CALI Study Randomization Card

Treatment: *CPAP & Caffeine*

Subject ID: _____ **Site #: _____**

Date/time of Randomization: ____/____/_____ ____:____
MM / DD / YYYY HH : MM

Complete at time of randomization	
1. CPAP Level?	_____ cmH2O
2. FiO2 requirement?	_____ %
3. Vitals: HR/SpO2	HR: _____Bpm SpO2 _____%
4. Caffeine Therapy started in LDR/Resuscitation Rm?	□ Yes □ No
Notes/comments:	

If infant requires intubation within 72 hours of randomization, Please complete Intubation Card and call Neonatal Research at x6307

Affix patient label to back of this card

Completed By (Name): _____ Date: ___/____/_____

Sharp Mary Birch Hospital for Women & Newborns. (2020). CaLI Study Randomization Card. v1.0

(Supplemental File 2)