

Note: Optional data elements appear in the Get With The Guidelines® - Resuscitation PMT as dark grey shaded areas.

1.1 Admission Data	Admission Tab
System Entry Date/Time: ____/____/____ ____:____ <input type="checkbox"/> Time Not Documented	
Born this admission (or transferred from birth hospital)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date/Time of Birth: ____/____/____ ____:____ <input type="checkbox"/> DOB Unknown/Not Documented <input type="checkbox"/> Time Not Documented	
Age at System Entry: _____ in years months weeks days hours minutes <input type="checkbox"/> Estimated? <input type="checkbox"/> Age Unknown/Not Documented	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> UTD	
OPTIONAL: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Japanese <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No/UTD Optional, If Yes: <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latin or Spanish Origin	
Birth Weight (patients <30 days old only): _____ Units: <input type="checkbox"/> pounds <input type="checkbox"/> kilograms <input type="checkbox"/> grams <input type="checkbox"/> Birth Weight Unknown/Not Documented <input type="checkbox"/> Weight same as birth weight	
Weight (required for pediatric and newborn/neonate patients only): _____ Units: <input type="checkbox"/> pounds <input type="checkbox"/> kilograms <input type="checkbox"/> grams <input type="checkbox"/> Weight Unknown/ND	
Length (patients <30 days old only): _____ Units: <input type="checkbox"/> inches <input type="checkbox"/> centimeters <input type="checkbox"/> Length Unknown/Not Documented	
Head Circumference (patients <30 days old only): _____ Units: <input type="checkbox"/> inches <input type="checkbox"/> centimeters <input type="checkbox"/> Circum. Unknown/Not Documented	
CPC/PCPC Scoring Definitions	
Admission CPC: _____ <input type="checkbox"/> Unknown/Not Documented/Not Applicable	
Admission PCPC: _____ <input type="checkbox"/> Unknown/Not Documented/Not Applicable (newborn)	
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
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

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1.2 Newborn/Neonate	Admission Tab				
<p>Did mother receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Documented</p> <p>Maternal Conditions (check all that apply)</p> <p><input type="checkbox"/> Not Documented</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> None <input type="checkbox"/> Alcohol use <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Cocaine/Crack use <input type="checkbox"/> Diabetes </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Eclampsia <input type="checkbox"/> GHTN (Pregnancy induced / gestational hypertension) <input type="checkbox"/> Magnesium exposure <input type="checkbox"/> Major trauma <input type="checkbox"/> Maternal Group B Strep (Positive) </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Maternal infection <input type="checkbox"/> Methamphetamine/ICE use <input type="checkbox"/> Narcotic given to mother within 4 hours of delivery <input type="checkbox"/> Narcotics addiction and/or on methadone maintenance </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Prior Cesarean <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Other _____ (specify) _____ </td> </tr> </table>		<input type="checkbox"/> None <input type="checkbox"/> Alcohol use <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Cocaine/Crack use <input type="checkbox"/> Diabetes	<input type="checkbox"/> Eclampsia <input type="checkbox"/> GHTN (Pregnancy induced / gestational hypertension) <input type="checkbox"/> Magnesium exposure <input type="checkbox"/> Major trauma <input type="checkbox"/> Maternal Group B Strep (Positive)	<input type="checkbox"/> Maternal infection <input type="checkbox"/> Methamphetamine/ICE use <input type="checkbox"/> Narcotic given to mother within 4 hours of delivery <input type="checkbox"/> Narcotics addiction and/or on methadone maintenance	<input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Prior Cesarean <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Other _____ (specify) _____
<input type="checkbox"/> None <input type="checkbox"/> Alcohol use <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Cocaine/Crack use <input type="checkbox"/> Diabetes	<input type="checkbox"/> Eclampsia <input type="checkbox"/> GHTN (Pregnancy induced / gestational hypertension) <input type="checkbox"/> Magnesium exposure <input type="checkbox"/> Major trauma <input type="checkbox"/> Maternal Group B Strep (Positive)	<input type="checkbox"/> Maternal infection <input type="checkbox"/> Methamphetamine/ICE use <input type="checkbox"/> Narcotic given to mother within 4 hours of delivery <input type="checkbox"/> Narcotics addiction and/or on methadone maintenance	<input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Prior Cesarean <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Other _____ (specify) _____		
<p><u>Delivery Details</u></p> <p>Fetal Monitoring:</p> <p><input type="checkbox"/> External <input type="checkbox"/> Internal <input type="checkbox"/> Performed, method unknown <input type="checkbox"/> Unknown/Not documented <input type="checkbox"/> None</p> <p>Delivery Mode:</p> <p><input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal-operative <input type="checkbox"/> C-section/ scheduled <input type="checkbox"/> C-section/ emergent <input type="checkbox"/> Unknown/Not Documented</p> <p>Presentation:</p> <p><input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Unknown/Not Documented</p> <p>Apgar Scores</p> <p>1 min: _____ <input type="checkbox"/> Unknown/-Not assigned</p> <p>5 min: _____ <input type="checkbox"/> Unknown/-Not assigned</p> <p>10 min: _____ <input type="checkbox"/> Unknown/Not assigned</p> <p>15 min: _____ <input type="checkbox"/> Unknown/Not assigned</p> <p>20 min: _____ <input type="checkbox"/> Unknown/Not assigned</p> <p>Cord pH: _____ <input type="checkbox"/> Unknown/Not documented Sample location: <input type="checkbox"/> Arterial <input type="checkbox"/> Venous <input type="checkbox"/> Unknown/Not Documented</p> <p>Best Estimate of gestational age (weeks): _____ <input type="checkbox"/> Unknown/Not documented</p> <p>Special Circumstances Recognized at Birth (select all that apply):</p>					

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- | | | |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> None | | |
| <input type="checkbox"/> Abdominal Wall Defects | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Congenital Cystic Adenomatoid Malformation/Congenital Pulmonary Airway Malformation | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Congenital Diaphragmatic Hernia | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Cardiac Malformation/Abnormality – Acyanotic | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Cardiac Malformation/Abnormality – Cyanotic | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Congenital Malformation/Abnormality (Non-Cardiac) | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Cord Prolapse | | |
| <input type="checkbox"/> Decelerations | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Fetal Hydrops | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Meconium Aspiration | | |
| <input type="checkbox"/> Multiple Gestations | <input type="checkbox"/> Prenatal Dx | <input type="checkbox"/> Postnatal Dx |
| <input type="checkbox"/> Nuchal Cord | | |
| <input type="checkbox"/> Placenta Abruption | | |
| <input type="checkbox"/> Placenta Previa | | |
| <input type="checkbox"/> Shoulder Dystocia | | |
| <input type="checkbox"/> Other: _____ | | |

1.3 Induced Hypothermia

Discharge Tab

Was induced hypothermia initiated? Yes No/Not Documented N/A

1.4 Discharge Data

Discharge Tab

Discharge Status:

- Dead
- Alive
- Disposition Pending

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 unable to determine

If Other Health Care 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: ____/____/____ ____:____ Time Not Documented

Declared DNAR during this admission? Yes No

If yes, Date/Time of DNAR order: ____/____/____ ____:____ Time Not Documented

If patient died:

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Was Life Support Withdrawn? Yes No

Were organs recovered? Yes No

If patient survived to discharge:

CPC at Discharge: _____ Unknown/Not Documented

PCPC at Discharge: _____ Unknown/Not Documented

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

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

Comments & Optional Fields – Do not enter any Personal Health Information/Protected Health Information into this section.

Field 1	Field 2
Field 3	Field 4
Field 5	Field 6
Field 7	Field 8
Field 9	Field 10
Field 11	Field 12
Field 13	Field 14