Print Form

Children's Medical Services Perinatal Data System
Neonatal Component

___/___/_____
Month/Day/Year
Date completed

_____
Mother's Social Security Number
(Unique Number)

_____ _____ _____
Mother's Hospital Number Mother's Last Name Mother's First Name

_____ _____ _____
Child's Hospital Number Child's Last Name Child's First Name

NEONATAL ADMITTING DATA

_____ _____ ____/____/____
Child's Status Code Birth County Number Month/ Day /Year
EL IE UF HM NN Hospital
Admission Date

DISCHARGE DATA

_____ ____/____/____ ____/____/____
Weight (Grams) at Month/ Day /Year Month/ Day /Year
NICU Discharge Date of Discharge Date of Discharge
From Level 3 NICU From Center

RESPIRATORY ASSISTANCE AND SURGERY

Codes
14 Assisted Ventilation
If coded 14 then

Yes/No _____Ventilation >48 hours

_____Total Hours on Ventilation

_____Total Hours on Oxygen >40%

15 Oxygen >4 Hours

16 Continuous Positive Airway Pressure (CPAP)

18 Surgery Major (See Procedures)*

19 Extracorporeal Membrane Oxygenation (ECMO)

Completed by_____

Date entered in System_____/_____/_____

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DISCHARGE DIAGNOSIS_____**PROCEDURES**_____

ENTER ICD-9 CODES (Code 779.9 for Infant Mortality) *If 18 (Surgery, Major is Coded) A Surgical ICD-9 Procedure Code Must Be Entered

A_____ F_____

B_____ G_____ A_____

C_____ H_____ B_____

D_____ I_____ C_____

E_____ J_____

Completed by_____ Date entered in System_____/_____/_____