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Collection: LOGIN
Contains: DATSTAT_ALTPID



Salud Mesoamerica Initiative (SMI)
Login page for the Health Facility Survey

Question: DATSTAT_ALTPID
Required



ID:

Collection: MEDICAL_RECORD_REVIEW
Contains: MRR_LOG_IN, MRR_OBSTETRIC

Medical Record Review

Collection: MRR_LOG_IN
Contains: MRR_DATE, MRR_INTERVW_ID1, MRR_INTERVW_ID2, MRR_TYPE_UNIT, DISTRICT_ID, FACILITY_ID

Please keep in mind that all questions in this section refer to newborn measurements and procedures, unless otherwise specified.

Question: MRR_DATE
Required



1. Today's date:

 (DD/MM/YYYY)

Question: MRR_INTERVW_ID1
Required



2. Interviewer ID 1:

Question: MRR_INTERVW_ID2



3. Interviewer ID 2:

Question: MRR_TYPE_UNIT
Required



Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit/ Polyclinic	<i>Never Shown</i>
2	Community Hospital	
3	Regional Hospital	

4. What type of health facility is this?

- ☐ Health Clinic / Health Post / Mobile Unit/ Polyclinic
☐ Community Hospital
☐ Regional Hospital

Question: DISTRICT_ID
Required



Scale Summary		
Code	Label	Show-If
2001	Orange Walk	
2002	Corozal District	
2004	Cayo District	
995	Other	






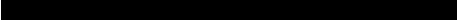





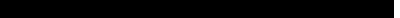






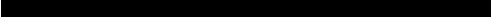

5. District ID:

- ☐ Orange Walk

- ☐ Other

Scale Summary

[illegible]

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☐ Other (specify):

Contains: NEONATAL_COMPLICATIONS

Conjunction: NEO_NATURAL_COMPLICATIONS
Contains: NEO_BIRTH_DATE, NEO_BIRTH_TIME, NEO_BIRTH_WEIGHT, NEO_BIRTH_WHERE, MRR_SELECTION, MRR_SELECTION_BACKUP, MRR_NEO_COMP, MRR_NEO_GEN, GEN_COMPL_INFO, NEO_SEPSIS, NEO_LBW, NEO_PRE, NEO_ASP, GEN_DISPOSITION
Show if: (FACILITY_TYPE >= 2)

**Question
Required**

Scale Summary		
Code	Label	Show-If
1	Yes:	
-1	Not recorded	

Date of birth

- ☐ Yes: (DD/MM/YYYY)
- ☐ Not recorded

**Question
Required**

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

8. Please note if the following is recorded for the baby:

Time of birth

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: NEO_BIRTH_WEIGHT
Minimum checks: 1

9. Please note if the weight of the baby was recorded at the time of birth (for example: 2600 grams)

- ☐ Weight (in grams):
- ☐ Weight (in kilograms):
- ☐ Weight (in pounds):
- ☐ Weight (in ounces):
- ☐ Not recorded

Question: NEO_BIRTH_WHERE
Required

Scale Summary		
Code	Label	Show-If
1	In this health facility	
2	In another health facility	
3	In the home	
4	En route to this facility	
995	Other (specify):	
-1	Not recorded	

10. Where did the birth occur?

- ☐ In this health facility
- ☐ In another health facility
- ☐ In the home
- ☐ En route to this facility
- ☐ Other (specify):
- ☐ Not recorded

This file is ineligible. Please check records with birth dates between 24/09/2015 - 20/09/2017 or 04/04/2011-31/03/2013.

Jump-To: JMP2

Description:

Jump-To-Item: END

Jump-If: ((DATE_ELEGIBILITY_2015 = 0) and (DATE_ELEGIBILITY_2017 = 1)) or ((DATE_ELEGIBILITY_2017 = 0) and (DATE_ELEGIBILITY_2015 = 1)) or ((DATE_ELEGIBILITY_2011 = 0) and (DATE_ELEGIBILITY_2013 = 1)) or ((DATE_ELEGIBILITY_2011 = 1) and (DATE_ELEGIBILITY_2013 = 0))

Review the Hospital Admission and Exit Record Sheet and record the discharge and diagnostic codes that are included

Custom Layout Question: NEO_ICD_CODE

11.

ICD-10 code (for example: W55.2 or S10.87) Discharge diagnosis

Principal ICD-10 code	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="radio"/> Not recorded	<input type="text"/>	<input type="radio"/> Not recorded
Second ICD-10 code	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="radio"/> Not recorded	<input type="text"/>	<input type="radio"/> Not recorded
Third ICD-10 code	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="radio"/> Not recorded	<input type="text"/>	<input type="radio"/> Not recorded
Fourth ICD-10 code	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="radio"/> Not recorded	<input type="text"/>	<input type="radio"/> Not recorded
Fifth ICD-10 code	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="radio"/> Not recorded	<input type="text"/>	<input type="radio"/> Not recorded

Question: MRR_SELECTION
Required

Scale Summary		
Code	Label	Show-If
1	Sample determined by IHME (including backups)	
2	Electronic sample at the health facility	
3	Manual sample at the health facility	
995	Other:	

12. Method used to select the medical record:

- ☐ Sample determined by IHME (including backups)
- ☐ Electronic sample at the health facility

- ☐ Manual sample at the health facility
- ☐ Other:

Question: MRR_SELECTION_BACKUP

Required

Show if: (MRR_SELECTION = 1:[Sample determined by IHME (including backups)])


Scale Summary		
Code	Label	Show-If
1	Yes	
2	No, this was a backup medical record determined by IHME	
995	Other:	

 13. Was this record from the original sample determined by IHME?

- ☐ Yes
- ☐ No, this was a backup medical record determined by IHME
- ☐ Other:

Question: MRR_NEO_COMP

Minimum checks: 1

 14. Did the baby have any of the following complications?

- ☐ Sepsis
- ☐ Low birth weight
- ☐ Birth asphyxia
- ☐ Prematurity
- ☐ None of the above

Jump-To: JMP3

Description:

Jump-To-Item: NO_COMPL

Jump-If: (MRR_NEO_COMP is-any-of)


Collection: MRR_NEO_GEN

Contains: MRR_AGE_BABY, MRR_AGE_MOM, MRR_MOM_LITERACY, MRR_MOM_EDU, MRR_MOM_MAR_STAT, MRR_MOM_ETHNICITY, MRR_MOM_BOOKING, MRR_MOM_SICKLE, MRR_MOM_DIST

Question: MRR_AGE_BABY

Required

Scale Summary		
Code	Label	Show-If
3	Age in years:	Never Shown
2	Age in months:	
1	Age in days:	
0	Age in hours:	
-1	Not registered	


 15. Age of the child

- ☐ Age in years:
- ☐ Age in months:
- ☐ Age in days:
- ☐ Age in hours:
- ☐ Not registered

Question: MRR_AGE_MOM

Required

Scale Summary		
Code	Label	Show-If
1	Age:	
-1	Not recorded	


 16. Age of the mother

- ☐ Age:
- ☐ Not recorded

Question: MRR_MOM_LITERACY

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	
-1	Not recorded	

 17. Read and write (mother)

- ☐ Yes
- ☐ No
- ☐ Not recorded

Question: MRR_MOM_EDU**Required**

Scale Summary		
Code	Label	Show-If
1	None	
2	Primary	
3	Secondary	
5	University	
-1	Not recorded	

**18. Education:**

- ☐ None
☐ Primary
☐ Secondary
☐ University
☐ Not recorded

Question: MRR_MOM_MAR_STAT**Required**

Scale Summary		
Code	Label	Show-If
1	Married	
2	Single	
3	Common law wife	
5	Divorced	
6	Widowed	
995	Other (specify):	
-1	Not recorded	

**19. Marital status:**

- ☐ Married
☐ Single
☐ Common law wife
☐ Divorced
☐ Widowed
☐ Other (specify):
☐ Not recorded

Question: MRR_MOM_ETHNICITY**Required**

Scale Summary		
Code	Label	Show-If
1	Creole	
2	East Indian	
3	Garifuna	
4	Chinese / Taiwanese	
5	Mayan (Mopan, Yucatec, Ketchi)	
6	Caucasian	
7	Mestizo	
8	Mennonite	
995	Other (specify)	
-1	Not recorded	

**20. Ethnicity:**

- ☐ Creole
☐ East Indian
☐ Garifuna
☐ Chinese / Taiwanese
☐ Mayan (Mopan, Yucatec, Ketchi)
☐ Caucasian
☐ Mestizo
☐ Mennonite
☐ Other (specify)
☐ Not recorded

Question: MRR_MOM_BOOKING

Scale Summary		
Code	Label	Show-If
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21. Booking facility identified on the CLAP form:

- ☐ Other (specify):
- ☐ Not recorded

Question:
Required

22. Sick Cell status:

- ☐ Neg
- ☐ Not recorded

Question:
Required

23. What district is the woman from:

- ☐ Other
- ☐ Not recorded

Contains: NEO_ADM_REFFROM, NEO_REF_ACCOMFROM, NEO_REF_DATEFROM, NEO_REF_TIMEFROM, NEO_REF_NAMEFROM, NEO_REF_TYPEFROM, NEO_REF_WEIGHTFROM, NEO_ADM_DATES, NEO_ADM_TIMES, NEO_GESTAGES, NEO_GENDERS, NEO_MOMCOMPLS, NEO_MOMCOMPLS_PRE

Required

☐ Yes

☐ No

- ☐ Yes, by a doctor
- ☐ Yes, by a nurse
- ☐ Yes, by another
- ☐ No
- ☐ Not recorded

☐ Date: (DD/MM/YYYY)

☐ Not recorded

☐ Time (HH:MM)


☐ Not recorded

○ [REDACTED]

- Question:** NEO_REF_TYPEFROM
Required
Show if: (NEO_ADM_REFFROM = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

 30. Please note if the weight was recorded before the referral/transfer (for example: 2600 grams)

☐ Weight (in grams):

☐ Weight (in kilograms):

☐ Weight (in pounds):

☐ Weight (in ounces):


☐ Not recorded

31. Please note if date of admission is recorded:

☐ Yes: (DD/MM/YYYY)

☐ Not recorded

Question: NEO_ADM_TIMES		
Required		
Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	


 32. Please note if the time of admission is recorded

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: NEO_GESTAGES

Required

Scale Summary		
Code	Label	Show-If
1	Age:	
-1	Not recorded	


 33. Gestational age of the baby

- ☐ Age: semanas
- ☐ Not recorded

Question: NEO_GENDERS

Required


Scale Summary		
Code	Label	Show-If
1	Male	
2	Female	
-1	Not recorded	

 34. Gender of the baby

- ☐ Male
- ☐ Female
- ☐ Not recorded

Question: NEO_MOMCOMPLS

Minimum checks: 1

 35. Did the mother have the following complications? (Select all that apply)


- ☐ Pre eclampsia
- ☐ Eclampsia
- ☐ Sepsis
- ☐ Hemorrhage
- ☐ Other
- ☐ No complications
- ☐ Not recorded

Question: NEO_MOMCOMPLS_PRE

Required

Show if: (NEO_MOMCOMPLS is-any-of)

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	
-1	Not recorded	

 36. Did the mother have severe pre-eclampsia?

- ☐ Yes
- ☐ No
- ☐ Not recorded

Collection: NEO_SEPSIS

Contains: NEO_SEP

Show if: (MRR_NEO_COMP is-any-of)

Note whether the following was recorded for the patient with sepsis.


Collection: NEO_SEP

Contains: NEO_SEP_CONSULT, NEO_SEP_CON_EVER, NEO_SEP_SPECIAL_EVER, NEO_SEP_SPECIAL_TYPE, NEO_SEP_CONSULT_DATE, NEO_SEP_CONSULT_TIME, NEO_SEP_CONSULT_SPECIAL_DATE, NEO_SEP_CONSULT_SPECIAL_TIME, NEO_SEP_MEDICATIONS_, NEO_SEP_OTHER_COMP

Show if: (FACILITY_TYPE >= 2)

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup for each item listed below**.

Custom Layout Question: NEO_SEP_CHECK1

	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
 37. Blood pressure (bp)	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first checkup for each item listed below**.

Custom Layout Question: NEO_SEP_CHECK2

38.	Recorded Date (DD/MM/YYYY)	Time (HH:MM)
Skin color	<input type="text"/>	<input type="text"/>
Distal temperature (ex: distal coldness)	<input type="text"/>	<input type="text"/>
Abdominal examination	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.

Custom Layout Question: NEO_SEP_LAB

39.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count	<input type="text"/> x10 ^ 3 litro	<input type="text"/>	<input type="text"/>
C-reactive protein	<input type="text"/> mg/dL or +/-	<input type="text"/>	<input type="text"/>
Erythrocyte sedimentation rate	<input type="text"/> mm/h	<input type="text"/>	<input type="text"/>
Oxygen saturation	<input type="text"/> %	<input type="text"/>	<input type="text"/>
Platelets	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hemoglobin	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hematocrit	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood culture	<input type="text"/>	<input type="text"/>	<input type="text"/>
Neutrophil band ratio	<input type="text"/>	<input type="text"/>	<input type="text"/>
Absolute neutrophil count	<input type="text"/>	<input type="text"/>	<input type="text"/>
Neutrophil morphology	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glycemia	<input type="text"/> mg/dL	<input type="text"/>	<input type="text"/>
Complete blood count	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: NEO_SEP_CONSULT

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	
-1	Not recorded	

40. Was the baby evaluated by a doctor at the time of admission?

☐ Yes
☐ No
☐ Not recorded

Question: NEO_SEP_CON_EVER

Required

Scale Summary		
Code	Label	Show-If

1	Yes	
0	No	

41. Was the baby ever evaluated by a doctor?

- ☐ Yes
☐ No

Question: NEO_SEP_SPECIAL_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	

42. Was the baby ever evaluated by a specialist?

- ☐ Yes, marked with an 'ME' notation in the signature
☐ Yes, marked with a stamp
☐ Yes, marked with another method (specify)
☐ No
☐ Not recorded

Question: NEO_SEP_SPECIAL_TYPE

Required

Show if: (NEO_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Pediatrician	
2	Obstetrician	
3	Gynecologist	
4	OBGYN	
5	Surgeon	
6	Neonatologist	
995	Other (specify):	
-1	Not recorded	

43. What type of specialist evaluated the baby?

- ☐ Pediatrician
☐ Obstetrician
☐ Gynecologist
☐ OBGYN
☐ Surgeon
☐ Neonatologist
☐ Other (specify):
☐ Not recorded

Question: NEO_SEP_CONSULT_DATE

Required

Show if: (NEO_SEP_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

44. Date of the first evaluation by a doctor

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: NEO_SEP_CONSULT_TIME

Required

Show if: (NEO_SEP_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

45. Time of the first evaluation by a doctor:

- ☐ Time: (HH:MM)
☐ Not recorded

Question: NEO_SEP_CONSULT_SPECIAL_DATE

Required

Show if: (NEO_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If

1	Date:	
-1	Not recorded	

46. Date of the first evaluation by a specialist

- ☐ Date: (DD/MM/YYYY)
- ☐ Not recorded

Question: NEO_SEP_CONSULT_SPECIAL_TIME

Required

Show if: (NEO_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

47. Time of the first evaluation by a specialist

- ☐ Time: (HH:MM)
- ☐ Not recorded

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: NEO_SEP_MED1

48.	Administered Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Amikacine	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Sulbactam	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Piperacillin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Clindamycin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Gentamicin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Metronidazole	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Penicillin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Crystalline Penicillin	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Tazobactam	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other antibiotic (specify)	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

Question: NEO_SEP_MEDICATIONS_

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

49. Were any of the above mentioned medications administered at the same time during this hospitalization?

- ☐ Yes
- ☐ No

Question Block: NEO_SEP_OTHER_COMP

Contains: NEO_SEP_OTHER_COMP_MULT, NEO_SEP_OTHER_COMP_HEMO, NEO_SEP_OTHER_COMP_SHOCK, NEO_SEP_OTHER_COMP_OTH

Required

Scale Summary		
Code	Label	Show-If

1	Yes	
0	No	

50. Note if there were any other complications with the baby:

	Yes	No
Multi-organ failure	<input type="radio"/>	<input type="radio"/>
Hemodynamic failure	<input type="radio"/>	<input type="radio"/>
Septic shock	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Collection: NEO_LBW_

Contains: NEO_LBW_

Show if: (MRR_NEO_COMP is-any-of)

Note whether the following was recorded for the patient with low birth weight.

Collection: NEO_LBW_

Contains: NEO_LBW_GEST_METHOD, NEO_LBW_CLASSIFICATION, NEO_LBW_GLY_TYPE, NEO_LBW_CONSULT, NEO_LBW_CON_EVER, NEO_LBW_SPECIAL_EVER, NEO_LBW_SPECIAL_TYPE, NEO_LBW_CONSULT_DATE, NEO_LBW_CONSULT_TIME, NEO_LBW_CONSULT_SPECIAL_DATE, NEO_LBW_CONSULT_SPECIAL_TIME, NEO_LBW_PROC_OXY, NEO_LBW_PROC_HEAT, NEO_LBW_PROC_OTHER, NEO_LBW_CPR, NEO_LBW_PROC_OXYOTH_SPEC, NEO_LBW_PROC_HTOOTH_SPEC, NEO_LBW_PROC_OTHOTH_SPEC, NEO_LBW_BABYFOOD, NEO_LBW_MEDICATIONS, NEO_LBW_OTHER_COMP

Show if: (FACILITY_TYPE >= 2)

Question Block: NEO_LBW_GEST_METHOD

Contains: NEO_LBW_GEST_METHOD_1, NEO_LBW_GEST_METHOD_2, NEO_LBW_GEST_METHOD_3, NEO_LBW_GEST_METHOD_4, NEO_LBW_GEST_METHOD_5, NEO_LBW_GEST_METHOD_995

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
-1	Not recorded	

54. Please check the method of gestational age assessment (select all that apply)

	Yes	Not recorded
LMP (last menstrual period)	<input type="radio"/>	<input type="radio"/>
ECO	<input type="radio"/>	<input type="radio"/>
Ballard test	<input type="radio"/>	<input type="radio"/>
Head circumference	<input type="radio"/>	<input type="radio"/>
Capurro test	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: NEO_LBW_CLASSIFICATION

Required

Scale Summary		
Code	Label	Show-If
1	Low weight	
2	Very low weight	
3	Extreme low weight	
995	Other (specify)	
-1	Not recorded	

60. Classification according to weight:

- ☐ Low weight
☐ Very low weight
☐ Extreme low weight
☐ Other (specify)
☐ Not recorded

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup for each item listed below.**

Custom Layout Question: NEO_LBW_CHECK1

61.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="checkbox"/> <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="checkbox"/> <input type="text"/> per minute	<input type="text"/>	<input type="text"/>

Temperature (T°)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Weight	<input type="text"/>	<input type="text"/>	<input type="text"/>
Length/height	<input type="text"/>	<input type="text"/>	<input type="text"/>
Head circumference	<input type="text"/>	<input type="text"/>	<input type="text"/>
Downes score	<input type="text"/>	<input type="text"/>	<input type="text"/>
Silverman score	<input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 1 minute	<input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 5 minutes	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first checkup for each item listed below**.

Custom Layout Question: NEO_LBW_CHECK2

62.	Recorded Date (DD/MM/YYYY)	Time (HH:MM)
Skin color	<input type="text"/>	<input type="text"/>
Abdominal examination	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.

Custom Layout Question: NEO_LBW_LAB1

63.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Oxygen saturation level	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glycemia	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: NEO_LBW_GLY_TYPE

Required

Show if: (NEO_LBW_LAB_REG_GLY = 1)

Scale Summary		
Code	Label	Show-If
1	Test strip	
2	Blood test	
995	Other (specify):	
-1	Not recorded	

64. What type of test was used for glycemia?
<input type="radio"/> Test strip <input type="radio"/> Blood test <input type="radio"/> Other (specify): <input type="text"/> <input type="radio"/> Not recorded

Question: NEO_LBW_CONSULT

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

65. Was the baby evaluated by a doctor at the time of admission?
--

- ☐ Yes
☐ No

Question: NEO_LBW_CON_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	


 66. Was the baby ever evaluated by a doctor?

- ☐ Yes
☐ No

Question: NEO_LBW_SPECIAL_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify):	
0	No	
-1	Not recorded	

 67. Was the baby ever evaluated by a specialist?


- ☐ Yes, marked with an 'ME' notation in the signature
☐ Yes, marked with a stamp
☐ Yes, marked with another method (specify):
☐ No
☐ Not recorded

Question: NEO_LBW_SPECIAL_TYPE

Required

Show if: (NEO_LBW_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_LBW_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_LBW_SPECIAL_EVER = 995:[Yes, marked with another method (specify):])

Scale Summary		
Code	Label	Show-If
1	Pediatrician	
2	Obstetrician	
3	Gynecologist	
4	OBGYN	
5	Surgeon	
6	Neonatologist	
995	Other (specify):	
-1	Not recorded	

 68. What type of specialist evaluated the baby?


- ☐ Pediatrician
☐ Obstetrician
☐ Gynecologist
☐ OBGYN
☐ Surgeon
☐ Neonatologist
☐ Other (specify):
☐ Not recorded

Question: NEO_LBW_CONSULT_DATE

Required

Show if: (NEO_LBW_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 69. Date of the first evaluation by doctor:


- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: NEO_LBW_CONSULT_TIME

Required

Show if: (NEO_LBW_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 70. Time of the first evaluation by a doctor:

- ☐ Time: (HH:MM)


☐ Not recorded

Question: NEO_LBW_CONSULT_SPECIAL_DATE

Required

Show if: (NEO_LBW_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_LBW_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_LBW_SPECIAL_EVER = 995:[Yes, marked with another method (specify):])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 71. Date of the first evaluation by a specialist:

☐ Date: (DD/MM/YYYY)


☐ Not recorded

Question: NEO_LBW_CONSULT_SPECIAL_TIME

Required

Show if: (NEO_LBW_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_LBW_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_LBW_SPECIAL_EVER = 995:[Yes, marked with another method (specify):])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 72. Time of the first evaluation by a specialist:

☐ Time: (HH:MM)


☐ Not recorded

Question Block: NEO_LBW_PROC_OXY

Contains: NEO_LBW_PROC_OXY_AMBU, NEO_LBW_PROC_OXY_POSVENT, NEO_LBW_PROC_OXY_VENTMEC, NEO_LBW_PROC_OXY_BOLSA, NEO_LBW_PROC_OXY_100, NEO_LBW_PROC_OXY_MASKOXY, NEO_LBW_PROC_OXY_MASK, NEO_LBW_PROC_OXY_MASKRES, NEO_LBW_PROC_OXY_CAMP, NEO_LBW_PROC_OXY_HELMET, NEO_LBW_PROC_OXY_CAMPCEF, NEO_LBW_PROC_OXY_CYL, NEO_LBW_PROC_OXY_CYLCAP, NEO_LBW_PROC_OXY_CPAP, NEO_LBW_PROC_OXY_BIG, NEO_LBW_PROC_OXY_NASAL, NEO_LBW_PROC_OXY_CATH, NEO_LBW_PROC_OXY_CANULA, NEO_LBW_PROC_OXY_VENT, NEO_LBW_PROC_OXY_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 73. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Oxygen Application:		
Ambu	<input type="radio"/>	<input type="radio"/>
Positive pressure ventilation	<input type="radio"/>	<input type="radio"/>
Mechanical ventilation	<input type="radio"/>	<input type="radio"/>
Resuscitation bag	<input type="radio"/>	<input type="radio"/>
Oxygen at 100%	<input type="radio"/>	<input type="radio"/>
Oxygen mask	<input type="radio"/>	<input type="radio"/>
Mask	<input type="radio"/>	<input type="radio"/>
Mask with reservoir	<input type="radio"/>	<input type="radio"/>
Oxygen hood	<input type="radio"/>	<input type="radio"/>
Cephalic helmit	<input type="radio"/>	<input type="radio"/>
Cephalic hood	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder with cap	<input type="radio"/>	<input type="radio"/>
Oxygen CPAP	<input type="radio"/>	<input type="radio"/>
Bigotera	<input type="radio"/>	<input type="radio"/>
Nasal tips	<input type="radio"/>	<input type="radio"/>
Tips/oxygen catheter		

	<input type="radio"/>	<input type="radio"/>
Cannula	<input type="radio"/>	<input type="radio"/>
Venturi system	<input type="radio"/>	<input type="radio"/>
Other method of oxygen	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_LBW_PROC_HEAT

Contains: NEO_LBW_PROC_HEAT_INC, NEO_LBW_PROC_HEAT_WRAP, NEO_LBW_PROC_HEAT_WARMSHEET, NEO_LBW_PROC_HEAT_LAMP, NEO_LBW_PROC_HEAT_WARMER, NEO_LBW_PROC_HEAT_KANG, NEO_LBW_PROC_HEAT_PLASTIC, NEO_LBW_PROC_HEAT_BACIN, NEO_LBW_PROC_HEAT_SERVO, NEO_LBW_PROC_HEAT_SERVOCUNA, NEO_LBW_PROC_HEAT_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

93. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Heat application:		
Incubator	<input type="radio"/>	<input type="radio"/>
Wrapped in sheets/blankets/towels	<input type="radio"/>	<input type="radio"/>
Warm sheets	<input type="radio"/>	<input type="radio"/>
Radiant heat lamp	<input type="radio"/>	<input type="radio"/>
Radiant warmer	<input type="radio"/>	<input type="radio"/>
Kangaroo mother care	<input type="radio"/>	<input type="radio"/>
Transparent plastic bag	<input type="radio"/>	<input type="radio"/>
Bassinet with radiant heat	<input type="radio"/>	<input type="radio"/>
Servo	<input type="radio"/>	<input type="radio"/>
Servocuna	<input type="radio"/>	<input type="radio"/>
Other method of heat application	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_LBW_PROC_OTHER

Contains: NEO_LBW_PROC_OTH_SEC, NEO_LBW_PROC_OTH_INTUB, NEO_LBW_PROC_OTH_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

104. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Other:		
Secretion suction	<input type="radio"/>	<input type="radio"/>
Endotracheal intubation	<input type="radio"/>	<input type="radio"/>
Other procedures	<input type="radio"/>	<input type="radio"/>

Question: NEO_LBW_CPR

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

107. Was CPR performed on the baby immediately after delivery?

- ☐ Yes
☐ No

Question: NEO_LBW_PROC_OXYOTH_SPEC**Required****Show if:** (NEO_LBW_PROC_OXY_OTH = 1:[Yes])

108. What is the other method of oxygen application?

Question: NEO_LBW_PROC_HTOTH_SPEC**Required****Show if:** (NEO_LBW_PROC_HEAT_OTH = 1:[Yes])

109. What is the other method of heat application?

Question: NEO_LBW_PROC_OTHOTH_SPEC**Required****Show if:** (NEO_LBW_PROC_OTH_OTH = 1:[Yes])

110. What other procedure was performed?

Question Block: NEO_LBW_BABYFOOD**Contains:** NEO_LBW_BABYFOOD_BF, NEO_LBW_BABYFOOD_GLUCOSEIV, NEO_LBW_BABYFOOD_IV, NEO_LBW_BABYFOOD_ORAL, NEO_LBW_BABYFOOD_FORMULA, NEO_LBW_BABYFOOD_OTH**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

111. Please check how the baby was fed:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Breastfeeding	<input type="radio"/>	<input type="radio"/>
Glucose serum IV	<input type="radio"/>	<input type="radio"/>
Intravenous feeding (other)	<input type="radio"/>	<input type="radio"/>
Oral glucose serum	<input type="radio"/>	<input type="radio"/>
Formula	<input type="radio"/>	<input type="radio"/>
Other procedures	<input type="radio"/>	<input type="radio"/>

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: NEO_LBW_MED1

117.

Administered Dose

Date (DD/MM/YYYY)

Time (HH:MM)

Ampicillin

☐ ☐

Amikacine

☐ ☐

Sulbactam

☐ ☐

Piperacillin

☐ ☐

Clindamycin

☐ ☐

Gentamicin

☐ ☐

Metronidazole

☐ ☐

Penicillin

☐ ☐

Crystalline Penicillin

☐ ☐

Tazobactam	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other antibiotic (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Custom Layout Question: NEO_LBW_MED2

118. Administered Dose Date (MM/DD/YYYY) Time (HH:MM)

Diphenylhydantoin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diazepam	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other anticonvulsants (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: NEO_LBW_MEDICATIONS**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

119. Were any of the above mentioned medications administered at the same time during this hospitalization?

☐ Yes

☐ No

Question Block: NEO_LBW_OTHER_COMP

Contains: NEO_LBW_OTHER_COMP_PNEU, NEO_LBW_OTHER_COMP_RESP, NEO_LBW_OTHER_COMP_DIA, NEO_LBW_OTHER_COMP_CONV, NEO_LBW_OTHER_COMP_HIPO, NEO_LBW_OTHER_COMP_NEURO, NEO_LBW_OTHER_COMP_OTH, NEO_LBW_OTHER_COMP_NONE

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

120. What other complications did the baby have (excluding sepsis, asphyxia, low birth weight, and prematurity)?

	Yes	No
Pneumonia	<input type="radio"/>	<input type="radio"/>
Respiratory distress	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>
Hypoglycemia	<input type="radio"/>	<input type="radio"/>
Neurological complications	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>
None	<input type="radio"/>	<input type="radio"/>

Collection: NEO_PRE

Contains: NEO_PRE_

Show if: (MRR_NEO_COMP is-any-of)

Note whether the following was recorded for the patient with prematurity.

Collection: NEO_PRE

Contains: NEO_PRE_GEST_METHOD, NEO_PRE_CLASSIFICATION, NEO_PRE_GLY_TYPE, NEO_PRE_CONSULT, NEO_PRE_CON_EVER, NEO_PRE_SPECIAL_EVER, NEO_PRE_SPECIAL_TYPE, NEO_PRE_CONSULT_DATE, NEO_PRE_CONSULT_TIME, NEO_PRE_CONSULT_SPECIAL_DATE, NEO_PRE_CONSULT_SPECIAL_TIME, NEO_PRE_CPR, NEO_PRE_PROC_OXY, NEO_PRE_PROC_HEAT, NEO_PRE_PROC_OTHER, NEO_PRE_PROC_OXYOTH_SPEC, NEO_PRE_PROC_HTOTH_SPEC, NEO_PRE_PROC_OTHOTH_SPEC, NEO_PRE_BABYFOOD, NEO_PRE_MEDICATIONS, NEO_PRE_OTHER_COMP

Show if: (FACILITY_TYPE >= 2)

Question Block: NEO_PRE_GEST_METHOD

Contains: NEO_PRE_GEST_METHOD_1, NEO_PRE_GEST_METHOD_2, NEO_PRE_GEST_METHOD_3, NEO_PRE_GEST_METHOD_4, NEO_PRE_GEST_METHOD_5, NEO_PRE_GEST_METHOD_995

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
-1	Not recorded	

128. Please check the method of gestational age assessment (select all that apply)

	Yes	Not recorded
LMP (last menstrual period)	<input type="radio"/>	<input type="radio"/>
ECO	<input type="radio"/>	<input type="radio"/>
Ballard test	<input type="radio"/>	<input type="radio"/>
Head circumference	<input type="radio"/>	<input type="radio"/>
Capurro test	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: NEO_PRE_CLASSIFICATION
Required

Scale Summary		
Code	Label	Show-If
1	Small	
2	Large	
3	Adequate	
995	Other	
-1	Not recorded	

134. Classification of the newborn according to gestational age:

- ☐ Small
☐ Large
☐ Adequate
☐ Other
☐ Not recorded

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first checkpoint for each item listed below**.

Custom Layout Question: NEO_PRE_CHECK1

135.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="checkbox"/> <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="checkbox"/> <input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="checkbox"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Weight	<input type="checkbox"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Length/height	<input type="checkbox"/> <input type="text"/> cm	<input type="text"/>	<input type="text"/>
Head circumference	<input type="checkbox"/> <input type="text"/> cm	<input type="text"/>	<input type="text"/>
Downes score	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Silverman score	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 1 minute	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 5 minutes	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/> <input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first checkpoint for each item listed below**.

Custom Layout Question: NEO_PRE_CHECK2

136. Recorded Date (DD/MM/YYYY) Time (HH:MM)

Skin color

Abdominal examination

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first** **checkup** for each item listed below.

Custom Layout Question: NEO_PRE_LAB1

137. Recorded Value Date (DD/MM/YYYY) Time (HH:MM)

Oxygen saturation level %

Glycemia mg/dL

Other (specify)

Other (specify)

Other (specify)

Question: NEO_PRE_GLY_TYPE**Required**

Show if: (NEO_PRE_LAB_REG_GLY = 1)

Scale Summary		
Code	Label	Show-If
1	Test strip	
2	Blood test	
995	Other (specify):	
-1	Not recorded	

138. What type of test was used for glycemia?

☐ Test strip

☐ Blood test

☐ Other (specify):

☐ Not recorded

Question: NEO_PRE_CONSULT**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

139. Was the baby evaluated by a doctor at the time of admission?

☐ Yes

☐ No

Question: NEO_PRE_CON_EVER**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

140. Was the baby ever evaluated by a doctor?

☐ Yes

☐ No

Question: NEO_PRE_SPECIAL_EVER**Required**

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an ME notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	

141. Was the baby ever evaluated by a specialist?

☐ Yes, marked with an ME notation in the signature

☐ Yes, marked with a stamp

☐ Yes, marked with another method (specify)

- ☐ No
- ☐ Not recorded

Question: NEO_PRE_SPECIAL_TYPE

Required

Show if: (NEO_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Pediatrician	
2	Obstetrician	
3	Gynecologist	
4	OBGYN	
5	Surgeon	
6	Neonatologist	
995	Other (specify):	
-1	Not recorded	

142. What type of specialist evaluated the baby?

- ☐ Pediatrician
- ☐ Obstetrician
- ☐ Gynecologist
- ☐ OBGYN
- ☐ Surgeon
- ☐ Neonatologist
- ☐ Other (specify):
- ☐ Not recorded

Question: NEO_PRE_CONSULT_DATE

Required

Show if: (NEO_PRE_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

143. Date of the first evaluation by a doctor:

- ☐ Date: (DD/MM/YYYY)
- ☐ Not recorded

Question: NEO_PRE_CONSULT_TIME

Required

Show if: (NEO_PRE_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

144. Time of the first evaluation by a doctor:

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: NEO_PRE_CONSULT_SPECIAL_DATE

Required

Show if: (NEO_PRE_SPECIAL_EVER = 1:[Yes, marked with an ME notation in the signature]) or (NEO_PRE_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_PRE_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

145. Date of the first evaluation by a specialist:

- ☐ Date: (DD/MM/YYYY)
- ☐ Not recorded

Question: NEO_PRE_CONSULT_SPECIAL_TIME

Required

Show if: (NEO_PRE_SPECIAL_EVER = 1:[Yes, marked with an ME notation in the signature]) or (NEO_PRE_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_PRE_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])


Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

146. Time of the first evaluation by a specialist:

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: NEO_PRE_CPR**Required****Scale Summary**

Code	Label	Show-If
1	Yes	
0	No	

 147. Was CPR performed on the baby immediately after delivery?

- ☐ Yes
☐ No

Question Block: NEO_PRE_PROC_OXY

Contains: NEO_PRE_PROC_OXY_AMBU, NEO_PRE_PROC_OXY_POSVENT, NEO_PRE_PROC_OXY_VENTMEC, NEO_PRE_PROC_OXY_BOLSA, NEO_PRE_PROC_OXY_100, NEO_PRE_PROC_OXY_MASKOXY, NEO_PRE_PROC_OXY_MASK, NEO_PRE_PROC_OXY_MASKRES, NEO_PRE_PROC_OXY_CAMP, NEO_PRE_PROC_OXY_HELMET, NEO_PRE_PROC_OXY_CAMPCEF, NEO_PRE_PROC_OXY_CYL, NEO_PRE_PROC_OXY_CYLCAP, NEO_PRE_PROC_OXY_CPAP, NEO_PRE_PROC_OXY_BIG, NEO_PRE_PROC_OXY_NASAL, NEO_PRE_PROC_OXY_CATH, NEO_PRE_PROC_OXY_CANULA, NEO_PRE_PROC_OXY_VENT, NEO_PRE_PROC_OXY_OTH

Required**Scale Summary**

Code	Label	Show-If
1	Yes	
0	No	

 148. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Oxygen Application:		
Ambu	<input type="radio"/>	<input type="radio"/>
Positive pressure ventilation	<input type="radio"/>	<input type="radio"/>
Mechanical ventilation	<input type="radio"/>	<input type="radio"/>
Resuscitation bag	<input type="radio"/>	<input type="radio"/>
Oxygen at 100%	<input type="radio"/>	<input type="radio"/>
Oxygen mask	<input type="radio"/>	<input type="radio"/>
Mask	<input type="radio"/>	<input type="radio"/>
Mask with reservoir	<input type="radio"/>	<input type="radio"/>
Oxygen hood	<input type="radio"/>	<input type="radio"/>
Cephalic helmit	<input type="radio"/>	<input type="radio"/>
Cephalic hood	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder with cap	<input type="radio"/>	<input type="radio"/>
Oxígeno CPAP	<input type="radio"/>	<input type="radio"/>
Bigotera	<input type="radio"/>	<input type="radio"/>
Nasal tips	<input type="radio"/>	<input type="radio"/>
Tips/oxygen catheter	<input type="radio"/>	<input type="radio"/>
Cannula	<input type="radio"/>	<input type="radio"/>
Venturi system	<input type="radio"/>	<input type="radio"/>
Other method of oxygen	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_PRE_PROC_HEAT

Contains: NEO_PRE_PROC_HEAT_INC, NEO_PRE_PROC_HEAT_WRAP, NEO_PRE_PROC_HEAT_WARMSHEET, NEO_PRE_PROC_HEAT_LAMP, NEO_PRE_PROC_HEAT_WARMER, NEO_PRE_PROC_HEAT_KANG, NEO_PRE_PROC_HEAT_PLASTIC, NEO_PRE_PROC_HEAT_BACIN, NEO_PRE_PROC_HEAT_SERVO, NEO_PRE_PROC_HEAT_SERVOCUNA, NEO_PRE_PROC_HEAT_OTH

Required**Scale Summary**

Code	Label	Show-If
1	Yes	
0	No	

168. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Aplicación de calor:		
Incubator	<input type="radio"/>	<input type="radio"/>
Wrapped in sheets/blankets/towels	<input type="radio"/>	<input type="radio"/>
Warm sheets	<input type="radio"/>	<input type="radio"/>
Radiant heat lamp	<input type="radio"/>	<input type="radio"/>
Radiant warmer	<input type="radio"/>	<input type="radio"/>
Kangaroo mother care	<input type="radio"/>	<input type="radio"/>
Transparent plastic bag	<input type="radio"/>	<input type="radio"/>
Bassinette with radiant heat	<input type="radio"/>	<input type="radio"/>
Servo	<input type="radio"/>	<input type="radio"/>
Servocuna	<input type="radio"/>	<input type="radio"/>
Other method of heat application	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_PRE_PROC_OTHER

Contains: NEO_PRE_PROC_OTH_SEC, NEO_PRE_PROC_OTH_INTUB, NEO_PRE_PROC_OTH_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

179. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Other:		
Secretion suction	<input type="radio"/>	<input type="radio"/>
Endotracheal intubation	<input type="radio"/>	<input type="radio"/>
Other procedures	<input type="radio"/>	<input type="radio"/>

Question: NEO_PRE_PROC_OXYOTH_SPEC

Required

Show if: (NEO_PRE_PROC_OXY_OTH = 1:[Yes])

182. What is the other method of oxygen application?

Question: NEO_PRE_PROC_HTOTH_SPEC

Required

Show if: (NEO_PRE_PROC_HEAT_OTH = 1:[Yes])

183. What is the other method of heat application?

Question: NEO_PRE_PROC_OTHOTH_SPEC

Required

Show if: (NEO_PRE_PROC_OTH_OTH = 1:[Yes])

184. What other procedures were performed?

Question Block: NEO_PRE_BABYFOOD

Contains: NEO_PRE_BABYFOOD_BF, NEO_PRE_BABYFOOD_GLUCOSEIV, NEO_PRE_BABYFOOD_IV, NEO_PRE_BABYFOOD_ORAL, NEO_PRE_BABYFOOD_FORMULA, NEO_PRE_BABYFOOD_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	

0 No

185. Please check how the baby was fed:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Breastfeeding	<input type="radio"/>	<input type="radio"/>
Glucose serum IV	<input type="radio"/>	<input type="radio"/>
Intravenous feeding (other)	<input type="radio"/>	<input type="radio"/>
Oral glucose serum	<input type="radio"/>	<input type="radio"/>
Formula	<input type="radio"/>	<input type="radio"/>
Other procedures	<input type="radio"/>	<input type="radio"/>

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: NEO_PRE_MED1

191.	Administered Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Amikacine	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sulbactam	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Piperacillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Clindamycin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Gentamicin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Metronidazole	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Penicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Crystalline Penicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Tazobactam	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Packets/envelopes of oral rehydration salts	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other antibiotic (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Custom Layout Question: NEO_PRE_MED2

192.	Administered Dose	Date (MM/DD/YYYY)	Time (HH:MM)
Diphenylhydantoin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Diazepam	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other anticonvulsant (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Question: NEO_PRE_MEDICATIONS**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

193. Were any of the above mentioned medications administered at the same time during this hospitalization?

- ☐ Yes
☐ No

Question Block: NEO_PRE_OTHER_COMP

Contains: NEO_PRE_OTHER_COMP_PNEU, NEO_PRE_OTHER_COMP_RESP, NEO_PRE_OTHER_COMP_DIA, NEO_PRE_OTHER_COMP_CONV, NEO_PRE_OTHER_COMP_HIPO, NEO_PRE_OTHER_COMP_NEURO, NEO_PRE_OTHER_COMP_OTH, NEO_PRE_OTHER_COMP_NONE

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

194. Did the baby have any other complications (excluding sepsis, asphyxia, low birth weight, and prematurity)?

	Yes	No
Pneumonia	<input type="radio"/>	<input type="radio"/>
Respiratory distress	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>
Hypoglycemia	<input type="radio"/>	<input type="radio"/>
Neurological complications	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>
None	<input type="radio"/>	<input type="radio"/>

Collection: NEO_ASP**Contains:** NEO_ASP**Show if:** (MRR_NEO_COMP is-any-of)

Note whether the following was recorded for the patient with asphyxia.

Collection: NEO_ASP

Contains: NEO_ASP_CONSULT, NEO_ASP_CON_EVER, NEO_ASP_SPECIAL_EVER, NEO_ASP_SPECIAL_TYPE, NEO_ASP_CONSULT_DATE, NEO_ASP_CONSULT_TIME, NEO_ASP_CONSULT_SPECIAL_DATE, NEO_ASP_CONSULT_SPECIAL_TIME, NEO_ASP_COND, NEO_ASP_SECADO, NEO_ASP_STIM, NEO_ASP_RADIOGRAPHY, NEO_ASP_PROC_OXY, NEO_ASP_PROC_HEAT, NEO_ASP_PROC_OTHER, NEO_ASP_PROC_OXYOTH_SPEC, NEO_ASP_PROC_HTOTH_SPEC, NEO_ASP_PROC_OTHOTH_SPEC, NEO_ASP_MEDICATIONS

Show if: (FACILITY_TYPE >= 2)

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup for each item listed below**.

Custom Layout Question: NEO_ASP_CHECK1

202.

	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 1 minute	<input type="text"/>	<input type="text"/>	<input type="text"/>
APGAR at 5 minutes	<input type="text"/>	<input type="text"/>	<input type="text"/>
Downes score	<input type="text"/>	<input type="text"/>	<input type="text"/>
Silverman score	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first** **checkup for each item listed below**.

Custom Layout Question: NEO_ASP_CHECK2

203. Recorded Date (DD/MM/YYYY) Time (HH:MM)

Skin color

Abdominal Examination

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first** **checkup for each item listed below**.

Custom Layout Question: NEO_ASP_LAB1

204. Recorded Value Date (DD/MM/YYYY) Time (HH:MM)

Oxygen saturation level %

Leukocyte count $\times 10^3/\text{liter}$

Platelets $\times 10^3/\text{liter}$

Hemoglobin g/dL

C-reactive protein mg/dL o +/-

Erythrocyte sedimentation level mm/h

Blood culture

Glycemia

Other (specify)

Other (specify)

Other (specify)

Question: NEO_ASP_CONSULT

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

205. Was the baby evaluated by a doctor at the time of admission?

☐ Yes

☐ No

Question: NEO_ASP_CON_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

206. Was the baby ever evaluated by a doctor?

☐ Yes

☐ No

Question: NEO_ASP_SPECIAL_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	

207. Was the baby ever evaluated by a specialist?

☐ Yes, marked with an 'ME' notation in the signature

☐ Yes, marked with a stamp

☐ Yes, marked with another method (specify)

- ☐ No
- ☐ Not recorded

Question: NEO_ASP_SPECIAL_TYPE

Required

Show if: (NEO_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Pediatrician	
2	Obstetrician	
3	Gynecologist	
4	OBGYN	
5	Surgeon	
6	Neonatologist	
995	Other (specify)	
-1	Not recorded	

 208. What type of specialist evaluated the baby?


- ☐ Pediatrician
- ☐ Obstetrician
- ☐ Gynecologist
- ☐ OBGYN
- ☐ Surgeon
- ☐ Neonatologist
- ☐ Other (specify)
- ☐ Not recorded

Question: NEO_ASP_CONSULT_DATE

Required

Show if: (NEO_ASP_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 209. Date of the first evaluation by a doctor:


- ☐ Date: (DD/MM/YYYY)
- ☐ Not recorded

Question: NEO_ASP_CONSULT_TIME

Required

Show if: (NEO_ASP_CON_EVER = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 210. Time of the first evaluation by a doctor:


- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: NEO_ASP_CONSULT_SPECIAL_DATE

Required

Show if: (NEO_ASP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_ASP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_ASP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 211. Date of the first evaluation by a specialist:


- ☐ Date: (DD/MM/YYYY)
- ☐ Not recorded

Question: NEO_ASP_CONSULT_SPECIAL_TIME

Required

Show if: (NEO_ASP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (NEO_ASP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (NEO_ASP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])


Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 212. Time of the first evaluation by a specialist:

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question Block: NEO_ASP_COND**Contains:** NEO_ASP_COND_AMINIO, NEO_ASP_COND_HIPO, NEO_ASP_COND_NORESP, NEO_ASP_COND_CRY**Required**


Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 213. Record the condition of the baby:

	Yes	No
Meconium amniotic fluid	<input type="radio"/>	<input type="radio"/>
Hypotonic	<input type="radio"/>	<input type="radio"/>
Not breathing	<input type="radio"/>	<input type="radio"/>
Not crying	<input type="radio"/>	<input type="radio"/>

Question: NEO_ASP_SECADO**Required**


Scale Summary		
Code	Label	Show-If
1	Yes	
-1	Not recorded	

 217. Record whether the baby was dried

- ☐ Yes
☐ Not recorded

Question: NEO_ASP_STIM**Required**


Scale Summary		
Code	Label	Show-If
1	Yes	
-1	Not recorded	

 218. Note whether the baby was stimulated

- ☐ Yes
☐ Not recorded

Question: NEO_ASP_RADIOGRAPHY**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 219. Was a chest radiography done?

- ☐ Yes
☐ No

Question Block: NEO_ASP_PROC_OXY
Contains: NEO_ASP_PROC_OXY_AMBU, NEO_ASP_PROC_OXY_POSVENT, NEO_ASP_PROC_OXY_VENTMEC, NEO_ASP_PROC_OXY_BOLSA, NEO_ASP_PROC_OXY_100, NEO_ASP_PROC_OXY_MASKOXY, NEO_ASP_PROC_OXY_MASK, NEO_ASP_PROC_OXY_MASKRES, NEO_ASP_PROC_OXY_HEADBOX, NEO_ASP_PROC_OXY_CONE, NEO_ASP_PROC_OXY_HELMET, NEO_ASP_PROC_OXY_CAMPCEF, NEO_ASP_PROC_OXY_CYL, NEO_ASP_PROC_OXY_CYLCAP, NEO_ASP_PROC_OXY_CPAP, NEO_ASP_PROC_OXY_TANK, NEO_ASP_PROC_OXY_NASAL, NEO_ASP_PROC_OXY_CATH, NEO_ASP_PROC_OXY_CANULA, NEO_ASP_PROC_OXY_VENT, NEO_ASP_PROC_OXY_OTH
Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 220. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Oxygen Application:		
Ambu	<input type="radio"/>	<input type="radio"/>
Positive pressure ventilation	<input type="radio"/>	<input type="radio"/>
Mechanical ventilation	<input type="radio"/>	<input type="radio"/>
Resuscitation bag	<input type="radio"/>	<input type="radio"/>
Oxygen at 100%	<input type="radio"/>	<input type="radio"/>

Oxygen mask	<input type="radio"/>	<input type="radio"/>
Mask	<input type="radio"/>	<input type="radio"/>
Mask with reservoir	<input type="radio"/>	<input type="radio"/>
Head box	<input type="radio"/>	<input type="radio"/>
Oxygen cone	<input type="radio"/>	<input type="radio"/>
Cephalic helmit	<input type="radio"/>	<input type="radio"/>
Oxygen hood	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder	<input type="radio"/>	<input type="radio"/>
Oxygen cylinder with cap	<input type="radio"/>	<input type="radio"/>
Oxygen CPAP	<input type="radio"/>	<input type="radio"/>
Oxygen tank	<input type="radio"/>	<input type="radio"/>
Nasal tips	<input type="radio"/>	<input type="radio"/>
Oxygen tips	<input type="radio"/>	<input type="radio"/>
Nasal cannula	<input type="radio"/>	<input type="radio"/>
Venturi system	<input type="radio"/>	<input type="radio"/>
Other method of oxygen	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_ASP_PROC_HEAT

Contains: NEO_ASP_PROC_HEAT_INC, NEO_ASP_PROC_HEAT_WRAP, NEO_ASP_PROC_HEAT_WARMSHEET, NEO_ASP_PROC_HEAT_LAMP, NEO_ASP_PROC_HEAT_WARMER, NEO_ASP_PROC_HEAT_KANG, NEO_ASP_PROC_HEAT_PLASTIC, NEO_ASP_PROC_HEAT_BACIN, NEO_ASP_PROC_HEAT_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 241. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Heat Application:		
Incubator	<input type="radio"/>	<input type="radio"/>
Wrapped in sheets/blankets/towels	<input type="radio"/>	<input type="radio"/>
Warm sheets	<input type="radio"/>	<input type="radio"/>
Radiant heat lamp	<input type="radio"/>	<input type="radio"/>
Radiant warmer	<input type="radio"/>	<input type="radio"/>
Kangaroo mother	<input type="radio"/>	<input type="radio"/>
Transparent plastic bag	<input type="radio"/>	<input type="radio"/>
Bassinet with radiant heat	<input type="radio"/>	<input type="radio"/>
Other method of heat application	<input type="radio"/>	<input type="radio"/>

Question Block: NEO_ASP_PROC_OTHER

Contains: NEO_ASP_PROC_OTH_SEC, NEO_ASP_PROC_OTH_INTUB, NEO_ASP_PROC_OTH_MESSAGE, NEO_ASP_PROC_OTH_COMPRESSION, NEO_ASP_PROC_OTH_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 250. Please note if the following procedures were carried out:

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Otro:		
Secretion suction	<input type="radio"/>	<input type="radio"/>
Endotracheal intubation	<input type="radio"/>	<input type="radio"/>
Cardiac massage	<input type="radio"/>	<input type="radio"/>
Chest compressions	<input type="radio"/>	<input type="radio"/>
Other procedure	<input type="radio"/>	<input type="radio"/>

Question: NEO_ASP_PROC_OXYOTH_SPEC

Required

Show if: (NEO_ASP_PROC_OXY_OTH = 1:[Yes])

255. What is the other method of oxygen application?

Question: NEO_ASP_PROC_HTOTH_SPEC

Required

Show if: (NEO_ASP_PROC_HEAT_OTH = 1:[Yes])

256. What is the other method of heat application?

Question: NEO_ASP_PROC_OTHOTH_SPEC

Required

Show if: (NEO_ASP_PROC_OTH_OTH = 1:[Yes])

257. What other procedure was performed?

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: NEO_ASP_MED1

258.	Recorded Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Ampicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Amikacine	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sulbactam	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Piperacillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Gentamicin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other antibiotic (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Question: NEO_ASP_MEDICATIONS

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
-1	Not recorded	

259. Were any of the above mentioned medications administered at the same time during this hospitalization?

- ☐ Yes
☐ Not recorded


Collection: GEN_DISPOSITION

Contains: NEO_DISPOSITION, NEO_REF_ACCOMTO, NEO_REF_NAMETO, NEO_REF_TYPTETO, NEO_SEP_REF_REAS, NEO_LBW_REF_REAS, NEO_PRE_REF_REAS, NEO_ASP_REF_REAS, NEO_REF_HOW, NEO_DIS_DATE, NEO_DIS_TIME, NEO_DEATH_DATE, NEO_DEATH_TIME

Show if: (MRR_NEO_COMP is-any-of)

Question: NEO_DISPOSITION**Required**


Scale Summary		
Code	Label	Show-If
1	Death in hospital	
2	Discharged home	
3	Transferred/referred to another facility	
4	Left against medical advice	
5	Unknown	
995	Other (specify):	
-1	Not recorded	

 260. Disposition:

- ☐ Death in hospital
- ☐ Discharged home
- ☐ Transferred/referred to another facility
- ☐ Left against medical advice
- ☐ Unknown
- ☐ Other (specify):
- ☐ Not recorded

Question: NEO_REF_ACCOMTO**Required****Show if:** (NEO_DISPOSITION = 3:[Transferred/referred to another facility])


Scale Summary		
Code	Label	Show-If
1	Yes, by a doctor	
2	Yes, by a nurse	
995	Yes, by another worker	
0	No	
-1	Not recorded	

 261. Was the baby accompanied by a health facility worker?

- ☐ Yes, by a doctor
- ☐ Yes, by a nurse
- ☐ Yes, by another worker
- ☐ No
- ☐ Not recorded

Question: NEO_REF_NAMETO**Show if:** (NEO_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	[REDACTED]	
2	[REDACTED]	
3	[REDACTED]	
4	[REDACTED]	
5	[REDACTED]	
6	[REDACTED]	
7	[REDACTED]	
8	[REDACTED]	
9	[REDACTED]	
10	[REDACTED]	
11	[REDACTED]	
12	[REDACTED]	
13	[REDACTED]	
14	[REDACTED]	
15	[REDACTED]	
16	[REDACTED]	
17	[REDACTED]	
18	[REDACTED]	
19	[REDACTED]	
20	[REDACTED]	
21	[REDACTED]	
22	[REDACTED]	
23	[REDACTED]	
24	[REDACTED]	
25	[REDACTED]	
26	[REDACTED]	
27	[REDACTED]	
28	[REDACTED]	
29	[REDACTED]	
30	[REDACTED]	
31	[REDACTED]	
32	[REDACTED]	
33	[REDACTED]	
34	[REDACTED]	
35	[REDACTED]	
36	[REDACTED]	
37	[REDACTED]	
38	[REDACTED]	
39	[REDACTED]	
40	[REDACTED]	
41	[REDACTED]	
42	[REDACTED]	
43	[REDACTED]	
44	[REDACTED]	
45	[REDACTED]	
46	[REDACTED]	
47	[REDACTED]	
48	[REDACTED]	
49	[REDACTED]	
50	[REDACTED]	
51	[REDACTED]	
52	[REDACTED]	
53	[REDACTED]	
54	[REDACTED]	
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67	[REDACTED]	
68	[REDACTED]	
69	[REDACTED]	
70	[REDACTED]	
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72	[REDACTED]	
73	[REDACTED]	
74	[REDACTED]	
75	[REDACTED]	
76	[REDACTED]	
77	[REDACTED]	
78	[REDACTED]	
79	[REDACTED]	
80	[REDACTED]	
81	[REDACTED]	
82	[REDACTED]	
83	[REDACTED]	
84	[REDACTED]	
85	[REDACTED]	
86	[REDACTED]	
87	[REDACTED]	
88	[REDACTED]	
89	[REDACTED]	
90	[REDACTED]	
91	[REDACTED]	
92	[REDACTED]	
93	[REDACTED]	
94	[REDACTED]	
95	Other (specify):	
-1	Not recorded	

 262. What facility was the baby transferred/referred to?

- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]
- ☐ [REDACTED]


- ☐ 
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☐ Other (specify):
☐ Not recorded

Question: NEO_REF_TYPETO

Required

Show if: (NEO_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	


 263. Type of facility the baby was transferred/referred to:

- ☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

Question: NEO_SEP_REF_REAS

Minimum checks: 1

Show if: (NEO_DISPOSITION = 3:[Transferred/referred to another facility]) and (MRR_NEO_COMP is-any-of)

 264. SEPSIS

Reason for the baby's transfer:

- ☐ High temperature
☐ High leukocyte
☐ Hypoglycemia
☐ Hyperglycemia
☐ Other
☐ Not recorded

Question: NEO_LBW_REF_REAS

Minimum checks: 1

Show if: (MRR_NEO_COMP is-any-of) and (NEO_DISPOSITION = 3:[Transferred/referred to another facility])

 265. LOW BIRTH WEIGHT

Reason for baby's transfer:

- ☐ High temperature
☐ High leukocyte
☐ Hypoglycemia
☐ Hyperglycemia
☐ Low birth weight
☐ Low Downes score
☐ Low Silverman score
☐ Low oxygen saturation level
☐ Other
☐ Not recorded

Question: NEO_PRE_REF_REAS

Minimum checks: 1

Show if: (MRR_NEO_COMP is-any-of) and (NEO_DISPOSITION = 3:[Transferred/referred to another facility])

 266. PREMATURITY

Reason for the baby's transfer:

- ☐ High temperature
☐ High leukocyte
☐ Hypoglycemia
☐ Hyperglycemia
☐ Low birth weight
☐ Low Downes score
☐ Low Silverman score
☐ Low oxygen saturation level
☐ Other
☐ Not recorded

Question: NEO_ASP_REF_REAS

Minimum checks: 1

Show if: (MRR_NEO_COMP is-any-of) and (NEO_DISPOSITION = 3:[Transferred/referred to another facility])



267. BIRTH ASPHYXIA

Reason for baby's transfer:

- ☐ High temperature
☐ Low APGAR score
☐ Hypoglycemia
☐ Hyperglycemia
☐ Other
☐ Not recorded

Question: NEO_REF_HOW

Minimum checks: 1

Show if: (NEO_DISPOSITION = 3:[Transferred/referred to another facility]) and (MRR_NEO_COMP is-any-of)



268. Please check how the baby was transferred (Select ALL that apply):

- ☐ Incubator
☐ Oxygen administration
☐ Other
☐ Not recorded

Question: NEO_DIS_DATE

Required

Show if: (NEO_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



269. Date of discharge/transfer/referral:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: NEO_DIS_TIME

Required

Show if: (NEO_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	



270. Time of discharge/transfer/referral

- ☐ Time: (HH:MM)
☐ Not recorded

Question: NEO_DEATH_DATE

Required

Show if: (NEO_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



271. Date of death

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: NEO_DEATH_TIME

Required

Show if: (NEO_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	



272. Time of death

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: COMMENT_COMPL_NEONATAL

273. Enter relevant comments about this section

You indicated the baby did not have any complications. Please review only records of sepsis, asphyxia, prematurity and low birth weight.

You have reached the end of the survey.

Please click the button 'submit' to submit your responses and close the survey. You cannot modify any responses after the survey has been submitted.

If you believe that this page was reached in error, please click 'Previous' and revise your responses as necessary.

Thank you for your time today.

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