Patient's Name: _____ Medical Record:_____

(Please do not transmit information in this box)

VERMONT OXFORD NETWORK - Infant Follow-Up - *HEALTH STATUS REPORT*

Center Number: _____ Center Name: _____

Network ID Number: _____ Year of Birth (YYYY): _____

Follow-up Category: ☐ ELBW 2016 ☐ Clinical study (*specify*): _____

Status at 18 – 24 Months Corrected Age: ☐ Alive ☐ Expired ☐ Unknown

Consent Obtained: ☐ Yes ☐ No

SECTION A: HEALTH STATUS

1. Corrected Age at the follow-up visit (months/days): ___ ___ months ___ ___ days

SECTION B: LIVING SITUATION

2. Maternal Age at Infant Birth: ___ ___years ☐ Unknown
3. Home Child Resides: ☐ Parent/Family member ☐ Foster care ☐ Institutional
4. Caregivers: ☐ Single parent ☐ Two parent ☐ Institutional
   Check (✓) only one ☐ Single parent extended family ☐ Two parent extended family
5. Primary Caregiver Education: ☐ Some High School or less ☐ Some college/university
   Check (✓) only one ☐ High School degree/GED ☐ College/university degree
   ☐ Not applicable ☐ Unknown

USA CENTERS ONLY

6. Income Below 2016 HHS Poverty Guideline: ☐ Yes ☐ No ☐ Unknown
7. Caregiver(s) Primary Language: ☐ English ☐ Spanish ☐ Other

Income 2016 HHS Poverty Guidelines
(48 contiguous states and District of Columbia)

Persons	Income	Persons	Income
2	$ 16,020	6	$ 32,580
3	$ 20,160	7	$ 36,730
4	$ 24,300	8	$ 40,890
5	$ 28,440	Additional	$ 4,160

Source: Federal Registrar Vol. 81, No.15, January 25, 2016, pp.4036-4037.

SECTION C: SUPPORT AFTER DISCHARGE

8. Any Outpatient Support: ☐ Yes ☐ No ☐ Unsure

If yes, *complete the following*	Any time *after discharge*			At present *clinic visit*	
a. Tracheostomy:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
b. Ventilator:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
c. Oxygen:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
d. Gastrostomy:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
e. Nasogastric or Post-pyloric Feeds:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
f. Apnea or CP monitor:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
g. Pulse Oximetry:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
h. Respiratory Medications:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
i. Oral Feeding Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
j. Speech Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No
k. Motor Support:	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No

Complete form on reverse side

SECTION D: MEDICAL RE-HOSPITALIZATIONS AFTER DISCHARGE

9. Any Medical Readmissions (after ultimate discharge): ☐ Yes ☐ No ☐ Unsure

If yes, *complete the following* # Admissions

a. Respiratory Illness: ☐ Yes ☐ No ☐ Unsure ____ ____

b. Nutrition/ Failure to Thrive: ☐ Yes ☐ No ☐ Unsure ____ ____

c. Seizure Disorder: ☐ Yes ☐ No ☐ Unsure ____ ____

d. Shunt Complication: ☐ Yes ☐ No ☐ Unsure ____ ____

e. *Infections (not respiratory or shunt infections)*

i. Meningitis: ☐ Yes ☐ No ☐ Unsure ____ ____

ii. Urinary Tract Infection: ☐ Yes ☐ No ☐ Unsure ____ ____

iii. Gastrointestinal Infection: ☐ Yes ☐ No ☐ Unsure ____ ____

iv. Other infection: ☐ Yes ☐ No ☐ Unsure

If yes, specify: _____ ____ ____

f. Other Medical Readmissions: ☐ Yes ☐ No ☐ Unsure

If yes, specify: _____ ____ ____

SECTION E: SURGERIES

10. Surgical procedures (after ultimate discharge): ☐ Yes ☐ No ☐ Unsure

If Yes, *put all that apply* # Procedures

a. *(P-Code)* _____ ____ ____

b. *(P-Code)* _____ ____ ____

c. *(P-Code)* _____ ____ ____

d. *(P-Code)* _____ ____ ____

e. *(P-Code)* _____ ____ ____

SURGICAL PROCEDURE CODES (P-CODES)

P-Code	Procedure	P-Code	Procedure
	Central Nervous System Surgery		Otolaryngology Surgery
P-101	Shunt or shunt revision for hydrocephalus	P-501	Tracheostomy
P-102	Other neurosurgical procedure	P-502	Tympanostomy tubes
	Congenital Heart Defect Surgery	P-503	Other ENT surgical procedure
P-201	Cardiac surgery		Ophthalmologic Surgery
	Gastrointestinal Surgery	P-601	Retinal cryosurgery or laser surgery: single eye
P-301	Gastrostomy tube placement	P-602	Retinal cryosurgery or laser surgery: both eyes
P-302	Inguinal hernia repair	P-603	Strabismus surgery
P-303	Other gastrointestinal surgical procedure	P-604	Other ophthalmologic surgical procedure
	Genitourinary Surgery		
P-401	Circumcision	P-900	Other Surgical Procedure
P-402	Other genitourinary surgical procedure		

Patient's Name: _____ Medical Record: _____

(Please do not transmit information in this box)

VERMONT OXFORD NETWORK - Infant Follow-Up - *DEVELOPMENTAL STATUS REPORT*

Center Number: _____ Center Name: _____

Network ID Number: _____ Year of Birth (YYYY): _____

Follow-up Category: ☐ **ELBW Birth Year 2016** ☐ **Clinical trial (*specify*): _____**

SECTION A: GROWTH PARAMETERS

1. Corrected Age Growth Parameters Were Obtained (months/days): _____months _____days
2. Weight: ___ ___.___ ___ kg
3. Head Circumference: ___ ___.___ cm

SECTION B: VISION & HEARING

4. Post Discharge Eye Treatment: ☐ Laser ☐ Anti-VEGF ☐ Both ☐ Neither ☐ Unsure
5. Blindness: ☐ One eye ☐ Both eyes ☐ Neither ☐ Unsure
6. Prescription Glasses: ☐ Yes ☐ No
7. Hearing Impairment: ☐ One ear ☐ Both ears ☐ Neither ☐ Unsure
8. Amplification: ☐ Yes ☐ No

SECTION C: CEREBRAL PALSY

9. Cerebral Palsy: ☐ Yes ☐ No
   If Yes, impairment: ☐ Diplegia ☐ Hemiplegia ☐ Quadriplegia
   If No, muscle tone: ☐ Hypotonia ☐ Hypertonia ☐ Both ☐ Normal

SECTION D: GROSS MOTOR MILESTONES

10. Sits independently: ☐ Yes ☐ No
    If No, sits with support: ☐ Yes ☐ No
11. Walks ten (10) steps independently: ☐ Yes ☐ No
    If No, walks ten (10) steps with support: ☐ Yes ☐ No

SECTION E: DEVELOPMENTAL TESTING

12. Developmental Evaluation: ☐ Completed ☐ Partially completed ☐ Not done
    a. If partially completed or not done, check (✓) why:
    ☐ Neurosensory impairment ☐ Too severely delayed ☐ Uncooperative ☐ Other
    b. If completed or partially completed, check (✓) which test:
    ☐ Bayley Scales of Infant Development-III ☐ Griffiths Mental Development Scales ☐ Other
13. Corrected Age Used In Scoring (months/days): _____months _____days
14. Results (BSID-III):

		Scaled Score	Composite Score
☐ BSID-III Cognitive:		___ ___	___ ___
☐ BSID-III Language:	(Sum)	___ ___	___ ___
Expressive Communication:		___ ___	Not applicable
Receptive Communication:		___ ___	Not applicable
☐ BSID-III Motor:	(Sum)	___ ___	___ ___
Gross Motor:		___ ___	Not applicable
Fine Motor:		___ ___	Not applicable

15. Results (GMDS)

	Uncorrected Score	Corrected Score
☐ Total Scale (GQ):	___ ___ ___	___ ___ ___
☐ Locomoter:	___ ___ ___	___ ___ ___
☐ Personal-Social:	___ ___ ___	___ ___ ___
☐ Hearing and Speech:	___ ___ ___	___ ___ ___
☐ Hand and Eye Coordination:	___ ___ ___	___ ___ ___
☐ Performance Tests:	___ ___ ___	___ ___ ___

SECTION F: OVERALL CLINICAL APPRAISAL

16. Clinical Appraisal:

Cognitive function:	☐ Normal	☐ Suspect	☐ Impaired
Language:	☐ Normal	☐ Suspect	☐ Impaired
Motor function:	☐ Normal	☐ Suspect	☐ Impaired