

<p>1. WAS THIS INFANT TRANSFERRED FROM ANOTHER INSTITUTION?</p>	<p>2. DATE INFANT WAS TRANSFERRED IN</p> <p style="text-align: right;">             _____ / _____ / _____  <i>Mo. Day Yr.</i> </p>		
<p>3. IF YES, TRANSFERRING FACILITY NAME AND LOCATION</p> <p style="text-align: center;">             _____  <i>(Name) (City/Town) (County)</i> </p>			
<p>4. PROCEDURES/INTERVENTIONS <i>(Check all that apply)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <p><b>INFUSIONS</b></p> <p>01 <input type="checkbox"/> IV Antibiotics</p> <p>02 <input type="checkbox"/> Blood Transfusion</p> <p>03 <input type="checkbox"/> Exchange Transfusion</p> <p>04 <input type="checkbox"/> Parenteral Alimentation</p> <p>05 <input type="checkbox"/> Ototoxic Drugs (&gt;5 days or w/loop diuretic)</p> <p><b>SURGERY</b></p> <p>06 <input type="checkbox"/> Circumcision</p> <p>07 <input type="checkbox"/> Other Surgery</p> <p><b>CATHETERIZATIONS</b></p> <p>08 <input type="checkbox"/> Umbilical Artery Catheterization (UAC)</p> <p>09 <input type="checkbox"/> Umbilical Vein Catheterization (UVC)</p> </td> <td style="width:50%; vertical-align: top;"> <p><b>ASSISTED VENTILATION</b></p> <p>10 <input type="checkbox"/> Oxygen Therapy</p> <p>10A. Duration _____ Days</p> <p>11 <input type="checkbox"/> CPAP</p> <p>11A. Duration _____ Days</p> <p>12 <input type="checkbox"/> Mechanical Ventilation</p> <p>12A. Duration _____ Days</p> <p><b>OTHER</b></p> <p>13 <input type="checkbox"/> ECMO</p> <p>14 <input type="checkbox"/> Phototherapy</p> <p>15 <input type="checkbox"/> Surfactant Therapy</p> <p>16 <input type="checkbox"/> Other, Specify: _____</p> <p>00 <input type="checkbox"/> None</p> </td> </tr> </table>		<p><b>INFUSIONS</b></p> <p>01 <input type="checkbox"/> IV Antibiotics</p> <p>02 <input type="checkbox"/> Blood Transfusion</p> <p>03 <input type="checkbox"/> Exchange Transfusion</p> <p>04 <input type="checkbox"/> Parenteral Alimentation</p> <p>05 <input type="checkbox"/> Ototoxic Drugs (&gt;5 days or w/loop diuretic)</p> <p><b>SURGERY</b></p> <p>06 <input type="checkbox"/> Circumcision</p> <p>07 <input type="checkbox"/> Other Surgery</p> <p><b>CATHETERIZATIONS</b></p> <p>08 <input type="checkbox"/> Umbilical Artery Catheterization (UAC)</p> <p>09 <input type="checkbox"/> Umbilical Vein Catheterization (UVC)</p>	<p><b>ASSISTED VENTILATION</b></p> <p>10 <input type="checkbox"/> Oxygen Therapy</p> <p>10A. Duration _____ Days</p> <p>11 <input type="checkbox"/> CPAP</p> <p>11A. Duration _____ Days</p> <p>12 <input type="checkbox"/> Mechanical Ventilation</p> <p>12A. Duration _____ Days</p> <p><b>OTHER</b></p> <p>13 <input type="checkbox"/> ECMO</p> <p>14 <input type="checkbox"/> Phototherapy</p> <p>15 <input type="checkbox"/> Surfactant Therapy</p> <p>16 <input type="checkbox"/> Other, Specify: _____</p> <p>00 <input type="checkbox"/> None</p>
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<p>5. DIAGNOSIS OF INFANT (Conditions occurring any time prior to discharge) <i>(Check all that apply)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <p>01 <input type="checkbox"/> Normal Newborn</p> <p>02 <input type="checkbox"/> Abnormal Neurologic Exam</p> <p><b>NEUROLOGIC</b></p> <p>03 <input type="checkbox"/> Seizures</p> <p>04 <input type="checkbox"/> Central Nervous System Hemorrhage</p> <p>05 <input type="checkbox"/> Palsy</p> <p>06 <input type="checkbox"/> Brachioplexis Injury</p> <p><b>CONGENITAL MALFORMATION</b></p> <p>07 <input type="checkbox"/> Reportable Birth Defect</p> <p><b>HEMATOLOGIC DISEASE</b></p> <p>08 <input type="checkbox"/> Coombs Positive</p> <p>09 <input type="checkbox"/> RH Hemolytic</p> <p>10 <input type="checkbox"/> Hyperbilirubinemia</p> <p>11 <input type="checkbox"/> Polycythemia (Venous Hct &gt;65)</p> <p>12 <input type="checkbox"/> Other Hematologic</p> <p><b>INFECTIOUS DISEASE</b></p> <p>13 <input type="checkbox"/> Meningitis (Bacterial/Viral)</p> <p>14 <input type="checkbox"/> Proven Sepsis</p> <p>15 <input type="checkbox"/> In Utero Infection (TORCH)</p> <p>16 <input type="checkbox"/> Syphilis Serology Positive</p> </td> <td style="width:50%; vertical-align: top;"> <p><b>RESPIRATORY</b></p> <p>17 <input type="checkbox"/> Home Monitoring</p> <p>18 <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD)</p> <p>19 <input type="checkbox"/> Meconium Aspiration Syndrome</p> <p>20 <input type="checkbox"/> Pneumonia</p> <p>21 <input type="checkbox"/> Air Leak Syndrome</p> <p>22 <input type="checkbox"/> Home on Oxygen</p> <p>23 <input type="checkbox"/> Respiratory Distress Syndrome/Hyaline Membrane Disease (RDS/HMD)</p> <p>24 <input type="checkbox"/> Transient Tachypnea of Newborn (TTN)</p> <p>25 <input type="checkbox"/> Persistent Pulmonary Hypertension (PPHN)</p> <p><b>MISCELLANEOUS</b></p> <p>26 <input type="checkbox"/> Drug Dependency</p> <p>27 <input type="checkbox"/> Fetal Alcohol Syndrome</p> <p>28 <input type="checkbox"/> Fracture/Dislocation</p> <p>29 <input type="checkbox"/> Necrotizing Enterocolitis</p> <p>30 <input type="checkbox"/> Cephalic Molding</p> <p>31 <input type="checkbox"/> Symptomatic Hypoglycemia + Glucose &lt;20</p> <p>32 <input type="checkbox"/> Stigmata/Anomalies Associated with Hearing Loss</p> <p>33 <input type="checkbox"/> Other, Specify: _____</p> </td> </tr> </table>		<p>01 <input type="checkbox"/> Normal Newborn</p> <p>02 <input type="checkbox"/> Abnormal Neurologic Exam</p> <p><b>NEUROLOGIC</b></p> <p>03 <input type="checkbox"/> Seizures</p> <p>04 <input type="checkbox"/> Central Nervous System Hemorrhage</p> <p>05 <input type="checkbox"/> Palsy</p> <p>06 <input type="checkbox"/> Brachioplexis Injury</p> <p><b>CONGENITAL MALFORMATION</b></p> <p>07 <input type="checkbox"/> Reportable Birth Defect</p> <p><b>HEMATOLOGIC DISEASE</b></p> <p>08 <input type="checkbox"/> Coombs Positive</p> <p>09 <input type="checkbox"/> RH Hemolytic</p> <p>10 <input type="checkbox"/> Hyperbilirubinemia</p> <p>11 <input type="checkbox"/> Polycythemia (Venous Hct &gt;65)</p> <p>12 <input type="checkbox"/> Other Hematologic</p> <p><b>INFECTIOUS DISEASE</b></p> <p>13 <input type="checkbox"/> Meningitis (Bacterial/Viral)</p> <p>14 <input type="checkbox"/> Proven Sepsis</p> <p>15 <input type="checkbox"/> In Utero Infection (TORCH)</p> <p>16 <input type="checkbox"/> Syphilis Serology Positive</p>	<p><b>RESPIRATORY</b></p> <p>17 <input type="checkbox"/> Home Monitoring</p> <p>18 <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD)</p> <p>19 <input type="checkbox"/> Meconium Aspiration Syndrome</p> <p>20 <input type="checkbox"/> Pneumonia</p> <p>21 <input type="checkbox"/> Air Leak Syndrome</p> <p>22 <input type="checkbox"/> Home on Oxygen</p> <p>23 <input type="checkbox"/> Respiratory Distress Syndrome/Hyaline Membrane Disease (RDS/HMD)</p> <p>24 <input type="checkbox"/> Transient Tachypnea of Newborn (TTN)</p> <p>25 <input type="checkbox"/> Persistent Pulmonary Hypertension (PPHN)</p> <p><b>MISCELLANEOUS</b></p> <p>26 <input type="checkbox"/> Drug Dependency</p> <p>27 <input type="checkbox"/> Fetal Alcohol Syndrome</p> <p>28 <input type="checkbox"/> Fracture/Dislocation</p> <p>29 <input type="checkbox"/> Necrotizing Enterocolitis</p> <p>30 <input type="checkbox"/> Cephalic Molding</p> <p>31 <input type="checkbox"/> Symptomatic Hypoglycemia + Glucose &lt;20</p> <p>32 <input type="checkbox"/> Stigmata/Anomalies Associated with Hearing Loss</p> <p>33 <input type="checkbox"/> Other, Specify: _____</p>
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