

## Neonatal Medical Record Face Sheet

(To be completed on every record selected)

MRN #	Last Name:		
	Delivery Date/Time:	Gestational Age/Wt:	Apgars:
Maternal History/Complications /Diagnoses:          Prenatal Care: Yes <input type="checkbox"/> No <input type="checkbox"/>	Inborn <input type="checkbox"/> Transfer In <input type="checkbox"/>  Admit/Arrival Date and Time:  Delivery complications:		
Mode of Delivery: Vaginal <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/>  VBAC <input type="checkbox"/> Attempt <input type="checkbox"/>  Cesarean <input type="checkbox"/> Urgent <input type="checkbox"/> Emergent <input type="checkbox"/>	Neonatal Team Present at Birth:  Yes <input type="checkbox"/> No <input type="checkbox"/>  Multiple:  Yes <input type="checkbox"/> No <input type="checkbox"/>	Resuscitation at Birth: Yes <input type="checkbox"/> No <input type="checkbox"/>  Intubation at Birth: Yes <input type="checkbox"/> # attempts: _____  Medications: <input type="checkbox"/>	
Neonatal Diagnoses/Complications:			
Additional Neonatal Care Requirements:	Echo <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI <input type="checkbox"/> TPN <input type="checkbox"/> Gastric feeds <input type="checkbox"/> Antibiotics <input type="checkbox"/>		
Additional Critical Treatments:	Ventilator – iNO <input type="checkbox"/> High Frequency <input type="checkbox"/> Conventional <input type="checkbox"/> Days: _____ Days: _____ Days: _____  CPAP <input type="checkbox"/> Days: _____ Central Lines <input type="checkbox"/> Days: _____		
Surgical or Interventional Procedures:  Bedside <input type="checkbox"/> OR <input type="checkbox"/>	List procedures and complications:		
Consult Specialties:			
Telemedicine: Yes <input type="checkbox"/> No <input type="checkbox"/>	Specialty: _____		
Ancillary Services:	Social Services <input type="checkbox"/> Spiritual Care <input type="checkbox"/> Lactation <input type="checkbox"/> Dietary <input type="checkbox"/> Physical Therapy/Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Other:		

Patient Final Disposition Date:	Expired <input type="checkbox"/> Transfer Out <input type="checkbox"/> Discharged Home <input type="checkbox"/> Other:	Total Length of Stay:
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1) PI Event Identified and Level of Harm Event:  Level of Harm:  Date:	Primary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Secondary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Tertiary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
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Action Items that Occurred as Result of Review:	Loop Closure: Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing <input type="checkbox"/>
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2) PI Event Identified and Level of Harm Event:  Level of Harm:  Date:	Primary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Secondary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Tertiary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
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Action Items that Occurred as Result of Review:	Loop Closure: Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing <input type="checkbox"/>
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3) PI Event Identified and Level of Harm Event:  Level of Harm:  Date:	Primary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Secondary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Tertiary Review: Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
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Action Items that Occurred as Result of Review:	Loop Closure: Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing <input type="checkbox"/>
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Outreach Education to Transferring Facility/Transport:	Identified and Documented: Yes <input type="checkbox"/> No <input type="checkbox"/>
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