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| **instructions.** This form should be completed by the research nurse on a daily basis for any preterm admitted to the NICU who is enrolled in SIP. This form should be reviewed by the research clinician. Check ‘DK’ or write “Don’t know” in space if information is not available | | | | | |
| 1.Enter **day** of exam: *(i.e., 1,2,3, etc.starting within   6-12 hrs ofSIP enrollment)* 2.Enter **date** of exam  (DD/MM) | **Day** |**\_\_**|  |\_\_|\_\_|-|\_\_|\_\_| | **Day |\_\_|**  |\_\_|\_\_|-|\_\_|\_\_| | **Day |\_\_|**  |\_\_|\_\_|-|\_\_|\_\_| | **Day |\_\_|**  |\_\_|\_\_|-|\_\_|\_\_| | **Day |\_\_|**  |\_\_|\_\_|-|\_\_|\_\_| |
| **General Appearance** | *Record for first exam of the day (indicate all that apply)* | | | | |
| 3. Color  1=NORMAL/PINK  2=PALE  3=CYANOTIC  4=PLETHORIC  5= Jaundice |  |  |  |  |  |
| 4. Jaundice (all that apply)  1=absent  2=face  3=chest  4=abdomen  5 = SOLE |  |  |  |  |  |
| 5. Wakefulness  1=Awake  2=SLEEPY/LETHARIC  3=COMATOSE |  |  |  |  |  |
| 6. Movement/activity  1=ACTIVE/NORMAL  2=DECREASED  3=ABSENT (FLACID) |  |  |  |  |  |
| **Signs/SYMPTOMS** | *Record for first exam of the day* | | | | |
| 7. Ambo bag Resuscitation done | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK |
| 8. Chest indrawing | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK |
| 9. Patency of airway  1=OPEN  2=APNEA 3=GRUNTING  4=GASPING |  |  |  |  |  |
| 10. Seizures present | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 11. Vomiting 1=None  2= Ingested milk  3=dark(coffe ground )  4= bilious yellow/green   5=red/blood |  |  |  |  |  |
| **Vital Signs** | **Write “DK” in space if “Don’t know’ the information.** | | | | |
| 12. Respiratory rate (AM) | |\_\_|\_\_|/min | |\_\_|\_\_|/ min | |\_\_|\_\_| /min | |\_\_|\_\_|/ min | |\_\_|\_\_|/ min |
| 12.1 Respiratory rate(PM) | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| |
| 13. Apical heart rate (AM) | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| |
| 13.1 Apical heart rate (PM) | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| |
| 14. Temperature (C) (AM) | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| |
| 14.1 Temperature (PM) | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| |
| 15. Saturation (%) (AM) | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% |
| 15.1 Saturation (PM) | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% | |\_\_|\_\_|% |
| 16.**Daily** weight (g) | |\_\_|\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_|\_\_| |
| 17. **Weekly** head circumference (cm) | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| | |\_\_|\_\_|.|\_\_| |
| 18. **Weekly** length (cm) | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| |
| **GI System** |  |  |  |  |  |
| 19. Abdominal distension | 1Yes2No | 1Yes2No | 1Yes2No | 1Yes2No | 1Yes2No |
| 20. Bowel sounds | 1Yes2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 21. Stool present | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 22. Urine output | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| **Oxygen and Fluids** |  |  |  |  |  |
| 23. Oxygen 1=NONE 2=YES w/NASAL PRONG  3=CPAP 4=OTHER (SPECIFY) | |\_\_| | |\_\_| | |\_\_| | |\_\_| | |\_\_| |
| 23.1 If oxygen given, flow  rate (litres/min) | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| | |\_\_|\_\_| |
| 22.1.1 shard | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 23.2 If oxygen, concentration given (%) | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| |
| 23.3. If CPAP, **major** malfunction in last 24 hrs | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK |
| 24. Any IV fluids? | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK | 1Yes 2No 3DK |
| 24.1 If Yes, amount in past  24 hrs (ml) | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| |
| **Feeding in last 24 hours** | | | | | |
| 25. Feeding method  0=NPO  1=Breast milk  2=formula(preterm)  3=formula (term)  4= mixed |  |  |  |  |  |
| 25.1 In prior 24h, cup LG tube feeding amount (ml) | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| | |\_\_|\_\_|\_\_| |
| 26. Any suckling? | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| **Antibiotics/medication In last 24 hours** | | | | | |
| 27. Antibiotics given | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 27.1. If yes, specify: |  |  |  |  |  |
| 1. Ampicillin |  |  |  |  |  |
| 2 .Gentamicin |
| 3. Cephtriaxone |
| 4.Cephotaxime |
| 5. Cephtazidime |
| 6. Vancomycin |
| 7.Cloxacillin |
| 8. Metronidazole |
| 9.if other specify |
| 27.2.of the above which was discontinued |  |  |  |  |  |
| 27.3. Antibiotics stopped? | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 28. Other medications? | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 28.1 If yes, specify: |  |  |  |  |  |
| **DIAGNOSES MADE IN LAST 24 HOURS** | | | | | |
| 29. Were any new diagnoses made?  If Yes, Tick Q.29-43 | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 30. Hypoglycemia | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 31. RDS | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 32. PPHN | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 33. Pneumonia | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 34. Meningitis | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 35. IVH | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 36. Sepsis | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 37. NEC | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 38. Hypothermia (<36.5C) | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 39. Apnea | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 40. Anemia | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 41. Renal failure | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 42. Tetanus | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| 43Other (Specify)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No | 1Yes 2No |
| **LOCATION OF BABY** |  |  |  |  |  |
| 44. Location of baby:  1=Incubator  2=Cot/crib  3=KMC  4=SleepING W/moM 5=DiED (**form 06**  6=Other |  |  |  |  |  |
| **FORM COMPLETION** |  |  |  |  |  |
| 45. Nurse completing form |  |  |  |  |  |
| 46. Doctor who reviewed |  |  |  |  |  |
| 47. Date completed (DD-MM) | |\_\_|\_\_|-|\_\_|\_\_| | |\_\_|\_\_|-|\_\_|\_\_| | |\_\_|\_\_|-|\_\_|\_\_| | |\_\_|\_\_|-|\_\_|\_\_| | |\_\_|\_\_|-|\_\_|\_\_| |