OPTIONAL: Local Event ID:	_____		
DEMOGRAPHICS			***Demographics Tab***
Gender	○ Male	○ Female	○ Unknown
Date/Time of Birth:	____/____/_____ ____:____ (MM/DD/YYYY HH:MM)		❑ DOB Unknown/Not Documented ❑ Time Not Documented
RACE AND ETHNICITY			***Demographics Tab***
Race	❑ American Indian or Alaska Native ❑ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian		❑ Black or African American ❑ Native Hawaiian or Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ❑ White ❑ UTD
Hispanic Ethnicity	○ Yes		○ No/UTD
Optional, If Yes:	❑ Mexican, Mexican American, Chicano/a ❑ Puerto Rican		❑ Cuban ❑ Another Hispanic, Latino, or Spanish Origin
1.1 ADMISSION DATA			***Admission Tab***
System Entry Date:	____/____/_____ ___:___ (MM/DD/YYYY HH:MM)		○ Time Not Documented
Age at Event (in yrs., months, weeks, days, hrs., or minutes):	_____ ○ Years ○ Months ○ Weeks ○ Days ○ Hours ○ Minutes		❑ Estimated ❑ Age Unknown / Not Documented
Born this admission (or transferred from birth hospital)?	○ Yes		○ No
Birth Weight (patients <30 days old only)	_____Units	○ Pounds ○ Kilograms ○ Grams	❑ Birth Weight Unknown/Not Documented ❑ Weight same as birth weight
Weight (required for pediatric and newborn/neonate patients only):	_____Units	○ Pounds ○ Kilograms ○ Grams	❑ Weight Unknown/Not Documented
Length (patients <30 days old only):	_____Units	○ Inches ○ Centimeters	❑ Length Unknown/Not Documented
Head Circumference (patients <30 days old only):	_____Units	○ Inches ○ Centimeters	❑ Circumference Unknown/Not Documented
CPC/PCPC SCORING DEFINITIONS			***Admission Tab***
Admission CPC:	_____	❑ Unknown/Not Documented/Not Applicable	
Admission PCPC:	_____	❑ Unknown/Not Documented/Not Applicable (newborn)	
VACCINATIONS AND TESTING			***Admission Tab***
COVID-19 Vaccination:	○ COVID-19 vaccine was given during this hospitalization ○ COVID-19 vaccine was received prior to admission, not during this hospitalization ○ Documentation of patient's refusal of COVID-19 vaccine ○ Allergy/sensitivity to COVID-19 vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD		
COVID-19 Vaccination date:	___/___/_____ ____:____		○ Not Documented

Is there documentation that this patient was included in a COVID-19 vaccine trial?	○ Yes	○ No
Influenza Vaccination:	○ Influenza vaccine was given during this hospitalization during the current flu season ○ Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization ○ Documentation of patient's refusal of influenza vaccine ○ Allergy/sensitivity to influenza vaccine or if medically contraindicated ○ Vaccine not available ○ None of the above/Not documented/UTD	

1.2 NEWBORN/NEONATE *Newborn/Neonate Tab*

Did mother receive prenatal care?	○ Yes	○ No	○ Not Documented
Maternal Conditions (check all that apply)	❑ Not Documented ❑ None ❑ Alcohol Use ❑ Chorioamnionitis ❑ Cocaine/Crack use ❑ Diabetes ❑ Eclampsia ❑ Magnesium Exposure ❑ Major Trauma ❑ Maternal Infection	❑ GHTN (Pregnancy induced/Gestational Hypertension) ❑ Maternal Group B Strep (Positive) ❑ Methamphetamine/ICE use ❑ Narcotic given to mother within 4 hrs. of delivery ❑ Narcotics addiction and/or on methadone maintenance ❑ Pre-eclampsia ❑ Prior Cesarean ❑ Urinary Tract Infection (UTI) ❑ 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	
	Presentation		
	○ Cephalic	○ Breech	○ Unknown/Not Documented
Apgar Scores:	1 min: _____	❑ Unknown/Not Assigned	
	5 min: _____	❑ Unknown/Not Assigned	
	10 min: _____	❑ Unknown/Not Assigned	
	15 min: _____	❑ Unknown/Not Assigned	
	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

1.3 INDUCED HYPOTHERMIA			***Discharge Tab***
Was induced hypothermia initiated after return of circulation (ROC) achieved?	○ Yes	○ No/Not Documented	○ N/A

1.4 DISCHARGE DATA			***Discharge Tab***
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 ❑ 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:	___/___/_____ ____:____	○ Not Documented	○ 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	
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	_____/_____/_____ ____:____ (MM/DD/YYYY HH:MM)	○ Time Not Documented	
Declared DNAR during this admission?	○ Yes	○ No	
If yes, Date/Time of DNAR order	_____/_____/_____ ____:____ (MM/DD/YYYY HH:MM)	○ Time Not Documented	

If patient died:	Was Life Support Withdrawn?	○ Yes	○ No
	Were organs recovered?	○ Yes	○ No
If patient survives to discharge	_____	❑ Unknown/Not Documented	
	_____	❑ Unknown/Not Documented	
Comments			

NOTE: Please do not enter any patient identifiable information in these optional fields.

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 ____/____/_____ ____:____

END OF ADMISSION & DISCHARGE FORM