### Demographics Tab

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>Male, Female, Unknown</td>
</tr>
<tr>
<td><strong>Patient Gender Identity</strong></td>
<td>Male, Female, Male-to-Male (FTM)/Transgender Male/Trans Man, Male-to-Female (MTF)/Transgender Female/Trans Woman, Genderqueer, neither exclusively male nor female, Additional gender category or other: ______________, Did not disclose</td>
</tr>
<tr>
<td><strong>Patient-Identified Sexual Orientation</strong></td>
<td>Straight or heterosexual, Lesbian or gay, Bisexual, Queer, pansexual, and/or questioning, Something else, please specify: ______________, Don’t know, Declined to answer</td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td><strong>/</strong>/<strong><strong>:</strong></strong>, Unknown</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>______________, Age Unit: Years, Months, Weeks, Days, Hours, Minutes</td>
</tr>
<tr>
<td><strong>Patient Zip Code</strong></td>
<td>__________________, Homeless</td>
</tr>
<tr>
<td><strong>Payment Source</strong></td>
<td>Medicare Title 18, Medicaid – Private/ HMO/ PPO/ Other, Self Pay/ No Insurance, Medicaid Title 19, Private/ HMO/ PPO/ Other, Other/ Not Documented/ UTD, Medicare – Private/ HMO/ PPO/ Other, VA/ CHAMPVA/ Tricare</td>
</tr>
</tbody>
</table>

### Race and Ethnicity Tab

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td>American Indian/Alaska Native, White, Native Hawaiian or Pacific Islander [if native Hawaiian or Pacific Islander selected], Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, UTD</td>
</tr>
<tr>
<td><strong>Hispanic Ethnicity</strong></td>
<td>Yes, No/UTD</td>
</tr>
</tbody>
</table>

### Admission Tab

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Born this admission (or transferred from birth hospital)</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Birth Weight (patients &lt;30 days old only)</strong></td>
<td>Pounds, Kilograms, Grams, Birth Weight Unknown/Not Documented, Weight same as birth weight</td>
</tr>
<tr>
<td>Weight (required for pediatric and newborn/neonate patients only):</td>
<td>____</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Length (patients &lt;30 days old only):</td>
<td>____</td>
</tr>
<tr>
<td>Head Circumference (patients &lt;30 days old only):</td>
<td>____</td>
</tr>
<tr>
<td>Admission CPC:</td>
<td></td>
</tr>
<tr>
<td>Admission PCPC:</td>
<td></td>
</tr>
<tr>
<td>COVID-19 Vaccination:</td>
<td></td>
</tr>
<tr>
<td>COVID-19 Vaccination date:</td>
<td><strong><strong>/</strong></strong>/_______</td>
</tr>
<tr>
<td>COVID-19 Vaccination Manufacturer:</td>
<td></td>
</tr>
<tr>
<td>Did the patient receive both doses of vaccine? (if applicable)</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Did there documentation that this patient was included in a COVID-19 vaccine trial?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>Influenza Vaccination:</td>
<td></td>
</tr>
<tr>
<td>Physician:</td>
<td></td>
</tr>
</tbody>
</table>

**Newborn/Neonate Tab**

| Did mother receive prenatal care? | ☐ Yes | ☐ No | ☐ Not Documented |
| Maternal Conditions (check all that apply) | ☐ Not Documented | ☐ GHTN (Pregnancy induced/Gestational Hypertension) |
| | ☐ None | ☐ Maternal Group B Strep (Positive) |
| | ☐ Alcohol Use | ☐ Methamphetamine/ICE use |
| | ☐ Chorioamnionitis | ☐ Narcotic given to mother within 4 hrs. of delivery |
| | ☐ Cocaine/Crack use | ☐ Narcotics addiction and/or on methadone maintenance |
| | ☐ Diabetes | ☐ Prior Cesarean |
| | ☐ Eclampsia | ☐ Urinary Tract Infection (UTI) |
| | ☐ Magnesium Exposure | |
## Major Trauma
- [ ] Other, Specify: ____________________

## Maternal Infection
- [ ] Other, Specify: ____________________

### Delivery Details

#### Fetal Monitoring
- [ ] None
- [ ] External
- [ ] Internal
- [ ] Performed, method unknown
- [ ] Unknown/Not documented

#### Delivery Mode
- [ ] Vaginal/Spontaneous
- [ ] Vaginal/Operative
- [ ] VBAC
- [ ] C-section/ Scheduled
- [ ] C-section/ Emergent
- [ ] Unknown/Not Documented

### Fetal Delivery Presentation
- [ ] Cephalic
- [ ] Breech
- [ ] Unknown/Not Documented

#### Apgar Scores:
- 1 min: _________
- 5 min: _________
- 10 min: _________
- 15 min: _________
- 20 min: _________
- [ ] Unknown/Not Assigned

#### Cord pH
- _________
- [ ] Unknown/Not Documented

#### Sample Location
- [ ] Arterial
- [ ] Venous
- [ ] Unknown/Not Documented

#### Best Estimate of gestational age (weeks)
- _________
- [ ] Unknown/Not Documented

### Special Circumstances Recognized at Birth (select all that apply)

- [ ] None
- [ ] Cord Prolapse
- [ ] Meconium Aspiration
- [ ] Nuchal Cord
- [ ] Placenta Abruption
- [ ] Placenta Previa
- [ ] Shoulder Dystocia
- [ ] Other, Specify ___________
- [ ] Abdominal Wall Defects
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Congenital Cystic Adenomatoid Malformation/Congenital Pulmonary Airway Malformation
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Congenital Diaphragmatic Hernia
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Cardiac Malformation / Abnormality - Acyanotic
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Cardiac Malformation / Abnormality - Cyanotic
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Congenital Malformation / Abnormality (Non-cardiac)
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Decelerations
- [ ] Prenatal Dx
- [ ] Postnatal Dx
- [ ] Fetal Hydrops
- [ ] Prenatal Dx
- [ ] Postnatal Dx

### DISCHARGE DATA

#### Discharge Tab

**Was induced hypothermia initiated after return of circulation (ROC) achieved?**
- [ ] Yes
- [ ] No/Not Documented
- [ ] N/A

**Discharge Status**
- [ ] Dead
- [ ] Alive
- [ ] Disposition Pending

**During this admission, was a standardized health related social needs form or assessment completed?**
- [ ] Yes
- [ ] No/ND

**If yes, identify the areas of unmet social need. (select all that apply):**
- [ ] None of the areas of unmet social need listed
- [ ] Education
- [ ] Employment
- [ ] Financial Strain
- [ ] Food
- [ ] Living Situation/Housing
- [ ] Mental Health
- [ ] Personal Safety
- [ ] Substance Abuse
- [ ] Transportation Barriers
- [ ] Utilities

**Was there Active or Suspected COVID-19 diagnosis in the 2 weeks prior to admission or during this hospitalization?**
- [ ] Yes, prior to admission
- [ ] Yes, during hospitalization
- [ ] No
- [ ] Unknown/ND
Method of Diagnosis:
- COVID-19 confirmed by a lab test
- Clinical diagnosis assigned by hospital-specific criteria (suspected)
- Unknown/ND

Date/Time of Diagnosis: ____________________________ : ____________  □ Unknown

Discharge Disposition:
- 1 Home
- 2 Hospice - Home
- 3 Hospice - Health Care Facility
- 4 Acute Care Facility
- 5 Other Healthcare Facility
- 6 Expired
- 7 Left Against Medical Advice
- 8 Not Documented or UTD

Facility patient was transferred to:

If Acute Care Facility, Reason(s) for transfer (select all that apply):
- □ Administrative
- □ Patient/family request
- □ Procedure/Service not available at this hospital

If Other Healthcare Facility:
- □ Skilled Nursing Facility (SNF)
- □ Inpatient Rehabilitation Facility (IRF)
- □ Long Term Care Hospital (LTCH)
- □ Intermediate Care Facility (ICF)
- □ Other

Date/Time of Hospital Discharge/Death ____________________________ : ____________  □ Unknown

Declared DNAR during this admission?  □ Yes  □ No

If yes, Date/Time of DNAR order ____________________________ : ____________  □ Time Not Documented

If patient died:

Was Life Support Withdrawn?  □ Yes  □ No

Were organs recovered?  □ Yes  □ No

Discharge Adult Cerebral Performance Categories/CPC Scale:
- □ 1 Good cerebral performance
- □ 2 Moderate cerebral disability
- □ 3 Severe cerebral disability
- □ 4 Coma or vegetative state
- □ 5 Brain death
- □ Unknown/Not Documented/Not Applicable

Discharge Pediatric/Neonate Cerebral Performance Categories/PCPC Scale:
- □ 1 Normal
- □ 2 Mild cerebral disability
- □ 3 Moderate cerebral disability
- □ 4 Severe cerebral disability
- □ 5 Coma or vegetative state
- □ 6 Brain death
- □ Unknown/Not Documented/Not Applicable

Comments

END OF ADMISSION & DISCHARGE FORM