Neonatal Medical Record Face Sheet

(To be completed on every record selected)

<table>
<tr><td rowspan="2">MRN #</td><td colspan="3">Last Name:</td></tr>
<tr><td>Delivery Date/Time:</td><td>Gestational Age/Wt:</td><td>Apgars:</td></tr>
<tr><td>Maternal History/Complications /Diagnoses:

Prenatal Care: Yes ☐ No ☐</td><td colspan="3">Inborn ☐ Transfer In ☐

Admit/Arrival Date and Time: _____

Delivery complications:</td></tr>
<tr><td>Mode of Delivery:
Vaginal ☐
Forceps ☐ Vacuum ☐

VBAC ☐ Attempt ☐

Cesarean ☐
Urgent ☐ Emergent ☐</td><td>Neonatal Team Present at Birth:

Yes ☐ No ☐

Multiple:

Yes ☐ No ☐</td><td colspan="2">Resuscitation at Birth:
Yes ☐ No ☐

Intubation at Birth:
Yes ☐ # attempts: _____

Medications: ☐
_____</td></tr>
<tr><td>Neonatal Diagnoses/Complications:</td><td colspan="3"></td></tr>
<tr><td>Additional Neonatal Care Requirements:</td><td colspan="3">Echo ☐ Ultrasound ☐ MRI ☐ TPN ☐ Gastric feeds ☐ Antibiotics ☐</td></tr>
<tr><td>Additional Critical Treatments:

_____</td><td colspan="3">Ventilator – iNO ☐ High Frequency ☐ Conventional ☐
Days: _____ Days: _____ Days: _____

CPAP ☐ Days: _____ Central Lines ☐ Days: _____</td></tr>
<tr><td>Surgical or Interventional Procedures:

Bedside ☐ OR ☐</td><td colspan="3">List procedures and complications:</td></tr>
<tr><td>Consult Specialties:</td><td colspan="3"></td></tr>
<tr><td>Telemedicine: Yes ☐
No ☐</td><td colspan="3">Specialty: _____</td></tr>
<tr><td>Ancillary Services:</td><td colspan="3">Social Services ☐ Spiritual Care ☐ Lactation ☐ Dietary ☐
Physical Therapy/Occupational Therapy ☐ Speech Therapy ☐
Respiratory Therapy ☐ Other: _____</td></tr>
</table>

Patient Final Disposition Date:	Expired ☐ Transfer Out ☐ Discharged Home ☐ Other: _____	Total Length of Stay:

1) PI Event Identified and Level of Harm Event: Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
2) PI Event Identified and Level of Harm Event: Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
3) PI Event Identified and Level of Harm Event Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
Outreach Education to Transferring Facility/Transport:	Identified and Documented: Yes ☐ No ☐