This form is to be completed by bedside caregiver(s) after each recording.

1. Date of aEEG recording

__ __ /__ __ /__ __ __ __
Month Day Year

2. Did the aEEG equipment interfere with your ability to assess or provide care for this patient? ___

1 = Not at all	**2** = Somewhat	**3** = Significantly

a. If 3, please describe _____

_____

_____

_____

Key used by research personnel for question #3

Description codes for PaEEG05, Survey of Bedside Caregivers

01 = Blood draw	**07** = PT/OT assessment/therapy
02 = Central line insertion	**08** = Subspecialty consult
03 = Cranial ultrasound	**09** = Kangaroo care
04 = Other ultrasound	**10** = Weight or length measurement
05 = X-ray	**11** = Head circumference measurement
06 = CT or MRI	**12** = Other (specify)

Time codes for PaEEG05

1 = <15 min **2** = 15 to <30 min **3** = 30 to <45 min **4** = 45 to <60 min **5** = ≥60 min

3. Were clinical activities delayed due to the aEEG recording? Y N
If YES, please code activity delayed and duration of delay

Delay No.	a. Duration	b. Please describe	**Office Use Only** (see PaEEG04/manual) c. Time Code	d. Description Code
1	___	_____	___	___ ___
2	___	_____	___	___ ___
3	___	_____	___	___ ___
4	___	_____	___	___ ___
5	___	_____	___	___ ___
6	___	_____	___	___ ___

Initials of person completing this form ___ ___ ___