

MATERNAL AND PERINATAL DATA
 (to be filled out only for randomized patients)

1. Infant's ID

2. Mother's Date of Birth

***** SES DATA *****

3. Education (check one for each parent)

	Mother	Father
Less than 7th grade	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Jr. High 9th grade	<input type="checkbox"/> 02	<input type="checkbox"/> 02
Partial high school (10th or 11th grade)	<input type="checkbox"/> 03	<input type="checkbox"/> 03
High school graduate	<input type="checkbox"/> 04	<input type="checkbox"/> 04
Partial college or trade school	<input type="checkbox"/> 05	<input type="checkbox"/> 05
College graduate	<input type="checkbox"/> 06	<input type="checkbox"/> 06
Graduate study	<input type="checkbox"/> 07	<input type="checkbox"/> 07
Refused to answer or Don't Know	<input type="checkbox"/> 08	<input type="checkbox"/> 08
Unknown	<input type="checkbox"/> 94	<input type="checkbox"/> 94

4. Marital Status (check one)

Married and living with spouse 01

Not married and living with
 infant's father 02

Not married and living with
 extended family 03

Single parent household 04

Other 05

5. Occupation:

A. Father's Occupation:

1. What is your husband's occupation (or the man you are living with now)?

2. What kind of work does he do day-to-day?

3. Has he been unemployed in the last year?

Yes No Don't Know
 01 02 94

For how long? weeks

B. Mother's Occupation:

1. Did you work outside the home before your baby was born?

Yes No
 01 02

2. What was your occupation? _____

3. What kind of work does that involve?

4. How much education, training or on the job experience did you need to get that job?

C. Occupational Classification: (check appropriate categories)

	<u>Mother</u>	<u>Father</u>
1. Professional, Technical High Level Administrative and Managerial Positions	<input type="checkbox"/> 01	<input type="checkbox"/> 01
2. Managers, Proprietors, "Lesser" Professionals and Technical Positions	<input type="checkbox"/> 02	<input type="checkbox"/> 02
3. Sales and Miscellaneous "White Collar" Positions	<input type="checkbox"/> 03	<input type="checkbox"/> 03
4. "Blue Collar" Supervisory Positions, Self-Employed in Skilled Trades, Trades Extensive Training Requirements, and Higher Level Service Workers	<input type="checkbox"/> 04	<input type="checkbox"/> 04
5. Skilled Trades at a Non-supervisory Level and Service Workers	<input type="checkbox"/> 05	<input type="checkbox"/> 05
6. Semi-skilled and Unskilled Workers	<input type="checkbox"/> 06	<input type="checkbox"/> 06
7. Other (specify) _____	<input type="checkbox"/> 07	<input type="checkbox"/> 07
8. Unknown	<input type="checkbox"/> 94	<input type="checkbox"/> 94

***** MEDICAL HISTORY *****

6. Prior to this pregnancy, has the mother ever had any of the following conditions? Yes No Don't Know
- A. Diabetes 01 02 94
- If YES, classification (check all that apply):
- Type I (insulin dependent) 01
- Type II (non-insulin dependent) 02
- Type III (gestational) 03
- Type IV (secondary) 04
- Don't Know 05
- B. Chronic hypertension 01 02 94
- C. Others (specify) _____ .. 01 02 94

***** PREGNANCY HISTORY *****

7. Pregnancy data including present delivery:

- A. gravida
- B. full term, premature (\leq 37 weeks)
- C. abortion
- D. stillborn
- E. neonatal deaths
- F. living children

8. On the average during the current pregnancy, how many cigarettes did the mother smoke per day?

9. On the average during the current pregnancy, how many drinks with alcohol did the mother drink per week?

10. Check any of the following drugs which the patient reported using during pregnancy:

	Yes	No	Don't Know
A. Marihuana	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
B. Heroin	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
C. Cocaine	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
D. Methadone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
E. Methaqualone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
F. Barbiturates	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
G. Other (specify) _____	<input type="checkbox"/> 01		
H. None	<input type="checkbox"/> 01		

11. Did the mother have any of the following during this pregnancy?

	Yes	No	Don't Know
A. Pregnancy induced hypertension	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
B. Gestational diabetes	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
If YES, insulin dependent	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
C. Previous episodes of premature labor	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
If YES, was beta sympathomimetic used?	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94

- D. Severe vaginal bleeding 01 02 94
- E. Other significant illness during pregnancy .. 01 02 94

Specify _____

***** LABOR *****

12. What was the gestational age of the baby (babies) when delivered (best obstetric estimate)? weeks, Unknown 94
13. Duration of rupture of membranes prior to this delivery Days Hours Unknown
14. Was labor
- A. Induced 01
 - B. Spontaneous .. 02
 - C. No labor 03
 - D. Don't Know ... 94
15. Length of labor in hours hours, Unknown 94
16. Did the mother have any of the following complications during labor?
- A. Fever 01 02 94
 - B. Endometritis 01 02 94

***** DRUGS DURING LABOR AND DELIVERY *****

17. Has the mother received any of the following within 48 hours prior to delivery? (check all that apply)
- A. Anesthesia
 - 1. General 01
 - 2. Spinal 02
 - 3. Epidural 03
 - 4. Local 04
 - 5. Don't Know 05
 - 6. None 06

- | | Yes | No | Don't Know |
|----------------------------|-----------------------------|-----------------------------|-----------------------------|
| B. Analgesia | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |
| C. Antibiotics | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |
| D. Oxytocin | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |
| E. Tocolytics | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |
| F. Magnesium sulfate | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |
| G. Other | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 94 |

Specify: _____

H. None 01

18. Did mother receive steroids to induce fetal lung maturity? 01 02 94

If YES, week of gestation

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

INFANT VENTILATOR DATA

I. Blood Gases, Ventilator, Cardiac Variables, and Medications

A. Qualifying Data:

	Pre 1	Pre 2	Preentry
1. Ventilation			
On CMV	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
No mechanical ventilation	<input type="checkbox"/> 02	<input type="checkbox"/> 02	<input type="checkbox"/> 02
2. Blood Gases			
Date	<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"/> <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"/>
Time (24-hr clock)	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
Source (arterial = 1; transcutaneous = 2; capillary = 3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PaO ₂ (mm Hg)	<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"/>
PaCO ₂ (mm Hg)	<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"/>
pH	<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"/>
3. % O₂	<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"/>
4. Ventilator Variables			
a Conventional ventilator			
Ventilator rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Inspiratory time (sec)	<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"/>
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<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"/>

	Pre 1	Pre 2	Preentry
4. Ventilator variables (con.)			
Paw (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
5. Cardiac/respiratory variables:			
Heart rate (bpm)	<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"/>
Respiratory rate (bpm)	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
Blood pressure—systolic (mm Hg)	<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"/>
Blood pressure—diastolic (mm Hg)	<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"/>
Blood pressure—Mean (mm Hg)	<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"/>
Method (direct = 1; indirect = 2)	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Medications			
Sodium bicarbonate/THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____
Dose	_____	_____	_____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____
Dose	_____	_____	_____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____
Dose	_____	_____	_____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____
Dose	_____	_____	_____

INFANT VENTILATOR DATA

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

B. Entry Data and Data Every Two Hours
Time Since Entry

1. Respiratory Support

- a CMV
- b HFV
- c CPAP (nasal)
- d Nasal cannula/prongs
- e Hood

	2 hr	4 hr	6 hr
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Blood Gases:

Date

2 hr	4 hr	6 hr
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>

Time

2 hr	4 hr	6 hr
<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"/> <input type="text"/> <input type="text"/> <input type="text"/>

Source (arterial = 1 transcutaneous = 2; capillary = 3)

2 hr	4 hr	6 hr
<input type="text"/>	<input type="text"/>	<input type="text"/>

PaO₂ (mm Hg)

2 hr	4 hr	6 hr
<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"/> <input type="text"/> <input type="text"/> <input type="text"/>

PaCO₂ (mm Hg)

2 hr	4 hr	6 hr
<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"/> <input type="text"/> <input type="text"/> <input type="text"/>

pH

2 hr	4 hr	6 hr
<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"/> . <input type="text"/> <input type="text"/> <input type="text"/>

3. % O₂

2 hr	4 hr	6 hr
<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"/>

4. Ventilator Variables:

a. High Frequency Ventilator

Ventilator rate (Hz)

2 hr	4 hr	6 hr
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

Stroke volume (mL)

2 hr	4 hr	6 hr
<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"/>

4. Ventilator Variables (con.)

	2 hr	4 hr	6 hr
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>

b. Conventional Ventilator

Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Sigh Data

Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Manual rate (cph)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>

6. Cardiac/Respiratory Variables:

Heart rate (bpm)

2 hr		
<input type="text"/>	<input type="text"/>	<input type="text"/>

4 hr		
<input type="text"/>	<input type="text"/>	<input type="text"/>

6 hr		
<input type="text"/>	<input type="text"/>	<input type="text"/>

Respiratory rate (bpm)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Blood pressure—systolic (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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Blood pressure—diastolic (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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Blood pressure—mean (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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Method (direct = 1; indirect = 2)

<input type="text"/>

<input type="text"/>

<input type="text"/>

7. Medications

Sodium bicarbonate/THAM

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Vasopressors

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Volume expanders

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Muscle relaxants

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

C. Data Every Six Hours
Time Since Entry

	12 hr	18 hr	24 hr	30 hr	36 hr
1. Respiratory Support					
a. CMV	01 <input type="checkbox"/>	01 <input type="checkbox"/>	01 <input type="checkbox"/>	01 <input type="checkbox"/>	01 <input type="checkbox"/>
b. HFV	02 <input type="checkbox"/>	02 <input type="checkbox"/>	02 <input type="checkbox"/>	02 <input type="checkbox"/>	02 <input type="checkbox"/>
c. CPAP (nasal)	03 <input type="checkbox"/>	03 <input type="checkbox"/>	03 <input type="checkbox"/>	03 <input type="checkbox"/>	03 <input type="checkbox"/>
d. Nasal cannula/prongs	04 <input type="checkbox"/>	04 <input type="checkbox"/>	04 <input type="checkbox"/>	04 <input type="checkbox"/>	04 <input type="checkbox"/>
e. Hood	05 <input type="checkbox"/>	05 <input type="checkbox"/>	05 <input type="checkbox"/>	05 <input type="checkbox"/>	05 <input type="checkbox"/>
2. Blood Gases:					
Date	<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"/> <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"/> / <input type="text"/> <input type="text"/>
Time	<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"/> <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"/> <input type="text"/> <input type="text"/>
Source (arterial = 1, transcutaneous = 2; capillary = 3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PaO ₂ (mm Hg)	<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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
PaCO ₂ (mm Hg)	<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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
pH	<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"/>	<input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> . <input type="text"/> <input type="text"/>
3. % O₂	<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"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4. Ventilator Variables:					
a. High Frequency Ventilator					
Ventilator rate (Hz)	<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"/> <input type="text"/>
Stroke volume (mL)	<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"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>

4. Ventilator Variables (con.)

12 hr

18 hr

24 hr

30 hr

36 hr

Amplitude (cm H₂O)

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PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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Flow rate (Lpm)

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b. Conventional Ventilator

Ventilator rate (cpm)

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Inspiratory time (sec)

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PEEP (cm H₂O)

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PIP (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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		.	
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		.	
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Flow rate (Lpm)

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5. Sigh Data

Machine rate (cpm)

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--	--

Manual rate (cph)

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Inspiratory time (sec)

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PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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6. Cardiac/Respiratory Variables:

	12 hr	18 hr	24 hr	30 hr	36 hr
Heart rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— systolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— diastolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— mean (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Method (direct = 1; indirect = 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Medications

Sodium bicarbonate/ THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

D. Data Every Twelve Hours

Time Since Entry

1. Respiratory Support

a. CMV

01

01

01

01

01

b. HFV

02

02

02

02

02

c. CPAP (nasal)

03

03

03

03

03

d. Nasal cannula/prongs

04

04

04

04

04

e. Hood

05

05

05

05

05

2. Blood Gases:

Date

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Time

Source (arterial = 1,
transcutaneous = 2,
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

 .
 .
 .
 .
 .

3. % O₂

4. Ventilator Variables:

a. High Frequency
Ventilator

Ventilator rate (Hz)

Stroke volume (mL)

 .
 .
 .
 .
 .

4 Ventilator Variables (con.)

48 hr

60 hr

72 hr

84 hr

96 hr

Amplitude (cm H₂O)

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--	--

PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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Flow rate (Lpm)

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b. Conventional Ventilator

Ventilator rate (cpm)

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Inspiratory time (sec)

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PEEP (cm H₂O)

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PIP (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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Flow rate (Lpm)

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5. Sigh Data

Machine rate (cpm)

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Manual rate (cph)

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				.	
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Inspiratory time (sec)

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PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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6. Cardiac/Respiratory Variables:

	48 hr	60 hr	72 hr	84 hr	96 hr
Heart rate (bpm)	<input type="text"/>				
Respiratory rate (bpm)	<input type="text"/>				
Blood pressure—systolic (mm Hg)	<input type="text"/>				
Blood pressure—diastolic (mm Hg)	<input type="text"/>				
Blood pressure—mean (mm Hg)	<input type="text"/>				
Method (direct = 1; indirect = 2)	<input type="checkbox"/>				

7. Medications

Sodium bicarbonate/THAM

	48 hr	60 hr	72 hr	84 hr	96 hr
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No					
Type _____					
Dose _____					

Vasopressors

	48 hr	60 hr	72 hr	84 hr	96 hr
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No					
Type _____					
Dose _____					

Volume expanders

	48 hr	60 hr	72 hr	84 hr	96 hr
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No					
Type _____					
Dose _____					

Muscle relaxants

	48 hr	60 hr	72 hr	84 hr	96 hr
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No					
Type _____					
Dose _____					

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

E. Every Two or Three Days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

- a CMV
- b HFV
- c CPAP (nasal)
- d Nasal cannula/prongs
- e Hood

	5 days	7 days	10 days
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Blood Gases:

Date

5 days	7 days	10 days
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>Month Day</small>

Time

<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Source (arterial = 1, transcutaneous = 2; capillary = 3)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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PaO₂ (mm Hg)

<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
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PaCO₂ (mm Hg)

<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
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pH

<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"/> . <input type="text"/> <input type="text"/> <input type="text"/>
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3. % O₂

<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
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4. Ventilator Variables:

a. High Frequency Ventilator

Ventilator rate (Hz)

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
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Stroke volume (mL)

<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"/>
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4. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

5 days

7 days

10 days

b. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP (cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

5. Sigh Data

Machine rate (cpm)

Manual rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cm H₂O)

6. Medications

Sodium bicarbonate/THAM

	5 days	7 days	10 days
	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
	Type _____	Type _____	Type _____
	Dose _____	Dose _____	Dose _____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
	Type _____	Type _____	Type _____
	Dose _____	Dose _____	Dose _____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
	Type _____	Type _____	Type _____
	Dose _____	Dose _____	Dose _____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
	Type _____	Type _____	Type _____
	Dose _____	Dose _____	Dose _____

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

F. Every Seven Days

**Time Since Entry
(as specified in the protocol-in days)**

1. Respiratory Support

a. CMV

b. HFV

c. CPAP (nasal)

d. Nasal cannula/prongs

e. Hood

2. Blood Gases:

Date

Time

Source (arterial = 1, transcutaneous = 2;
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

3. % O₂

4. Ventilator Variables:

a. High Frequency Ventilator

Ventilator rate (Hz)

Stroke volume (mL)

14 days

21 days

28 days

01

02

03

04

05

Month

Day

01

02

03

04

05

Month

Day

01

02

03

04

05

Month

Day

4. Ventilator Variables (con.)

14 days

21 days

28 days

Amplitude (cm H₂O)

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PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cmH₂O)

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Flow rate (Lpm)

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b. Conventional Ventilator

Ventilator rate (cpm)

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Inspiratory time (sec)

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PEEP(cm H₂O)

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PIP (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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Flow rate (Lpm)

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5. Sigh Data

Machine rate (cpm)

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Manual rate (cph)

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Inspiratory time (sec)

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PIP (peak) (cm H₂O)

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\bar{P}_{aw} (cm H₂O)

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Form D

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6. Medications

Sodium bicarbonate/THAM

14 days	21 days	28 days
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____	Type _____	Type _____
Dose _____	Dose _____	Dose _____
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____	Type _____	Type _____
Dose _____	Dose _____	Dose _____
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____	Type _____	Type _____
Dose _____	Dose _____	Dose _____
01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____	Type _____	Type _____
Dose _____	Dose _____	Dose _____

Vasopressors

Volume expanders

Muscle relaxants

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

G. After 28 days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

- a CMV 01
- b HFV 02
- c CPAP (nasal) 03
- d Nasal cannula/prongs 04
- e Hood 05

- 01
- 02
- 03
- 04
- 05

- 01
- 02
- 03
- 04
- 05

2. Blood Gases:

Date
Month Day

Month Day

Month Day

Time

Source (arterial = 1, transcutaneous = 2;
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

3. % O₂

4. Ventilator Variables:

a. High Frequency Ventilator

Ventilator rate (Hz)

Stroke volume (mL)

.

.

4. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

P̄aw (cmH₂O)

Flow rate (Lpm)

b. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

P̄aw (cm H₂O)

Flow rate (Lpm)

5. Sigh Data

Machine rate (cpm)

Manual rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

P̄aw (cm H₂O)

	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
P̄aw (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Conventional Ventilator			
Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
P̄aw (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Sigh Data			
Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Manual rate (cph)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
P̄aw (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>

6. Medications

Sodium bicarbonate/THAM

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

Vasopressors

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

Volume expanders

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

Muscle relaxants

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

01 Yes 02 No

Type _____

Dose _____

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

G. After 28 days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

- a CMV 01
- b HFV 02
- c CPAP (nasal) 03
- d. Nasal cannula/prongs 04
- e Hood 05

- 01
- 02
- 03
- 04
- 05

- 01
- 02
- 03
- 04
- 05

2. Blood Gases:

Date

Month Day

Month Day

Month Day

Time

Source (arterial = 1, transcutaneous = 2;
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

3. % O₂

4. Ventilator Variables:

a. High Frequency Ventilator

Ventilator rate (Hz)

Stroke volume (mL)

.

.

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6. Medications

Sodium bicarbonate/THAM

[] [] []

[] [] []

[] [] []

.01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Vasopressors

.01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Volume expanders

.01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Muscle relaxants

.01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

II. Nutrition, Environment, and Other Data

	Month	Day	Month	Day	Month	Day
A. Day	Day 0		Day 1		Day 2	
B. Nutrition						
1 Total Fluid Intake:						
a Parenteral (mL/24 hr)						
b Enteral (Kcal/24 hr)						
2 Caloric Intake (Kcal/24 hr)						
C. Weight (gm)						
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3, other = 4)						
E. Urine (mL/24 hr)						

II. Nutrition, Environment, and Other Data (continued)

	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day
A. Day	<u>Day 3</u>		<u>Day 4</u>		<u>Day 5</u>	
B. Nutrition						
1 Total Fluid Intake:						
a Parenteral (mL/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b Enteral (Kcal/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Caloric Intake (Kcal/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Weight (gm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3, other = 4)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
E. Urine (mL/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

II. Nutrition, Environment, and Other Data (continued)

	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day </div>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day </div>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day </div>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px;"> Month Day </div>
A. Day	<u>Day 7</u>	<u>Day 14</u>	<u>Day 21</u>	<u>Day 28</u>
B. Nutrition				
1 Total Fluid Intake:				
a Parenteral (mL/24 hr)	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>
b Enteral (Kcal/24 hr)	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>
2 Caloric Intake (Kcal/24 hr)	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>
C. Weight (gm)	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)	<div style="border: 1px solid black; width: 20px; height: 15px;"></div>	<div style="border: 1px solid black; width: 20px; height: 15px;"></div>	<div style="border: 1px solid black; width: 20px; height: 15px;"></div>	<div style="border: 1px solid black; width: 20px; height: 15px;"></div>
E. Urine (mL/24 hr)	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>	<div style="display: flex; justify-content: space-around;"><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div><div style="border: 1px solid black; width: 20px; height: 15px;"></div></div>

II. Nutrition, Environment, and Other Data (continued)

	Month	Day	Month	Day	Month	Day
A. Day	<input type="text"/>		<input type="text"/>		<input type="text"/>	
B. Nutrition						
1. Total Fluid Intake:						
a. Parenteral (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
b. Enteral (Kcal/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
2. Caloric Intake (Kcal/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
C. Weight (gm)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
E. Urine (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	

Signature of Clinical Coordinator _____ Date _____

II. Nutrition, Environment, and Other Data (continued)

	Month	Day	Month	Day	Month	Day
A. Day						
B. Nutrition						
1. Total Fluid Intake:						
a. Parenteral (mL/24 hr)						
b. Enteral (Kcal/24 hr)						
2. Caloric Intake (Kcal/24 hr)						
C. Weight (gm)						
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)						
E. Urine (mL/24 hr)						

Signature of Clinical Coordinator _____ Date _____

FLOW DATA FORM

1. Infant ID

2. Date of birth

Month Day Year

3. Sex 01 Male 02 Female

4. Time Schedule of Ventilator Usage: (exclude initial ventilator)

Make	Model	Serial No.	Starting Date			Ending Date		
			Month	Day	Year	Month	Day	Year
_____	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Time <input type="text"/>			Time <input type="text"/>		
_____	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Time <input type="text"/>			Time <input type="text"/>		
_____	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Time <input type="text"/>			Time <input type="text"/>		
_____	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Time <input type="text"/>			Time <input type="text"/>		
_____	_____	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Time <input type="text"/>			Time <input type="text"/>		

INFANT VENTILATOR DATA

I. Blood Gases, Ventilator, Cardiac Variables, and Medications

A. Qualifying Data:

1. Ventilation

On CMV

01

01

01

No mechanical ventilation

02

02

02

2. Blood Gases

Date

/ /

/ /

/ /

Time (24-hr clock)

Source (arterial = 1; transcutaneous = 2, capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

3. a. % O₂ (22-100%)

b. Nasal cannula (mL/minute of 100% O₂)

4. Conventional ventilators

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP (cm H₂O)

PIP (cm H₂O)

.

.

.

	Pre 1	Pre 2	Preentry
4. Conventional ventilators (con.)			
Paw (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
5. Cardiac/respiratory variables:			
Heart rate (bpm)	<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"/>
Respiratory rate (bpm)	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
Blood pressure—systolic (mm Hg)	<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"/>
Blood pressure—diastolic (mm Hg)	<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"/>
Blood pressure—Mean (mm Hg)	<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"/>
Method (direct = 1, indirect = 2)	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Medications			
Sodium bicarbonate/THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____

INFANT VENTILATOR DATA

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

B. Entry Data and Data Every Two Hours

Time Since Entry

1. Respiratory Support

- a. CMV
- b. HFV
- c. CPAP (nasal)
- d. Nasal cannula/prongs
- e. Hood

	2 hr	4 hr	6 hr
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Blood Gases:

Date

2 hr	4 hr	6 hr
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day

Time

<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
---	---	---

Source (arterial = 1, transcutaneous = 2; capillary = 3)

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

PaO₂ (mm Hg)

<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"/>
--	--	--

PaCO₂ (mm Hg)

<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"/>
--	--	--

pH

<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"/>
--	--	--

3. % O₂

<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"/>
--	--	--

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
---	---	---

Stroke volume (mL)

<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"/>
--	--	--

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

2 hr

4 hr

6 hr

	2 hr	4 hr	6 hr
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Cardiac/Respiratory Variables:

Heart rate (bpm)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Respiratory rate (bpm)

2 hr [][][][]

4 hr [][][][]

6 hr [][][][]

Blood pressure—systolic (mm Hg)

2 hr [][][]

4 hr [][][]

6 hr [][][]

Blood pressure—diastolic (mm Hg)

2 hr [][][]

4 hr [][][]

6 hr [][][]

Blood pressure—mean (mm Hg)

2 hr [][][]

4 hr [][][]

6 hr [][][]

Method (direct = 1; indirect = 2)

2 hr []

4 hr []

6 hr []

7. Medications

Sodium bicarbonate/THAM

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Vasopressors

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Volume expanders

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Muscle relaxants

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

C. Data Every Six Hours

12 hr

18 hr

24 hr

30 hr

36 hr

Time Since Entry

1. Respiratory Support

a CMV

01

01

01

01

01

b HFV

02

02

02

02

02

c CPAP (nasal)

03

03

03

03

03

d Nasal cannula/prongs

04

04

04

04

04

e Hood

05

05

05

05

05

2. Blood Gases:

Date

Month Day

Month Day

Month Day

Month Day

Month Day

Time

Source (arterial = 1,
transcutaneous = 2,
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

.

.

3. % O₂

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Stroke volume (mL)

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4. a. Ventilator Variables
(con.)

	12 hr	18 hr	24 hr	30 hr	36 hr
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

b. Machine Sigh Data

Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<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"/> • <input type="text"/>
PIP (peak) (cm H ₂ O)	<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"/> • <input type="text"/>

c. IHFO

HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Conventional Ventilator

Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<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"/> • <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/> • <input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Cardiac/Respiratory

Variables:

	12 hr	18 hr	24 hr	30 hr	36 hr
Heart rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— systolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— diastolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— mean (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Method (direct = 1; indirect = 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Medications

	12 hr	18 hr	24 hr	30 hr	36 hr
Sodium bicarbonate/ THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____					
Dose _____					
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____					
Dose _____					
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____					
Dose _____					
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type _____					
Dose _____					

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

D. Data Every Twelve Hours

Time Since Entry

1. Respiratory Support

a CMV

01

01

01

01

01

b HFV

02

02

02

02

02

c CPAP (nasal)

03

03

03

03

03

d Nasal cannula/prongs

04

04

04

04

04

e Hood

05

05

05

05

05

2. Blood Gases:

Date

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Month	Day
<input type="text"/>	<input type="text"/>

Time

Source (arterial = 1, transcutaneous = 2, capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

3. % O₂

4. HFV

a. Ventilator Variables:

Ventilator rate (Hz)

Stroke volume (mL)

4. a. Ventilator Variables (con.)

48 hr

60 hr

72 hr

84 hr

96 hr

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

P_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

P_{aw} (cm H₂O)

Flow rate (Lpm)

6. Cardiac/Respiratory Variables:

	48 hr	60 hr	72 hr	84 hr	96 hr
Heart rate (bpm)	<input type="text"/>				
Respiratory rate (bpm)	<input type="text"/>				
Blood pressure— systolic (mm Hg)	<input type="text"/>				
Blood pressure— diastolic (mm Hg)	<input type="text"/>				
Blood pressure— mean (mm Hg)	<input type="text"/>				
Method (direct = 1; indirect = 2)	<input type="checkbox"/>				

7. Medications

	48 hr	60 hr	72 hr	84 hr	96 hr
Sodium bicarbonate/ THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____	_____	_____
Dose	_____	_____	_____	_____	_____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____	_____	_____
Dose	_____	_____	_____	_____	_____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____	_____	_____
Dose	_____	_____	_____	_____	_____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
Type	_____	_____	_____	_____	_____
Dose	_____	_____	_____	_____	_____

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

E. Every Two or Three Days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

- a CMV
- b HFV
- c CPAP (nasal)
- d Nasal cannula/prongs
- e Hood

2. Blood Gases:

Date

Time

Source (arterial = 1, transcutaneous = 2;
capillary = 3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

3. % O₂

4. HFV

a. Ventilator Variables:

Ventilator rate (Hz)

Stroke volume (mL)

5 days

7 days

10 days

	5 days	7 days	10 days
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day
Time	<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"/> <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"/>
Source	<input type="text"/>	<input type="text"/>	<input type="text"/>
PaO ₂ (mm Hg)	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
PaCO ₂ (mm Hg)	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
pH	<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"/> . <input type="text"/> <input type="text"/> <input type="text"/>
% O ₂	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>
Ventilator rate (Hz)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Stroke volume (mL)	<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"/>

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

5 days

7 days

10 days

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I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

F. Every Seven Days

Time Since Entry
(as specified in the protocol-in days)

14 days

21 days

28 days

1 Respiratory Support

- a CMV
- b HFV
- c CPAP (nasal)
- d Nasal cannula/prongs
- e Hood

	14 days	21 days	28 days
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2 Blood Gases:

Date

Month	Day	Month	Day	Month	Day
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Time

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Source (arterial = 1 transcutaneous = 2, capillary = 3)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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PaO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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PaCO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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pH

<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"/>
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3. % O₂

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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4. HFV

a. Ventilator Variables:

Ventilator rate (Hz)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Stroke volume (mL)

<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
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4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

14 days

21 days

28 days

	14 days	21 days	28 days
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

[][][]

[][][]

[][][]

G. After 28 days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

a CMV

01 [][]

01 [][]

01 [][]

b HFV

02 [][]

02 [][]

02 [][]

c CPAP (nasal)

03 [][]

03 [][]

03 [][]

d Nasal cannula/prongs

04 [][]

04 [][]

04 [][]

e Hood

05 [][]

05 [][]

05 [][]

2. Blood Gases:

Date

[][] [][]
Month Day

[][] [][]
Month Day

[][] [][]
Month Day

Time

[][][][]

[][][][]

[][][][]

Source (arterial = 1, transcutaneous = 2,
capillary = 3)

[]

[]

[]

PaO₂ (mm Hg)

[][][]

[][][]

[][][]

PaCO₂ (mm Hg)

[][][]

[][][]

[][][]

pH

[] . [][]

[] . [][]

[] . [][]

3. % O₂

[][][]

[][][]

[][][]

4. HFV

a. Ventilator Variables:

Ventilator rate (Hz)

[][]

[][]

[][]

Stroke volume (mL)

[][] . []

[][] . []

[][] . []

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

P̄aw (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

P̄aw (cm H₂O)

Flow rate (Lpm)

	1	2	3	4	5	6	7	8	9	10
Amplitude (cm H ₂ O)										
PIP (peak) (cm H ₂ O)										
P̄aw (cmH ₂ O)										
Flow rate (Lpm)										
Machine rate (cpm)										
Machine rate (cph)										
Inspiratory time (sec)										
PIP (peak) (cm H ₂ O)										
HFO rate (cpm)										
HFO rate (cph)										
Duration (sec)										
Ventilator rate (cpm)										
Inspiratory time (sec)										
PEEP(cm H ₂ O)										
PIP (cm H ₂ O)										
P̄aw (cm H ₂ O)										
Flow rate (Lpm)										

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

G. After 28 days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

- a CMV
- b HFV
- c CPAP (nasal)
- d Nasal cannula/prongs
- e Hood

	<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"/>
01	<input type="text"/>	<input type="text"/>	<input type="text"/>	01	<input type="text"/>	<input type="text"/>	<input type="text"/>	01	<input type="text"/>
02	<input type="text"/>	<input type="text"/>	<input type="text"/>	02	<input type="text"/>	<input type="text"/>	<input type="text"/>	02	<input type="text"/>
03	<input type="text"/>	<input type="text"/>	<input type="text"/>	03	<input type="text"/>	<input type="text"/>	<input type="text"/>	03	<input type="text"/>
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05	<input type="text"/>	<input type="text"/>	<input type="text"/>	05	<input type="text"/>	<input type="text"/>	<input type="text"/>	05	<input type="text"/>

2. Blood Gases:

Date

<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"/>	<input type="text"/>	
Month		Day		Month		Day		Month		Da.

Time

<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"/>	<input type="text"/>
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Source (arterial = 1, transcutaneous = 2;
capillary = 3)

<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"/>	<input type="text"/>
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PaO₂ (mm Hg)

<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"/>	<input type="text"/>
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PaCO₂ (mm Hg)

<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"/>	<input type="text"/>
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pH

<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"/>
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3. % O₂

<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"/>	<input type="text"/>
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4. HFV

a. Ventilator Variables:

Ventilator rate (Hz)

<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"/>	<input type="text"/>
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Stroke volume (mL)

<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"/>
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4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

P̄aw (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

P̄aw (cm H₂O)

Flow rate (Lpm)

	Box 1	Box 2	Box 3	Box 4	Box 5	Box 6	Box 7	Box 8
Amplitude (cm H ₂ O)								
PIP (peak) (cm H ₂ O)								
P̄aw (cmH ₂ O)								
Flow rate (Lpm)								
Machine rate (cpm)								
Machine rate (cph)								
Inspiratory time (sec)			.			.		
PIP (peak) (cm H ₂ O)			.			.		
HFO rate (cpm)								
HFO rate (cph)								
Duration (sec)								
Ventilator rate (cpm)								
Inspiratory time (sec)								
PEEP(cm H ₂ O)								
PIP (cm H ₂ O)			.			.		
P̄aw (cm H ₂ O)			.			.		
Flow rate (Lpm)								

II. Nutrition, Environment, and Other Data

Month	Day	Month	Day	Month	Day
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A. Day

Day 0

Day 1

Day 2

B. Nutrition

1 Total Fluid Intake:

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)

E. Urine (mL/24 hr)

	Day 0	Day 1	Day 2
1 Total Fluid Intake:			
a Parenteral (mL/24 hr)			
b Enteral (mL/24 hr)			
2 Caloric Intake (Kcal/24 hr)			
C. Weight (gm)			
D. Type of Bed			
E. Urine (mL/24 hr)			

II. Nutrition, Environment, and Other Data (continued)

Month	Day	Month	Day	Month	Day
-------	-----	-------	-----	-------	-----

A. Day

Day 3

Day 4

Day 5

B. Nutrition

1 Total Fluid Intake

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1, incubator = 2, open crib/bassinette = 3; other = 4)

E. Urine (mL/24 hr)

	Day 3	Day 4	Day 5
1 Total Fluid Intake			
a Parenteral (mL/24 hr)			
b Enteral (mL/24 hr)			
2 Caloric Intake (Kcal/24 hr)			
C. Weight (gm)			
D. Type of Bed			
E. Urine (mL/24 hr)			

II. Nutrition, Environment, and Other Data (continued)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Month	Day	Month	Day	Month	Day

A Day

Day 7

Day 14

Day 21

Day 28

B Nutrition

1 Total Fluid Intake

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D Type of Bed (radiant warmer = 1, incubator = 2, open crib/bassinette = 3, other = 4)

E. Urine (mL/24 hr)

<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="text"/>	<input type="text"/>

II. Nutrition, Environment, and Other Data (continued)

A. Day

B Nutrition

1 Total Fluid Intake:

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1; incubator = 2;
open crib/bassinette = 3; other = 4)

E. Urine (mL/24 hr)

<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day
<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"/>
<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"/>	<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"/>
<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"/>	<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"/>
<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Clinical Coordinator _____ Date _____

II. Nutrition, Environment, and Other Data (continued)

	Month	Day	Month	Day	Month	Day
A Day	<input type="text"/>		<input type="text"/>		<input type="text"/>	
B Nutrition						
1 Total Fluid Intake						
a Parenteral (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
b Enteral (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
2 Caloric Intake (Kcal/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
C Weight (gm)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
D Type of Bed (radiant warmer = 1, incubator = 2, open crib/bassinette = 3, other = 4)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
E Urine (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	

Signature of Clinical Coordinator _____ Date _____

FLOW DATA FORM

1. Infant ID

2. Date of birth

Month Day Year

3. Sex 01 Male 02 Female

4. Time Schedule of Ventilator Usage: *(exclude initially assigned ventilator)*

Make	Model	Serial No.	Starting Date			Ending Date		
_____	_____	_____	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
			<input type="text"/> Time			<input type="text"/> Time		
_____	_____	_____	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
			<input type="text"/> Time			<input type="text"/> Time		
_____	_____	_____	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
			<input type="text"/> Time			<input type="text"/> Time		
_____	_____	_____	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
			<input type="text"/> Time			<input type="text"/> Time		
_____	_____	_____	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Year
			<input type="text"/> Time			<input type="text"/> Time		

INFANT VENTILATOR DATA

I. Blood Gases, Ventilator, Cardiac Variables, and Medications

A. Qualifying Data:

1. Ventilation

On CMV

01

01

01

No mechanical ventilation

02

02

02

2. Blood Gases

Date

Month Day Year

Month Day Year

Month Day Year

Time (24-hr clock)

Source (arterial = 1, transcutaneous = 2, capillary = 3, venous = 4)

Source

Source

Source

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

a. O₂ Saturation % (pulse oximeter)

3. % O₂ (22-100%)

4. Conventional ventilators

Ventilator rate (cpm)

Inspiratory time (sec)

.

.

.

PEEP (cm H₂O)

PIP (cm H₂O)

Pre 1

Pre 2

Preentry

4. Conventional ventilators (con.)

Paw (cm H₂O)

.

.

.

Flow rate (Lpm)

.

.

.

5. Cardiac/respiratory variables:

Heart rate (bpm)

Respiratory rate (bpm)

Blood pressure—systolic (mm Hg)

Blood pressure—diastolic (mm Hg)

Blood pressure—Mean (mm Hg)

Method (direct = 1; indirect = 2)

6. Medications

Sodium bicarbonate/THAM

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Vasopressors

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Volume expanders

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Muscle relaxants

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

INFANT VENTILATOR DATA

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

B. Entry Data and Data Every Two Hours

Time Since Entry

2 hr

4 hr

6 hr

1. Respiratory Support

a CMV

b HFV

c CPAP (nasal)

d Nasal cannula/prongs

e Hood/isolette

01

02

03

04

05

01

02

03

04

05

01

02

03

04

05

2. Blood Gases:

Date

Month Day

Month Day

Month Day

Time

Time

Time

Time

Source (arterial = 1, transcutaneous = 2, capillary = 3, venous = 4)

Source

Source

Source

PaO₂ (mm Hg)

PaO₂ (mm Hg)

PaO₂ (mm Hg)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

PaCO₂ (mm Hg)

PaCO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

pH

pH

pH

a. O₂ Saturation % (pulse oximeter)

O₂ Saturation %

O₂ Saturation %

O₂ Saturation %

3. a. % O₂ (22-100%)

% O₂

% O₂

% O₂

b. Nasal cannula (mL/min of 100% O₂)

Nasal cannula

Nasal cannula

Nasal cannula

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Ventilator rate (Hz)

Ventilator rate (Hz)

Ventilator rate (Hz)

Stroke volume (mL)

Stroke volume (mL)

Stroke volume (mL)

Stroke volume (mL)

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

	2 hr	4 hr	6 hr
Amplitude (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Flow rate (Lpm)	<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"/>
Machine rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Machine rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Inspiratory time (sec)	<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"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
HFO rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
HFO rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Duration (sec)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Ventilator rate (cpm)	<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"/>
Inspiratory time (sec)	<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"/> . <input type="text"/> <input type="text"/> <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<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"/>

6. Cardiac/Respiratory Variables:

Heart rate (bpm)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Respiratory rate (bpm)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Blood pressure—systolic (mm Hg)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Blood pressure—diastolic (mm Hg)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Blood pressure—mean (mm Hg)

2 hr [][] [][]

4 hr [][] [][]

6 hr [][] [][]

Method (direct = 1; indirect = 2)

2 hr []

4 hr []

6 hr []

7. Medications

Sodium bicarbonate/THAM

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Vasopressors

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Volume expanders

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Muscle relaxants

01 Yes 02 No

01 Yes 02 No

01 Yes 02 No

Type _____

Type _____

Type _____

Dose _____

Dose _____

Dose _____

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

C. Data Every Six Hours

Time Since Entry

1. Respiratory Support

a. CMV

01

01

01

01

01

b. HFV

02

02

02

02

02

c. CPAP (nasal)

03

03

03

03

03

d. Nasal cannula/prongs

04

04

04

04

04

e. Hood/isolette

05

05

05

05

05

2. Blood Gases:

Date

Month Day

Month Day

Month Day

Month Day

Month Day

Time

Source (arterial = 1, transcutaneous = 2, capillary = 3, venous = 4)

Source

Source

Source

Source

Source

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

.

.

a. O₂ Saturation % (pulse oximeter)

3. a. % O₂ (22-100%)

b. Nasal cannula (mL/min of 100% O₂)

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Stroke volume (mL)

.

.

.

.

.

4. a. Ventilator Variables (con.)

	12 hr	18 hr	24 hr	30 hr	36 hr
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<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"/> . <input type="text"/>

b. Machine Sigh Data

Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<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"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

c. IHFO

HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Conventional Ventilator

Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<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"/> . <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/> . <input type="text"/>
Flow rate (Lpm)	<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"/> . <input type="text"/>

6. Cardiac/Respiratory Variables:

	12 hr	18 hr	24 hr	30 hr	36 hr
Heart rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (bpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— systolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— diastolic (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Blood pressure— mean (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Method (direct = 1; indirect = 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Medications

Sodium bicarbonate/ THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

D. Data Every Twelve Hours

48 hr

60 hr

72 hr

84 hr

96 hr

Time Since Entry

1. Respiratory Support

a. CMV

01

01

01

01

01

b. HFV

02

02

02

02

02

c. CPAP (nasal)

03

03

03

03

03

d. Nasal cannula/prongs

04

04

04

04

04

e. Hood/isolette

05

05

05

05

05

2. Blood Gases:

Date

/
Month Day

/
Month Day

/
Month Day

/
Month Day

/
Month Day

Time

:

:

:

:

:

Source (arterial = 1;
transcutaneous = 2;
capillary = 3; venous = 4)

Source

Source

Source

Source

Source

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

.

.

a. O₂ Saturation %
(pulse oximeter)

3. a. % O₂ (22-100%)

b. Nasal cannula
(mL/min of 100% O₂)

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Stroke volume (mL)

.

.

.

.

.

4. a. Ventilator Variables
(con.)

	48 hr	60 hr	72 hr	84 hr	96 hr
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<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"/> . <input type="text"/>

b. Machine Sigh Data

Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<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"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

c. IHFO

HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Conventional Ventilator

Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<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"/> . <input type="text"/>
PEEP (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/> . <input type="text"/>
Flow rate (Lpm)	<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"/> . <input type="text"/>

6. Cardiac/Respiratory Variables:

	48 hr	60 hr	72 hr	84 hr	96 hr
Heart rate (bpm)	<input type="text"/>				
Respiratory rate (bpm)	<input type="text"/>				
Blood pressure—systolic (mm Hg)	<input type="text"/>				
Blood pressure—diastolic (mm Hg)	<input type="text"/>				
Blood pressure—mean (mm Hg)	<input type="text"/>				
Method (direct = 1; indirect = 2)	<input type="checkbox"/>				

7. Medications

	48 hr	60 hr	72 hr	84 hr	96 hr
Sodium bicarbonate/ THAM	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Vasopressors	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Volume expanders	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____
Muscle relaxants	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No Type _____ Dose _____

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

E. Every Two or Three Days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

a. CMV

01	<input type="checkbox"/>
----	--------------------------

01	<input type="checkbox"/>
----	--------------------------

01	<input type="checkbox"/>
----	--------------------------

b. HFV

02	<input type="checkbox"/>
----	--------------------------

02	<input type="checkbox"/>
----	--------------------------

02	<input type="checkbox"/>
----	--------------------------

c. CPAP (nasal)

03	<input type="checkbox"/>
----	--------------------------

03	<input type="checkbox"/>
----	--------------------------

03	<input type="checkbox"/>
----	--------------------------

d. Nasal cannula/prongs

04	<input type="checkbox"/>
----	--------------------------

04	<input type="checkbox"/>
----	--------------------------

04	<input type="checkbox"/>
----	--------------------------

e. Hood/isolette

05	<input type="checkbox"/>
----	--------------------------

05	<input type="checkbox"/>
----	--------------------------

05	<input type="checkbox"/>
----	--------------------------

2. Blood Gases:

Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day	

Time

<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

Source (arterial = 1, transcutaneous = 2; capillary = 3; venous = 4)

Source

Source

Source

PaO₂ (mm Hg)

<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"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

PaCO₂ (mm Hg)

<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"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

pH

<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"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	---	----------------------	----------------------	----------------------

a. O₂ Saturation % (pulse oximeter)

<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"/>
----------------------	----------------------	----------------------

3. a. % O₂ (22-100%)

<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"/>
----------------------	----------------------	----------------------

b. Nasal cannula (mL/min of 100% O₂)

<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

<input type="text"/>	<input type="text"/>
----------------------	----------------------

<input type="text"/>	<input type="text"/>
----------------------	----------------------

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Stroke volume (mL)

<input type="text"/>	.	<input type="text"/>
----------------------	---	----------------------

<input type="text"/>	.	<input type="text"/>
----------------------	---	----------------------

<input type="text"/>	.	<input type="text"/>
----------------------	---	----------------------

4. a. Ventilator Variables (con.)

	5 days	7 days	10 days
Amplitude (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Flow rate (Lpm)	<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"/>

b. Machine Sigh Data

Machine rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Machine rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Inspiratory time (sec)	<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"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

c. IHFO

HFO rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
HFO rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Duration (sec)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

5. Conventional Ventilator

Ventilator rate (cpm)	<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"/>
Inspiratory time (sec)	<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"/> . <input type="text"/> <input type="text"/> <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<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"/>

Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

F. Every Seven Days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

a CMV

b HFV

c CPAP (nasal)

d Nasal cannula/prongs

e Hood/isolette

2. Blood Gases:

Date

Time

Source (arterial = 1; transcutaneous = 2; capillary = 3; venous = 4)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

a. O₂ Saturation % (pulse oximeter)

3. a. % O₂ (22-100%)

b. Nasal cannula (mL/min of 100% O₂)

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Stroke volume (mL)

14 days

21 days

28 days

	14 days	21 days	28 days
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day
Time	<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"/> <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"/>
Source	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Source	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Source	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Source
PaO ₂ (mm Hg)	<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"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/>
PaCO ₂ (mm Hg)	<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"/> <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"/> <input type="text"/> <input type="text"/> <input type="text"/>
pH	<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"/> <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"/>
a. O ₂ Saturation %	<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"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. a. % O ₂	<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"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
b. Nasal cannula	<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"/> <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"/>
a. Ventilator rate (Hz)	<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"/>
Stroke volume (mL)	<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"/> <input type="text"/> <input type="text"/> . <input type="text"/>

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

14 days

21 days

28 days

	14 days	21 days	28 days
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
b. Machine Sigh Data			
Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. IHFO			
HFO rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
HFO rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Conventional Ventilator			
Ventilator rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
PEEP(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>
Flow rate (Lpm)	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>	<input type="text"/> . <input type="text"/>

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

G. After 28 days

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

a. CMV

01

01

01

b. HFV

02

02

02

c. CPAP (nasal)

03

03

03

d. Nasal cannula/prongs

04

04

04

e. Hood/isolette

05

05

05

2. Blood Gases:

Date

Month Day

Month Day

Month Day

Time

Source (arterial = 1; transcutaneous = 2; capillary = 3; venous = 4)

Source

Source

Source

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

.

.

.

a. O₂ Saturation % (pulse oximeter)

3. a. % O₂ (22-100%)

b. Nasal cannula (mL/min of 100% O₂)

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

Stroke volume (mL)

.

.

.

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

	1	2	3	4	5	6	7	8	9	10
Amplitude (cm H ₂ O)										
PIP (peak) (cm H ₂ O)										
\bar{P}_{aw} (cmH ₂ O)										
Flow rate (Lpm)										
Machine rate (cpm)										
Machine rate (cph)										
Inspiratory time (sec)										
PIP (peak) (cm H ₂ O)										
HFO rate (cpm)										
HFO rate (cph)										
Duration (sec)										
Ventilator rate (cpm)										
Inspiratory time (sec)										
PEEP(cm H ₂ O)										
PIP (cm H ₂ O)										
\bar{P}_{aw} (cm H ₂ O)										
Flow rate (Lpm)										

I. Blood Gases, Ventilator, Cardiac Variables, and Medications (continued)

G. After 28 days

[] [] [] []

[] [] [] []

[] [] [] []

Time Since Entry
(as specified in the protocol-in days)

1. Respiratory Support

a CMV

01 [] []

01 [] []

01 [] []

b HFV

02 [] []

02 [] []

02 [] []

c CPAP (nasal)

03 [] []

03 [] []

03 [] []

d Nasal cannula/prongs

04 [] []

04 [] []

04 [] []

e Hood/isolette

05 [] []

05 [] []

05 [] []

2. Blood Gases:

Date

[] [] [] []
Month Day

[] [] [] []
Month Day

[] [] [] []
Month Day

Time

[] [] [] []

[] [] [] []

[] [] [] []

Source (arterial = 1; transcutaneous = 2; capillary = 3; venous = 4)

Source

Source

Source

PaO₂ (mm Hg)

[] [] [] [] []

[] [] [] [] []

[] [] [] [] []

PaCO₂ (mm Hg)

[] [] [] [] []

[] [] [] [] []

[] [] [] [] []

pH

[] . [] [] []

[] . [] [] []

[] . [] [] []

a. O₂ Saturation % (pulse oximeter)

[] [] []

[] [] []

[] [] []

3. a. % O₂ (22-100%)

[] [] []

[] [] []

[] [] []

b. Nasal cannula (mL/min of 100% O₂)

[] [] [] []

[] [] [] []

[] [] [] []

4. HFV

a. Ventilator Variables

Ventilator rate (Hz)

[] []

[] []

[] []

Stroke volume (mL)

[] [] . []

[] [] . []

[] [] . []

4. a. Ventilator Variables (con.)

Amplitude (cm H₂O)

PIP (peak) (cm H₂O)

\bar{P}_{aw} (cmH₂O)

Flow rate (Lpm)

b. Machine Sigh Data

Machine rate (cpm)

Machine rate (cph)

Inspiratory time (sec)

PIP (peak) (cm H₂O)

c. IHFO

HFO rate (cpm)

HFO rate (cph)

Duration (sec)

5. Conventional Ventilator

Ventilator rate (cpm)

Inspiratory time (sec)

PEEP(cm H₂O)

PIP (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow rate (Lpm)

	1	2	3	4	5	6	7	8	9	10
Amplitude (cm H ₂ O)										
PIP (peak) (cm H ₂ O)										
\bar{P}_{aw} (cmH ₂ O)										
Flow rate (Lpm)										
Machine rate (cpm)										
Machine rate (cph)										
Inspiratory time (sec)										
PIP (peak) (cm H ₂ O)										
HFO rate (cpm)										
HFO rate (cph)										
Duration (sec)										
Ventilator rate (cpm)										
Inspiratory time (sec)										
PEEP(cm H ₂ O)										
PIP (cm H ₂ O)										
\bar{P}_{aw} (cm H ₂ O)										
Flow rate (Lpm)										

Nutrition, Environment, and Other Data

A. Day

B. Nutrition

1 Total Fluid Intake:

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)

E. Urine (mL/24 hr)

	Month	Day	Month	Day	Month	Day
	Day 0		Day 1		Day 2	
1 Total Fluid Intake:						
a Parenteral (mL/24 hr)						
b Enteral (mL/24 hr)						
2 Caloric Intake (Kcal/24 hr)						
C. Weight (gm)						
D. Type of Bed						
E. Urine (mL/24 hr)						

II. Nutrition, Environment, and Other Data (continued)

A. Day

B. Nutrition

1 Total Fluid Intake:

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1; incubator = 2;
open crib/bassinette = 3; other = 4)

E. Urine (mL/24 hr)

Month	Day

Month	Day

Month	Day

Month	Day

Month	Day

Month	Day

Day 3

Day 4

Day 5

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II. Nutrition, Environment, and Other Data (continued)

	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Day
A. Day	<u>Day 7</u>		<u>Day 14</u>		<u>Day 21</u>		<u>Day 28</u>	
B. Nutrition								
1 Total Fluid Intake								
a Parenteral (mL/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b Enteral (mL/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 Caloric Intake (Kcal/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Weight (gm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Type of Bed (radiant warmer = 1, incubator = 2; open crib/bassinette = 3; other = 4)	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
E. Urine (mL/24 hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

II. Nutrition, Environment, and Other Data (continued)

	Month	Day	Month	Day	Month	Day
A. Day	<input type="text"/>		<input type="text"/>		<input type="text"/>	
B. Nutrition						
1. Total Fluid Intake:						
a. Parenteral (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
b. Enteral (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
2. Caloric Intake (Kcal/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
C. Weight (gm)	<input type="text"/>				<input type="text"/>	
D. Type of Bed (radiant warmer = 1; incubator = 2; open crib/bassinette = 3; other = 4)	<input type="text"/>		<input type="text"/>		<input type="text"/>	
E. Urine (mL/24 hr)	<input type="text"/>		<input type="text"/>		<input type="text"/>	

II. Nutrition, Environment, and Other Data (continued)

Month	Day	Month	Day	Month	Day

A. Day

B. Nutrition

1 Total Fluid Intake

a Parenteral (mL/24 hr)

b Enteral (mL/24 hr)

2 Caloric Intake (Kcal/24 hr)

C. Weight (gm)

D. Type of Bed (radiant warmer = 1, incubator = 2, open crib/bassinette = 3, other = 4)

E. Urine (mL/24 hr)

Signature of Clinical Coordinator _____ Date _____

PROTOCOL INTERRUPTION

1. Infant ID Number

2. Date of Birth Month Day Year

3. Sex Male 01 Female 02

4. Ventilator at the time of interruption: CMV 01 HFV 02

Duration of Interruption:

from: Month Day Year Time

to:

Reason for Interruption:

INTERIM VISIT
(9 Months Post-Term)

1. Infant ID Number

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Month Day Year

2. Date of Examination

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3. Post-Term Age

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months

4. Infant Status at the Time of Examination:

01
Outpatient

02
Inpatient

If Inpatient: 01
Study Hospital

02
Other Hospital

5. Ventilatory Support:

A. Current Ventilatory Aid:

- 1. None 01
- 2. Conventional Mechanical Ventilation 02
- 3. High Frequency Ventilation 03
- 4. Continuous Distending Airway Pressure (CDAP) 04
- 5. O₂ Therapy 05

a) Continuous 01 02

1) % O₂ (22-100%)

2) Nasal Cannula
 (L/minutes of 100% O₂)

b) Intermittent O₂ Supplementation 01 02

B. If O₂ Therapy was discontinued after initial discharge,

record date

Month Day Year

6. Current Medications:

- A. Diuretics ⁰¹
- B. Bronchodilators ⁰²
 - 1) Systemic ⁰¹
 - 2) Aerosolized ⁰²
- C. Others (SPECIFY) _____ ... ⁰³

7. Respiratory Tract Complications Since Initial Discharge to Home:

- | A. Infections: | <u>None</u> | <u>1-2</u> | <u>More Than 2</u> |
|---------------------------------------|--|--|--|
| | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |
| 1. Otitis Media | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Upper respiratory infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Lower respiratory infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. Number of hospital admissions for respiratory infections

(Total) duration of hospital stay since original discharge for respiratory infections days

C. Number of hospital admissions for respiratory problems other than infections:

Specify: _____

Total Duration of hospital stay since original discharge for other respiratory problems days

8. Hospital Admissions For All Causes Since Discharge to Home:

A. Number of admissions since original discharge for all causes

Specify cause(s): _____

B. (Total) duration of hospital stay since original discharge for all causes days

***** PHYSICAL EXAMINATION *****

9. Condition During Exam:

Satisfactory (infant cooperative) 01

Suboptimal (SPECIFY) _____ ... 02

10. Growth Measurements:

A. Weight • kg

B. Length • cm

C. Head Circumference • cm

D. Temperature • °C

11. Respiratory System:

	<u>At Rest</u>	<u>After Exercise</u> (pull to sit x 3)
A. Rate (breaths per minute)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

	<u>At Rest</u>		<u>After Exercise</u> (pull to sit x 3)	
	Yes	No	Yes	No
B. Retractions	<input type="text"/> 01	<input type="text"/> 02	<input type="text"/> 01	<input type="text"/> 02

C. Stridor	<input type="text"/> 01	<input type="text"/> 02	<input type="text"/> 01	<input type="text"/> 02
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D. Wheezing	<input type="text"/> 01	<input type="text"/> 02	<input type="text"/> 01	<input type="text"/> 02
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	At Rest		After Exercise (pull to sit x 3)	
	Yes	No	Yes	No
E. Prolonged Expiratory Phase	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
F. Rales, rhonchi, etc.	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
G. Cyanosis	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
H. Clubbing	<input type="checkbox"/> 01	<input type="checkbox"/> 02		

12. Airway Pathology:

A. Voice Quality: (CHECK ALL THAT APPLY)

- 1. Absent 01
- 2. Hoarse 02
- 3. Low volume 03
- 4. Normal 04
- 5. Cannot score 05

B. Nose/Mouth:

- 1. Nasal discharge or obstruction 01
- 2. Deformation of nostrils 02
- 3. Palatal Groove 03

C. Tracheostomy 04

D. Subglottic stenosis 05

E. Other (SPECIFY) _____ 06

13. Cardiovascular System:

A. Heart Rate /min

B. Blood Pressure / Doppler ⁰¹ Other ⁰²

C. Abnormal Rhythm Yes ⁰¹ No ⁰²

D. Murmur ⁰¹ ⁰²

If yes:

a. Innocent yes ⁰¹ no ⁰²

b. Other ⁰¹ ⁰²

Clinical Impression: _____

E. Excess Precordial Activity Yes ⁰¹ No ⁰²

F. Other Abnormal Findings ⁰¹ ⁰²

(SPECIFY) _____

14. Abdomen:

A. Liver (measured below costal margin) cm

B. Spleen (measured below costal margin) cm

C. Inguinal Hernia Yes ⁰¹ No ⁰²

1) Already surgically corrected Yes ⁰¹ No ⁰²

D. Other Abnormalities (SPECIFY) _____ ... ⁰¹ ⁰²

15. Eyes:

Normal Abnormal

- A. Pupils ⁰¹ ⁰²
- B. Light Reflex ⁰¹ ⁰²
- C. Fixes ⁰¹ ⁰²
- D. Follows ⁰¹ ⁰²
- E. Nystagmus ⁰¹ ⁰²
- F. Other abnormal findings ⁰¹ ⁰²

	Yes	No
	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²

Specify: _____

16. Hearing:

- A. Responds to bell ⁰¹ ⁰²
- B. Responds to voice ⁰¹ ⁰²

	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²

17. Neurological Assessment:

- A. Tone:
- | | Increased | Decreased | Normal |
|-------------------------|--|--|--|
| 1. Neck Extensors | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |
| 2. Hamstrings | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |
| 3. Hip Adductors | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |
| 4. Gastrocnemii | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |
| 5. Trunk | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰³ |

B. Reflexes:

1. Deep Tendon Reflexes:

	Right	Left
a. Biceps:		
Increased with Clonus	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Increased, no Clonus	<input type="checkbox"/> 02	<input type="checkbox"/> 01
Absent or very diminished	<input type="checkbox"/> 03	<input type="checkbox"/> 03
Normal	<input type="checkbox"/> 04	<input type="checkbox"/> 04
b. Patellar:		
Increased with Clonus	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Increased, no Clonus	<input type="checkbox"/> 02	<input type="checkbox"/> 02
Absent or very diminished	<input type="checkbox"/> 03	<input type="checkbox"/> 03
Normal	<input type="checkbox"/> 04	<input type="checkbox"/> 04
c. Ankle:		
Increased with Clonus	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Increased, no Clonus	<input type="checkbox"/> 02	<input type="checkbox"/> 02
Absent or very diminished	<input type="checkbox"/> 03	<input type="checkbox"/> 03
Normal	<input type="checkbox"/> 04	<input type="checkbox"/> 04

2. Primary Reflexes Present (check all that apply):

	Yes	No
a. Moro	<input type="checkbox"/> 01	<input type="checkbox"/> 02
b. Asymmetric Tonic neck	<input type="checkbox"/> 01	<input type="checkbox"/> 02

- c. Standing 01 02
- d. Obligatory palmar grasp 01 02

C. Movements:

- 1. Voluntary movements 01 02
- 2. Involuntary movements:
 - a. Seizures (include by history) 01 02
 - b. Other (specify): _____ ... 01 02

- D. Hydrocephalus 01 02
- 1. Shunted 01 02

If YES, date

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18. Chest X-Ray:

- A. Normal 01
- B. Abnormal 02
- (SPECIFY) _____
- C. Not done 03

***** PULMONARY FUNCTION TESTING *****

19. Total Chloral Hydrate Given During PFT mg

20. O2 Saturation:

A. Brand and model number of pulse oximeter used:

B. Baseline Period Saturation at on room air:

1. 0 seconds..... %

2. 10 seconds..... %

3. 20 seconds..... %

4. 30 seconds..... %

5. 40 seconds..... %

6. 50 seconds..... %

a. Mean %

b. Standard Deviation %

C. Saturation at 17% O2 at:

1. One Minute %

2. Two Minutes %

3. Three Minutes %

4. Four Minutes %

5. Five Minutes %

- 6. Five Minutes, 10 Seconds %
- 7. Five Minutes, 20 Seconds %
- 8. Five Minutes, 30 Seconds %
- 9. Five Minutes, 40 Seconds %
- 10. Five Minutes, 50 Seconds %
- 11. Six Minutes %

a. Mean of values 6-11

b. Standard Deviation

21. Resistance and Compliance:

A. Inspiratory Time • seconds

B. Expiratory Time • seconds

C. Minute Ventilation mL/min

D. Tidal Volume (V_T) • mL

E. Peak Esophageal Inspiratory Pressure Cm H₂O

F. Dynamic Compliance • mL/cm H₂O

G. Dynamic Compliance (SPECIFIC) • mL/CmH₂O/LFRC

H. Total Pulmonary Resistance Cm H₂O/L/sec

I. Expiratory Pulmonary Resistance Cm H₂O/L/sec

J. E_TCO_2 (%)

K. Inspired Oxygen (%)

22. Forced Expiratory Maneuvers:

A. Expiratory Flow at 75% V_T • %

B. Expiratory Flow at 50% V_T • %

C. Expiratory Flow at 25% V_T • %

D. Expiratory Flow at FRC •

23. Functional Residual Capacity • mL

EXAMINER'S NAME: _____

INTERIM VISIT ADDENDA

1. Infant ID Number:

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2. If hydrocephalus was checked yes on Question 17D;

Yes

No

Arrested, No Shunt

01

02

FINAL VISIT AND BAYLEY EVALUATION ADDENDA

1. Infant ID Number:

2. Date of Birth: Month Day Year

3. If "hydrocephalus diagnosed since interim visit" was checked yes on Final Visit Form:

a. Arrested, No Shunt 01

b. Shunted 02

c. Date of Primary Shunt Insertion: Month Day Year

d. Number of Revisions:

4. Date of Bayley Evaluation: Month Day Year

5. Test Conditions: a. Optimal 01

b. Suboptimal 02

If suboptimal, state reason: _____

6. Was the Bayley evaluation performed at a place other than a HIFI center?

Yes No
a. 01 b. 02

If yes, give details: _____

7. Was the Bayley evaluation administered in the primary language of the child?

a. Yes 01 b. No 02

a. If not, were the instructions translated by a parent for the child?

a. Yes 01 b. No 02

b. Were the instructions translated by some other interpreter for the child?

a. Yes 01 b. No 02

BAYLEY MENTAL SCALE

1. Date Form Received:

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2. Infant ID Number:

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3. Date Tested:

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4. Reported Raw Score:

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5. Coordinating Center Calculated Raw Score:

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6. An indication as to whether or not the Coordinating Center made any changes in the raw score calculated by the test administrator.

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 01

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 02
Yes No
7. Number of Non-blank Test Items:

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BAYLEY SCALES OF INFANT DEVELOPMENT

MENTAL SCALE RECORD FORM



NAME _____ AGE _____ SEX _____

	Year	Month	Day
Date Tested	_____	_____	_____
Date of Birth	_____	_____	_____
Age	_____	_____	_____

	Raw Score	Development Index*
Mental Scale	_____	_____ (MDI)
Motor Scale	_____	_____ (PDI)

* The standard score for the Mental Scale is called the MDI (for Mental Development Index); for the Motor Scale it is the PDI (for Psychomotor Development Index). See Manual for discussion.

Note.—If both the MENTAL SCALE and the MOTOR SCALE are administered to the child, the information below need only be filled in on the Record Form for the MENTAL SCALE.

NOTES:

ADDRESS _____

BIRTHPLACE _____

BIRTH WEIGHT _____ BIRTH ORDER _____

PRENATAL OR BIRTH DIFFICULTIES _____

CHILD'S HEALTH _____

PARENT'S NAME _____

FATHER: EDUCATION _____ OCCUPATION _____

MOTHER: EDUCATION _____ OCCUPATION _____

HOUSEHOLD COMPOSITION															
	Father	Mother	Siblings						Other Children						
			1	2	3	4	5	6	7	8	1	2	3		
Check if Present in Household															
Approximate Age															
Sex (M for Male, F for Female)															
Comments:															

PLACE OF TESTING _____

TESTED BY _____

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To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
1	0.1	A	Responds to sound of bell				
2	0.1	B	Quiets when picked up				
3	0.1 (.1-3)	C	Responds to sound of rattle				
4	0.1 (.1-4)		Responds to sharp sound: click of light switch				
5	0.1 (.1-1)	D	Momentary regard of red ring				
6	0.2 (.1-1)	E	Regards person momentarily				
7	0.4 (.1-2)	D	Prolonged regard of red ring				
8	0.5 (.1-2)	D	Horizontal eye coordination: red ring				
9	0.7 (.3-3)	F	Horizontal eye coordination: light				
10	0.7 (.3-2)	E	Eyes follow moving person				
11	0.7 (.3-2)	E	Responds to voice				
12	0.8 (.3-3)	F	Vertical eye coordination: light				
13	0.9 (.5-3)	G	* Vocalizes once or twice				
14	1.0 (.5-3)	D	Vertical eye coordination: red ring				
15	1.2 (.5-3)	F	Circular eye coordination: light				
16	1.2 (.5-3)	D	Circular eye coordination: red ring				
17	1.3 (.5-3)	G ¹	* Free inspection of surroundings				
18	1.5 (.5-4)	E	Social smile: E talks and smiles				
19	1.6 (.7-4)	D	Turns eyes to red ring				
20	1.6 (.5-4)	F	Turns eyes to light				
21	1.6 (.5-5)	G	* Vocalizes at least 4 times				
22	1.7 (1-4)	B	Anticipatory excitement				
23	1.7 (.5-5)		Reacts to paper on face				
24	1.9 (1-4)		Blinks at shadow of hand				
25	2.0 (1-5)	E	Visually recognizes mother				

* May be observed incidentally.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
26	2.1 (.7-6)	E	Social smile: E smiles, quiet				
27	2.1 (1-6)	E	* Vocalizes to E's social smile and talk				
28	2.2 (.7-5)	AC	Searches with eyes for sound (Specify)				____ Bell ____ Rattle
29	2.3 (.7-5)		Eyes follow pencil				
30	2.3 (1-5)	G	* Vocalizes 2 different sounds				
31	2.4 (1-5)	E	Reacts to disappearance of face				
32T‡	2.5 (1-5)	H	Regards cube				
33	2.6 (1-5)	D ¹	Manipulates red ring				
34	2.6 (1-5)	AC	Glances from one object to another				
35	2.6 (1-6)	B	Anticipatory adjustment to lifting				
36	2.8 (2-5)	C	Simple play with rattle				
37	3.1 (1-5)	D ¹	Reaches for dangling ring				
38T	3.1 (2-5)		Follows ball visually across table				
39	3.2 (1-6)	G ¹	* Fingers hand in play				
40T	3.2 (1-5)	D ¹	Head follows dangling ring				
41T	3.2 (1-6)	I	Head follows vanishing spoon				
42	3.3 (2-6)	G ¹	* Aware of strange situation				
43T	3.3 (2-6)	G ²	* Manipulates table edge slightly				
44	3.8 (2-6)	D ¹	Carries ring to mouth				
45	3.8 (2-6)	G ¹	* Inspects own hands				
46	3.8 (2-6)	D ¹	Closes on dangling ring (Check hand preference)				____ Right ____ Left ____ None
47	3.8 (2-6)	A	Turns head to sound of bell				
48	3.9 (2-6)	C	Turns head to sound of rattle				
49	4.1 (2-6)	H	Reaches for cube				
50	4.3 (2-7)	G ²	* Manipulates table edge actively				

* May be observed incidentally.

‡ See Manual, Chapter 4, for explanation of "T."

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
51	4.4 (2-6)	H	Eye-hand coordination in reaching				
52	4.4 (2-7)	J	Regards pellet				
53	4.4 (2-7)	K	Mirror image approach				
54	4.6 (3-7)	H	Picks up cube (Check hand preference)				<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> None
55	4.6 (3-8)	G ³	* Vocalizes attitudes (Describe)				Pleasure: Displeasure: Eagerness: Satisfaction:
56	4.7 (3-7)	H	Retains 2 cubes				
57	4.8 (3-7)		Exploitive paper play				
58	4.8 (3-8)	E ¹	* Discriminates strangers				
59	4.9 (4-8)	C	Recovers rattle, in crib				
60	5.0 (3-8)	H	Reaches persistently				
61	5.1 (3-8)	E ¹	Likes frolic play				
62	5.2 (4-8)	I	Turns head after fallen spoon				
63	5.2 (4-8)	L	Lifts inverted cup				
64	5.4 (4-8)	H	Reaches for 2nd cube				
65	5.4 (3-12)	K	Smiles at mirror image				
66	5.4 (4-8)	G ²	* Bangs in play				
67	5.4 (4-8)	D ²	Sustained inspection of ring				
68	5.4 (4-8)	D ²	Exploitive string play				
69	5.5 (4-8)	G ²	* Transfers object hand to hand				
70	5.7 (4-8)	H	Picks up cube deftly and directly				
71	5.7 (4-8)	D ²	Pulls string: secures ring				
72	5.8 (4-8)	G ²	* Interest in sound production				
73	5.8 (4-11)	L	Lifts cup with handle				

* May be observed incidentally.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
74	5.8 (4-10)	M	Attends to scribbling				
75	6.0 (5-10)	I	Looks for fallen spoon				
76	6.2 (4-12)	K	Playful response to mirror				
77	6.3 (4-10)	H	Retains 2 of 3 cubes offered				
78	6.5 (5-10)	A ¹	Manipulates bell: interest in detail				
79	7.0 (5-12)	G ³	* Vocalizes 4 different syllables				
80	7.1 (5-10)	D ²	Pulls string adaptively: secures ring				
81	7.6 (5-12)	E ¹	Cooperates in games				Note skill at pat-a-cake for Motor Scale item 44
82	7.6 (5-14)	H	Attempts to secure 3 cubes				
83	7.8 (5-13)	A ¹	Rings bell purposively				
84	7.9 (5-14)	N	* Listens selectively to familiar words				
85	7.9 (5-14)	G ³	* Says "da-da" or equivalent				
86	8.1 (6-12)	H ¹	Uncovers toy				
87	8.9 (6-12)	O	Fingers holes in peg board				
88	9.0 (6-14)	L	Picks up cup: secures cube				
89	9.1 (6-14)	N	Responds to verbal request				
90	9.4 (6-13)	L	Puts cube in cup on command (Note number placed)				Items 90, 100, 114 _____ No. of cubes
91	9.5 (8-14)	P	Looks for contents of box				
92	9.7 (8-15)	L	Stirs with spoon in imitation				
93	10.0 (7-16)	Q	Looks at pictures in book				
94	10.1 (7-17)	M	Inhibits on command				
95	10.4 (7-15)	M	Attempts to imitate scribble				
96	10.5 (8-17)	H ¹	Unwraps cube				
97	10.8 (8-17)	E ¹	* Repeats performance laughed at				
98	11.2 (8-15)	M	Holds crayon adaptively				

* May be observed incidentally.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
99	11.3 (8-15)		Pushes car along				
100	11.8 (9-18)	L	Puts 3 or more cubes in cup				
101	12.0 (9-18)	G ³	* Jabbers expressively				
102	12.0 (9-17)	P	Uncovers blue box				
103	12.0 (8-18)	Q	Turns pages of book				
104	12.2 (8-19)		Pats whistle doll, in imitation				
105	12.4 (7-18)	D ²	Dangles ring by string				
106	12.5 (9-18)	N	* Imitates words (Record words used)				
107	12.9 (10-17)	P	Puts beads in box (6 of 8)				
108	13.0 (10-17)	O	Places 1 peg repeatedly				
109	13.4 (10-19)	J	Removes pellet from bottle				
110	13.6 (10-20)	R	Blue board: places 1 round block (Specify)				Items 110, 121, 129, 142, 155, 159, 160 ____ No. round placed ____ No. square placed ____ Completion time
111	13.8 (10-19)	H ¹	Builds tower of 2 cubes (Note number of cubes)				Items 111, 119, 143, 161 ____ No. of cubes
112	14.0 (10-21)	M	Spontaneous scribble				
113	14.2 (10-23)	G ³	* Says 2 words (Note words)				Heard: Reported:
114	14.3 (11-20)	L	Puts 9 cubes in cup				
115	14.6 (10-20)	P	Closes round box				
116	14.6 (11-19)		* Uses gestures to make wants known				
117	15.3 (11-23)	N	Shows shoes or other clothing, or own toy				
118	16.4 (13-20)	O	Pegs placed in 70 seconds (Note times)				Items 118, 123, 134, 156 Trial 1 2 3 Time _____
119	16.7 (13-21)	H ¹	Builds tower of 3 cubes				
120	16.8 (12-26)	S	Pink board: places round block (Specify)				Items 120, 137, 151 ____ Round placed ____ All placed ____ All placed (reversed board)
121	~ 17.0 (12-26)	R	Blue board: places 2 round blocks				

* May be observed incidentally.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
122	17.0 (12-24)		Attains toy with stick				
123	17.6 (14-22)	O	Pegs placed in 42 seconds				
124	17.8 (13-27)	T	Names 1 object (Check objects named)				Items 124, 138, 146 ___ Ball ___ Scissors ___ Watch ___ Cup ___ Pencil
125	17.8 (13-26)	M	Imitates crayon stroke				
126	17.8 (14-26)	U	Follows directions, doll (Check parts passed)				___ Chair ___ Cup ___ Handkerchief
127	18.8 (14-27)	G ³	* Uses words to make wants known				
128	19.1 (15-26)	U	Points to parts of doll (Check parts recognized)				___ Hair ___ Eyes ___ Mouth ___ Feet ___ Ears ___ Nose ___ Hands
129	19.3 (14-30+)	R	Blue board: places 2 round and 2 square blocks				
130	19.3 (14-27)	V	Names 1 picture (Check list)				Items 130, 132, 139, 141, 148, 149 Names Points Dog ___ ___ Shoe ___ ___ Cup ___ ___ House ___ ___ Clock ___ ___ Flag ___ ___ Star ___ ___ Leaf ___ ___ Purse ___ ___ Book ___ ___ No. Named ___ No. Pointed ___
131	19.7 (14-30+)		Finds 2 objects (Check successful trials)				Trial 1 2 3 Ball ___ ___ ___ Rabbit ___ ___ ___
132	19.9 (16-28)	V	Points to 3 pictures (Check list at item 130)				
133	19.9 (15-27)	W	Broken doll: mends marginally				
134	20.0 (16-29)	O	Pegs placed in 30 seconds				
135	20.5 (14-30+)	M	Differentiates scribble from stroke				
136	20.6 (16-30)	G ³	* Sentence of 2 words				
137	21.2 (16-30+)	S	Pink board: completes				
138	21.4 (16-30)	T	Names 2 objects				
139	21.6 (17-30+)	V	Points to 5 pictures (Check list at item 130)				

* May be observed incidentally.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
140	21.9 (15-30)	W	Broken doll: mends approximately				
141	22.1 (17-30+)	V	Names 3 pictures (Check list at item 130)				
142	22.4 (16-30+)	R	Blue board: places 6 blocks				
143	23.0 (17-30+)	H ¹	Builds tower of 6 cubes				
144	23.4 (16-30+)	X	Discriminates 2: cup, plate, box (Check which)				Items 144, 152 <input type="checkbox"/> Cup <input type="checkbox"/> Box <input type="checkbox"/> Plate <input type="checkbox"/> All
145	23.8 (17-30+)	Y	Names watch, 4th picture (Check at which named)				Items 145, 150 <input type="checkbox"/> 5th picture <input type="checkbox"/> 3rd picture <input type="checkbox"/> 4th picture <input type="checkbox"/> 2nd picture
146	24.0 (17-30+)	T	Names 3 objects				
147	24.4 (19-30+)	M	Imitates strokes: vertical and horizontal				
148	24.7 (19-30+)	V	Points to 7 pictures (Check list at item 130)				
149	25.0 (19-30+)	V	Names 5 pictures (Check list at item 130)				
150	25.2 (18-30+)	Y	Names watch, 2nd picture				
151	25.4 (18-30+)	S	Pink board: reversed				
152	25.6 (18-30+)	X	Discriminates 3: cup, plate, box				
153	26.1 (16-30+)	W	Broken doll: mends exactly				
154	26.1 (19-30+)	H ¹	Train of cubes				
155	26.3 (19-30+)	R	Blue board: completes in 150 seconds				
156	26.6 (19-30+)	O	Pegs placed in 22 seconds				
157	27.9 (22-30+)	M	Folds paper				
158	28.2 (22-30+)	Z	Understands 2 prepositions				
159	30.0 (22-30+)	R	Blue board: completes in 90 seconds				
160	30+ (22-30+)	R	Blue board: completes in 60 seconds				
161	30+ (22-30+)	H ¹	Builds tower of 8 cubes				
162	30+ (21-30+)	H ¹	Concept of one				
163	30+ (23-30+)	Z	Understands 3 prepositions				

BAYLEY MOTOR SCALE

1. Date Form Received:

--	--

--	--

--	--
2. Infant ID Number:

--	--	--	--	--	--	--	--	--	--
3. Date Tested:

--	--

--	--

--	--
4. Reported Raw Score:

--	--	--
5. Coordinating Center Calculated Raw Score:

--	--	--
6. An indication as to whether or not the Coordinating Center made any changes in the raw score calculated by the test administrator.

--

 01

--

 02
Yes No
7. Number of Non-blank Test Items:

--	--	--

BAYLEY SCALES OF INFANT DEVELOPMENT

MOTOR SCALE RECORD FORM



NAME _____ AGE _____ SEX _____

	Year	Month	Day
Date Tested	_____	_____	_____
Date of Birth	_____	_____	_____
Age	_____	_____	_____

	Raw Score	Development Index*
Mental Scale	_____	_____ (MDI)
Motor Scale	_____	_____ (PDI)

* The standard score for the Mental Scale is called the MDI (for Mental Development Index); for the Motor Scale it is the PDI (for Psychomotor Development Index). See Manual for discussion.

NOTES:

Note.—If both the MENTAL SCALE and the MOTOR SCALE are administered to the child, the information below need only be filled in on the Record Form for the MENTAL SCALE.

ADDRESS _____

BIRTHPLACE _____

BIRTH WEIGHT _____ BIRTH ORDER _____

PRENATAL OR BIRTH DIFFICULTIES _____

CHILD'S HEALTH _____

PARENT'S NAME _____

FATHER: EDUCATION _____ OCCUPATION _____

MOTHER: EDUCATION _____ OCCUPATION _____

HOUSEHOLD COMPOSITION																
	Father	Mother	Siblings								Other Children					
			1	2	3	4	5	6	7	8	1	2	3			
Check if Present in Household																
Approximate Age																
Sex (M for Male, F for Female)																
Comments:																

PLACE OF TESTING _____

TESTED BY _____

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The Psychological Corporation, Cleveland

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
1	0.1	A	Lifts head when held at shoulder				
2	0.1	A	Postural adjustment when held at shoulder				
3	0.1	B	Lateral head movements				
4	0.4 (.1-3)	B	Crawling movements				
5	0.8 (.3-3)	C	† Retains red ring				
6	0.8 (.3-2)	C	* Arm thrusts in play				
7	0.8 (.3-2)	C	* Leg thrusts in play				
8	0.8 (.3-3)	A	Head erect: vertical				
9	1.6 (.7-4)	A	Head erect and steady				
10	1.7 (.7-4)	C	Lifts head: dorsal suspension				
11	1.8 (.7-5)	C'	Turns from side to back				
12	2.1 (.7-5)	B	Elevates self by arms: prone				
13	2.3 (1-5)	D	Sits with support				
14	2.5 (1-5)	A	Holds head steady				
15	2.7 (.7-6)		* Hands predominantly open				
16	3.7 (2-7)	E	† Cube: ulnar-palmar prehension				
17	3.8 (2-6)	D	Sits with slight support				
18	4.2 (2-6)	A	Head balanced				
19	4.4 (2-7)	C'	* Turns from back to side				
20	4.8 (3-8)	F	Effort to sit				
21	4.9 (4-8)	E	† Cube: partial thumb opposition (radial-palmar)				
22	5.3 (4-8)	F	Pulls to sitting position				
23	5.3 (4-8)	D	Sits alone momentarily				
24	5.4 (4-8)	G	* Unilateral reaching				
25	5.6 (4-8)	H	† Attempts to secure pellet				
26	5.7 (4-8)	G	* Rotates wrist				
27	6.0 (5-8)	D	Sits alone 30 seconds or more				
28	6.4 (4-10)	C'	* Rolls from back to stomach				

* May be observed incidentally.

† May be presented during administration of Mental Scale.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
29	6.6 (5-9)	D	Sits alone, steadily				
30	6.8 (5-9)	H	† Scoops pellet				
31	6.9 (5-10)	D	Sits alone, good coordination				
32	6.9 (5-9)	E	† Cube: complete thumb opposition (radial-digital)				
33	7.1 (5-11)	B	Prewalking progression (Check method)				<input type="checkbox"/> On abdomen <input type="checkbox"/> Hands and knees <input type="checkbox"/> Hands and feet <input type="checkbox"/> Sits and hitches <input type="checkbox"/> Other (Describe):
34	7.4 (5-11)	I	Early stepping movements				
35	7.4 (6-10)	H	† Pellet: partial finger prehension (inferior pincer)				
36	8.1 (5-12)	F	Pulls to standing position				
37	8.3 (6-11)	J	Raises self to sitting position				
38	8.6 (6-12)	J	Stands up by furniture				
39	8.6 (6-12)	G	† Combines spoons or cubes: midline				
40	8.8 (6-12)	I	Stepping movements				
41	8.9 (7-12)	H	† Pellet: fine prehension (neat pincer)				
42	9.6 (7-12)	I	Walks with help				
43	9.6 (7-14)	I	Sits down				
44	9.7 (7-15)	G	† Pat-a-cake: midline skill				
45	11.0 (9-16)	I	Stands alone				
46	11.7 (9-17)	I	Walks alone				
47	12.6 (9-18)	K	Stands up: I				
48	13.3 (9-18)		† Throws ball				
49	14.1 (10-20)	L	Walks sideways				
50	14.6 (11-20)	L	Walks backward				
51	15.9 (12-21)	M	Stands on right foot with help				
52	16.1 (12-23)	M	Stands on left foot with help				
53	16.1 (12-23)	N	Walks up stairs with help				
54	16.4 (13-23)	N	Walks down stairs with help				

† May be presented during administration of Mental Scale.

To score: Check P (Pass) or F (Fail). If "Other," mark O (Omit), R (Refused), or RPT (Reported by mother).

Item No.	Age Placement and Range (Months)	Situation	Item Title	Score			Notes
				P	F	Other	
55	17.8 (13-26)	O	Tries to stand on walking board				
56	20.6 (15-29)	O	Walks with one foot on walking board				
57	21.9 (17-30+)	K	Stands up: II				
58	22.7 (15-30+)	M	Stands on left foot alone				
59	23.4 (17-30+)	P	Jumps off floor, both feet				
60	23.5 (16-30+)	M	Stands on right foot alone				
61	23.9 (18-30+)	Q	Walks on line, general direction				
62	24.5 (17-30+)	O	Walking board: stands with both feet				
63	24.8 (19-30+)	R	Jumps from bottom step				
64	25.1 (18-30+)	N	Walks up stairs alone: both feet on each step				
65	25.7 (16-30+)	Q	Walks on tiptoe, few steps				
66	25.8 (19-30+)	N	Walks down stairs alone: both feet on each step				
67	27.6 (19-30+)	O	Walking board: attempts step				
68	27.8 (20-30+)	Q	Walks backward, 10 feet				
69	28.1 (21-30+)	R	Jumps from second step				
70	29.1 (22-30+)	R	Distance jump: 4 to 14 inches (Note distance)				Items 70, 76, 78 Trial 1 2 3 Distance _____
71	30+ (22-30+)	K	Stands up: III				
72	30+ (23-30+)	N	Walks up stairs: alternating forward foot				
73	30+ (20-30+)	Q	Walks on tiptoe, 10 feet				
74	30+ (24-30+)	O	Walking board: alternates steps part way				
75	30+ (23-30+)	Q	Keeps feet on line, 10 feet				
76	30+ (25-30+)	R	Distance jump: 14 to 24 inches				
77	30+ (24-30+)	P	Jumps over string 2 inches high				
78	30+ (28-30+)	R	Distance jump: 24 to 34 inches				
79	30+ (30+)		Hops on one foot, 2 or more hops				
80	30+ (30+)	N	Walks down stairs: alternating forward foot				
81	30+ (28-30+)	P	Jumps over string 8 inches high				

AUTOPSY FORM

1. Infant ID

Grid for Infant ID: 7 empty boxes

2. Date of Death

Month Day Year grid: 2 boxes for Month, 2 for Day, 2 for Year

3. Date Autopsy Performed

Month Day Year grid: 2 boxes for Month, 2 for Day, 2 for Year

4. Brain:

Yes No

A. Evidence of IVH

Yes 01 No 02 grid

1. Blood in the germinal layer

Yes 01 No 02 grid

2. Blood in the ventricles

Yes 01 No 02 grid

3. Blood in the periventricular white matter

Yes 01 No 02 grid

B. Evidence of PVL

Yes 01 No 02 grid

C. Cysts or other structural abnormalities

Yes 01 No 02 grid

D. Brain weight grams

3 empty boxes for brain weight

5. Respiratory Tract:

A. Trachea:

1. Middle of trachea:

a. Not examined

06 grid

b. Normal

01 grid

c. Edema only

02 grid

d. Mucosal sloughing

03 grid

2. Carina:

- a. Not examined 06
- b. Normal 01
- c. Edema only 02
- d. Mucosal sloughing 03

B. Hilar Level:

- 1. Not examined 06
- 2. Normal 01
- 3. Inspissated mucus 02

C. Parenchyma:

- | | Present | Absent |
|-----------------------------------|-----------------------------|-----------------------------|
| 1. Hyaline membrane disease | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 2. Hemorrhage | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 3. Septal destruction | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 4. Metaplastic changes | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 5. Evidence of inflammation | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 6. Bacteria | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |

D. Lung Weight

--	--	--

 Right gm

--	--	--

 Left gm

6. Cardiac:

Present Absent

A. RV hypertrophy

01

02

B. LV hypertrophy

01

02

C. Cardiac weight grams

D. Structural defect: _____

7. Liver:

A. Weight grams

Yes

No

B. Congested

01

02

8. GI Tract

Normal
 01

Abnormal
 02

Not Examined
 06

9. Thyroid

01

02

06

10. Pituitary

01

02

06

11. Adrenal

01

02

06

12. Kidneys and collection system

01

02

06

If any of the above are abnormal, specify:

13. Evidence for Infection:

Yes

No

Not Examined

Positive splenic or other organ culture

01

02

03

14. Organism:

15. Other significant findings:

NAME OF PERSON REVIEWING AUTOPSY:

DATE:

FINAL VISIT
(18 Months Post-Term)

1. Infant ID Number

Month Day Year

2. Date of Examination

3. Post Term Age months

4. Infant Status at the Time of Examination:

01
Outpatient

02
Inpatient

If Inpatient: 01
Study Hospital

02
Other Hospital

5. Ventilation:

A. Current Ventilatory Aid:

1. None 01

2. Conventional Mechanical Ventilation 02

3. High Frequency Ventilation 03

4. Continuous Distending Airway Pressure (CDAP) 04

5. O₂ Therapy 05

If YES,
a. Continuous 01

b. Nighttime/Intermittent 02

B. If O₂ therapy was discontinued after interim visit,

Month Day Year
when discontinued

6. Current Medication:

- A. Diuretics ⁰¹
- B. Bronchodilators ⁰²
- C. Others (specify) _____ ... ⁰³

7. Respiratory Tract Complications Since Interim Visit:

A. Infections:

- | | None
<input type="text"/> ⁰¹ | 1-2
<input type="text"/> ⁰² | More Than 2
<input type="text"/> ⁰³ |
|---------------------------------------|--|---|---|
| 1. Otitis Media | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. Upper respiratory infections | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. Lower respiratory infections | <input type="text"/> | <input type="text"/> | <input type="text"/> |

B. Number of hospital admissions for respiratory infections

(Total) duration of hospital stay since interim visit for days
respiratory infections

C. Number of hospital admissions for other respiratory problems

Specify: _____

(Total) Duration of hospital stay since interim visit days
for other respiratory problems

8. Hospital Admission Since Interim Visit for All Causes:

A. Number of admissions

Specify cause(s): _____

B. (Total) duration of hospital stay since interim visit for all causes

days

Yes No

9. Seizures since Interim Visit

01 02

If YES,

Febrile

01 02

***** PHYSICAL EXAMINATION *****

10. Condition During Exam:

Satisfactory (infant cooperative)

01

Suboptimal (specify) _____ ...

02

11. Measurements:

A. Weight

• kg

B. Length

• cm

C. Head Circumference

• cm

D. Temperature

• °C

12. Respiratory System:

At Rest

After Exercise (pull to sit x 3)

A. Rate/(breaths per min)

Yes No

Yes No

B. Retractions

01 02

01 02

C. Stridor

01 02

01 02

D. Wheezing

01 02

01 02

E. Prolonged Expiration Phase

01 02

01 02

	At Rest		After Exercise (pull to sit x 3)	
	Yes	No	Yes	No
F. Rales	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
G. Cyanosis	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
H. Clubbing	<input type="checkbox"/> 01	<input type="checkbox"/> 02		

13. Airway Pathology:

A. Voice Quality (check all that apply):

1. Absent	<input type="checkbox"/> 01
2. Hoarse	<input type="checkbox"/> 02
3. Low Volume	<input type="checkbox"/> 03
4. Normal	<input type="checkbox"/> 04
5. Cannot score	<input type="checkbox"/> 05

B. Nose:

1. Nasal discharge or obstruction	<input type="checkbox"/> 01
2. Deformation of nostrils	<input type="checkbox"/> 02
3. Palatal Groove	<input type="checkbox"/> 03

C. Tracheostomy 04

D. Subglottic stenosis 05

E. Other (specify) _____ ... 06

14. Cardiovascular System:

A. Heart Rate /min.

B. Blood Pressure / Doppler ⁰¹ Other ⁰²
Yes No

C. Abnormal Rhythm ⁰¹ ⁰²

D. Murmur ⁰¹ ⁰²

If YES: Yes No

a. Innocent ⁰¹ ⁰²

b. Other ⁰¹ ⁰²

E. Excess Precordial Activity ⁰¹ ⁰²

F. Other Abnormal Findings ⁰¹ ⁰²
(specify) _____

15. Abdomen:

A. Liver (measured below costal margin) • cm

B. Spleen (measured below costal margin) • cm

C. Inguinal Hernia ⁰¹ ⁰²

D. Other abnormalities ⁰¹ ⁰²
(specify) _____

16. Eyes:

	Normal	Abnormal
A. Pupils	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
B. Light reflex	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²

	Yes	No
C. Fixes	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
D. Follows	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
E. Nystagmus	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²
F. Other abnormal findings	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²

(specify) _____

17. Neurological Examination

A. Movement:

	ARMS		LEGS	
	Right	Left	Right	Left
1. Voluntary:				
a. normal	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
b. decreased ...	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
2. Involuntary:				
a. absent	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
b. present	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
If present:				
a. tremor	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
b. athetosis ...	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
c. dystonic	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³

B. Tone:

1. Neck, Shoulder Extensors:

increased	<input type="checkbox"/> ⁰¹
decreased	<input type="checkbox"/> ⁰²
normal	<input type="checkbox"/> ⁰³

	Right	Left
2. Arms:		
a. increased	<input type="checkbox"/> 01	<input type="checkbox"/> 01
b. decreased	<input type="checkbox"/> 02	<input type="checkbox"/> 02
c. normal	<input type="checkbox"/> 03	<input type="checkbox"/> 03
3. Hamstrings:		
a. increased	<input type="checkbox"/> 01	<input type="checkbox"/> 01
b. decreased	<input type="checkbox"/> 02	<input type="checkbox"/> 02
c. normal	<input type="checkbox"/> 03	<input type="checkbox"/> 03
4. Hip Adductors:		
a. increased	<input type="checkbox"/> 01	<input type="checkbox"/> 01
b. decreased	<input type="checkbox"/> 02	<input type="checkbox"/> 02
c. normal	<input type="checkbox"/> 03	<input type="checkbox"/> 03
5. Gastrocnemii:		
a. increased	<input type="checkbox"/> 01	<input type="checkbox"/> 01
b. decreased	<input type="checkbox"/> 02	<input type="checkbox"/> 02
c. normal	<input type="checkbox"/> 03	<input type="checkbox"/> 03
6. Trunk:		
a. increased	<input type="checkbox"/> 01	
b. decreased	<input type="checkbox"/> 02	
c. normal	<input type="checkbox"/> 03	

C. Reflexes:

1. Deep Tendon Reflexes:

	Right	Left
a. Biceps:		
increased with clonus	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
increased, no clonus	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
absent or very diminished	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³
normal	<input type="checkbox"/> ⁰⁴	<input type="checkbox"/> ⁰⁴
b. Patellar:		
increased with clonus	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
increased, no clonus	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
absent or very diminished	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³
normal	<input type="checkbox"/> ⁰⁴	<input type="checkbox"/> ⁰⁴
c. Ankle:		
increased with clonus	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰¹
increased, no clonus	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰²
absent or very diminished	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰³
normal	<input type="checkbox"/> ⁰⁴	<input type="checkbox"/> ⁰⁴

2. Asymmetric Tonic Neck Reflex:

a. Present Bilateral	<input type="checkbox"/> ⁰¹
b. Present Unilateral	<input type="checkbox"/> ⁰²
c. Absent	<input type="checkbox"/> ⁰³

	RIGHT		LEFT	
3. Obligatory Grasp:	Yes	No	Yes	No
a. palmar	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
b. plantar	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
		Yes	No	
4. Primary standing	<input type="checkbox"/> 01	<input type="checkbox"/> 02		
5. Parachute response	<input type="checkbox"/> 01	<input type="checkbox"/> 02		
If YES, symmetrical		<input type="checkbox"/> 01		
asymmetrical		<input type="checkbox"/> 02		

	RIGHT		LEFT	
6. Babinski response: (toe flexes)	Yes	No	Yes	No
	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02

D. Posture Abnormalities:

1. Attitude and posture of limbs at rest (e.g., hands, fisted, thumb abducted, forearm fixed, legs scissored):

Upper Extremity	Lower Extremity
Abnormal	Abnormal
Normal	Normal
<input type="checkbox"/> 01	<input type="checkbox"/> 01
<input type="checkbox"/> 02	<input type="checkbox"/> 02

	Normal	Abnormal
2. Head Control (in upright position)	<input type="checkbox"/> 01	<input type="checkbox"/> 02
3. Sitting Position	<input type="checkbox"/> 01	<input type="checkbox"/> 02
4. Prone Position	<input type="checkbox"/> 01	<input type="checkbox"/> 02
5. Standing Position	<input type="checkbox"/> 01	<input type="checkbox"/> 02

E. Gross Motor:

- 1. Crawling:
 - a. absent 01
 - b. present, abnormal ... 02
 - c. present, normal 03
- 2. Cruising:
 - a. absent 01
 - b. present, abnormal ... 02
 - c. present, normal 03
- 3. Standing Alone:
 - a. absent 01
 - b. present, abnormal ... 02
 - c. present, normal 03
- 4. Walking (without assistance):
 - a. absent 01
 - b. present, abnormal ... 02
 - c. present, normal 03
- 5. Running (without assistance, ten feet):
 - a. absent 01
 - b. present, abnormal ... 02
 - c. present, normal 03

6. Stooping to retrieve object:
- a. absent ⁰¹
 - b. present, abnormal ... ⁰²
 - c. present, normal ⁰³

F. Fine Motor:

1. Fine pincer grasp:
- | | Right | Left |
|----------------------------|--|--|
| a. absent | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰¹ |
| b. present, abnormal | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰² |
| c. present, normal | <input type="checkbox"/> ⁰³ | <input type="checkbox"/> ⁰³ |
2. Finger exploration of toy:
- | | Right | Left |
|----------------------------|--|--|
| a. absent | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰¹ |
| b. present, abnormal | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰² |
| c. present, normal | <input type="checkbox"/> ⁰³ | <input type="checkbox"/> ⁰³ |
3. Handedness:
- a. Prefers Right ⁰¹
 - b. Prefers Left ⁰²
 - c. No preference ⁰³
4. Ataxia when reaching for object:
- | | Right | Left |
|------------------|--|--|
| a. present | <input type="checkbox"/> ⁰¹ | <input type="checkbox"/> ⁰¹ |
| b. absent | <input type="checkbox"/> ⁰² | <input type="checkbox"/> ⁰² |

G. Cranial Nerves - Motor Function:

	RIGHT		LEFT	
	Yes	No	Yes	No

- | | | | | |
|---------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| 1. Ptosis | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 2. Strabismus | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |

- | | | |
|---------------------------|-----------------------------|-----------------------------|
| | Normal | Abnormal |
| 3. Eye Movements: Right - | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| Left - | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |

- | | | |
|--|-----------------------------|-----------------------------|
| | Yes | No |
| 4. Nystagmus | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 5. Facial Weakness | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |
| 6. Chewing or swallowing abnormalities | <input type="checkbox"/> 01 | <input type="checkbox"/> 02 |

H. Hydrocephalus (diagnosed since interim visit) 01 02

Month Day Year

If YES, primary shunt insertion date

Number of revisions

18. Cognitive Evaluation - Bayley scales (use post-term age):

- A. Mental Development MDI (not raw scores)
- B. Motor Development PDI (not raw scores)
- C. Developmental Quotient (if Bayley <50 or non-applicable)

19. Chest X-ray (should be done on all infants with chronic lung disease as neonate unless chest X-ray was normal prior to this visit)

- Normal 01
- Abnormal (specify) 02
- Not Done 03

20. Clinical Impression at 18 months:

A. Respiratory System:

- 1. Normal 01
- 2. Chronic lung disease secondary to BPD 02
- 3. Chronic lung disease secondary to other causes 03

B. Cardiac System:

- 1. Normal 01
- 2. Right heart failure or dysfunction 02
- 3. Other abnormality 03

C. Neurologic Status:

- 1. Normal 01
- 2. Uncertain 02
- 3. Abnormal 03

If abnormal, check the following appropriate abnormalities:

		Degree of Handicap:		
		Severe	Moderate	Mild
I. Hydrocephalus:				
1. Shunted	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	
2. Not shunted	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	
II. Cerebral Palsy:				
1. Diplegia	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	
2. Quadriplegia	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	
3. Hemiplegia	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	

Degree of Handicap:
Severe Moderate Mild

III. Seizure Disorder	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03
IV. Other	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03
(specify) _____			
D. Hearing Impairment	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03
E. Visual Impairment	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03

***** ASSESSMENT OF ENVIRONMENT *****

		Yes	No
21. Does infant attend day care or nursery?		<input type="checkbox"/> 01	<input type="checkbox"/> 02
If YES, how many children are in the group?	<input type="checkbox"/> <input type="checkbox"/>		
22. How many people share infant's bedroom?	<input type="checkbox"/> <input type="checkbox"/>		
23. How many people smoke in the infant's home?	<input type="checkbox"/> <input type="checkbox"/>		
		Yes	No
24. Does a parent or sibling have asthma or chronic bronchitis?		<input type="checkbox"/> 01	<input type="checkbox"/> 02

SIGNATURE OF EXAMINER

SIGNATURE OF CLINICAL COORDINATOR

DATE: _____

SCREENING FORM

(To be completed on all infants who:

- 1. weigh between 750 and 2000 grams;
- 2. require oxygen or assisted ventilation; and
- 3. are less than or equal to 24 hours of age.)

***** BACKGROUND INFORMATION *****

1. Infant ID 67-74

--	--	--	--	--	--	--	--

2. Date and time of birth

75-76 Month	77-78 Day	79-80 Year	81-84 Time

3. A. Date and time of this screening

85-86	87-88	89-90	91-94

B. Has this patient been screened before?
Yes 01 No 02 95-96

4. Birth Weight 97-100

--	--	--	--	--

 grams

5. Infant data:
A. Inborn 01 Outborn 02 101-102
B. Male 01 Female 02 103-104
C. Gestational Age (Pediatric Assessment) ... 105-106

--	--

 weeks, Unknown 94

6. Preliminary Diagnoses (check all that apply):
A. Apnea 01 107-108
B. Pneumonia 02 109-110
C. Respiratory Distress Syndrome 03 111-112
D. Respiratory Distress Other 04 113-114
E. Drug related depression 05 115-116
F. Asphyxia 06 117-118
G. Other (specify) _____ 07 119-120
H. None 08 121-122

7. Is the infant on IPPV? 123-124
Yes 01 No 02
If YES, for how long? 125-126

		hours			minutes
--	--	-------	--	--	---------

127-128

8. Exclusion Diagnosis (check all that apply)
A. Meconium aspiration 01 129-130
B. Neuromuscular conditions affecting respiration 02 131-132

- C. Hydrops fetalis 133-134 03
- D. Congenital heart disease 135-136 04
- E. Major congenital malformations 137-138 05
- F. Multiple birth (> 3) 139-140 06
- G. Newborn non-viable 141-142 07
 - 1. Expired within three days 143-144 Yes 01 No 02
- H. None 145-146 08
- 9. Eligibility for the study at this point of screening Yes No

(If NO, sign and mail to RTI) 147-148
- 10. Mother's date of birth

152-153	154-155	156-157
Month	Day	Year
[] []	[] []	[] []
- 11. Ethnic Origin of Mother:
 - A. White, not of Hispanic origin 158-159 01
 - B. Black, not of Hispanic origin 02
 - C. Hispanic 03
 - D. Asian/Pacific Islander 04
 - E. American Indian/Alaskan Native 05
 - F. Other (specify) _____ ... 06
 - G. Don't Know 07
- 12. Twin Pregnancy 160-161 Yes 01 No 02
- 13. Qualifying Data
Infants may be treated with CMV for as long as 12 hours prior to qualifying. Infants weighing between 750 and 1250 grams need only require assisted mechanical ventilation to be eligible for randomization.
 - A. For infants between 750 and 1250 grams:
 Does infant meet ventilatory requirements for entry ? 162-163 01 02
 - B. For infants between 1251 and 2000 grams:
 Does infant meet blood gas criteria with 12 hours of ventilation? 164-165 01 02
 Does infant meet blood gas criteria within 24 hours of age? 166-167 01 02

14. Blood gases (enter only if the infant meets blood gas criteria for entry, i.e., both parts of Q.13.B are yes)

Time (24-hour Clock)	Measurements	
168-171	P_{aO_2} 172-174 mm Hg F_{IO_2} 175-176 P_{aO_2}/F_{IO_2} 143-145 mm Hg	\bar{P}_{aw} 179-182 cm H ₂ O
146-149	P_{aO_2} 190-192 mm Hg F_{IO_2} 193-196 P_{aO_2}/F_{IO_2} 201-203 mm Hg	\bar{P}_{aw} 197-200 cm H ₂ O

15. Infant involved in conflicting protocol(s)? 01 02 204-205
16. Ventilators available? 206-207
- A. CMV 01 02
- B. HFV 01 02 208-209
17. Agreed to participate in study? 01 02 210-211
- A. If NO, why? (check all that apply)
1. Parental/Guardian refusal 01 212-213
2. Physician refusal 02 214-215
3. Other (specify) _____ .. 03 216-217

B. Describe reasons for refusal: _____

18. Disposition of Infant: 218-219
- A. ⁰¹ Randomized ⁰² Excluded
- B. If the reason for exclusion is none of those listed above, specify ... _____

19. Ventilator assigned:

CMV 01 HFV 02

223-221

A. Date and Time of Random Assignment:

Month Day Year Time

20. Was patient withdrawn prior to initiation of study ventilator/protocol?

Yes 01 No 02

223-233

If YES, why? _____

AFFIX RANDOMIZATION LABEL BELOW.

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

INFANT ENTRY AND HOSPITAL FORM

1. Infant ID

Month Day Year

2. Date of Birth

3. Sex Male ⁰¹ Female ⁰²

4. Birth Order (for twins only)

5. Ventilator Assigned CMV ⁰¹ HFV ⁰²

A. Make, Model and Serial Number of assigned ventilator:

6. Date and time of initiation of infant on study ventilator

***** FETAL AND PERINATAL DATA *****

7. Complications (check all that apply):

- A. Placenta previa
- B. Abruptio placentae
- C. Cord prolapse
- D. Other (specify) _____ ..

Yes	No	Don't Know
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94

8. a. Was a test of fetal lung maturity done on amniotic fluid within 24 hours prior to birth?

<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
-----------------------------	-----------------------------	-----------------------------

b. If YES, which tests were done? (check all that apply)

- 1) L/S Ratio 01
- 2) Phosphatidyl Glycerol 02
- 3) Disaturated PC 03
- 4) Shake Test 04
- 5) Foam Stability Index 05
- 6) Other 06

9. Was fetal distress present?

Yes	No	Don't Know
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94

A. Fetal scalp pH?

<input type="checkbox"/> 01	<input type="checkbox"/> 02
-----------------------------	-----------------------------

If YES, lowest pH

B. Meconium stained amniotic fluid

<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 94
-----------------------------	-----------------------------	-----------------------------

10. Delivery Data:

A. Presentation:	Vertex	<input type="checkbox"/>	⁰¹	Breech (other compound)	<input type="checkbox"/>	⁰²
B. Route:	Vaginal	<input type="checkbox"/>	⁰¹	Caesarean	<input type="checkbox"/>	⁰²
If vaginal:	Forceps?	<input type="checkbox"/>	⁰¹	Spontaneous?	<input type="checkbox"/>	⁰²

11. Apgar Scores:

One minute	<input type="checkbox"/>	<input type="checkbox"/>	Not Recorded	<input type="checkbox"/>	⁰¹
Five minutes	<input type="checkbox"/>	<input type="checkbox"/>	Not Recorded	<input type="checkbox"/>	⁰¹

12. Infant resuscitated at birth?	<input type="checkbox"/>	⁰¹	Yes	<input type="checkbox"/>	⁰²	No
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A. If YES, how? (check all that apply):

1. Oxygen	<input type="checkbox"/>	⁰¹
2. Bag and Mask Ventilation	<input type="checkbox"/>	⁰²
3. Intubation	<input type="checkbox"/>	⁰³
4. Cardiac Massage	<input type="checkbox"/>	⁰⁴
5. Drugs/Fluids	<input type="checkbox"/>	⁰⁵

13. Physical Measurements at Randomization:

A. Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	gm
B. Length (to the nearest 0.5 cm)	<input type="checkbox"/>	<input type="checkbox"/>	.	<input type="checkbox"/>	cm
C. Head Circumference (to the nearest 0.5 cm)	<input type="checkbox"/>	<input type="checkbox"/>	.	<input type="checkbox"/>	cm

14. Ultrasound Data:

A. Ultrasound at Randomization ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound: Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade: Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

B. Ultrasound at Day 1 ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound: Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade: Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 2 ⁰¹ Yes ⁰² No

Month Day Year Time

If YES, date and time of ultrasound:

1. IVH ⁰¹ Yes ⁰² No

Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

If YES, indicate grade:

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 3 ⁰¹ Yes ⁰² No

Month Day Year Time

If YES, date and time of ultrasound:

1. IVH ⁰¹ Yes ⁰² No

Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

If YES, indicate grade:

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 4 ⁰¹ Yes ⁰² No

Month Day Year Time

If YES, date and time of ultrasound:

1. IVH ⁰¹ Yes ⁰² No

Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

If YES, indicate grade:

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 5 ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound: Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade: Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 6 ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound: Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade: Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

Ultrasound at Day 7 ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound: Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade: Grade 1 Grade 2 Grade 3 Grade 4
⁰¹ ⁰² ⁰³ ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

***** HOSPITAL COURSE *****

Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)

15. Major Diagnoses:

Condition	Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	Month	Day	Year	
A. Respiratory Distress Syndrome.....	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Pneumonia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Proven	Suspected		
- Congenital:	<input type="text"/> ⁰¹	<input type="text"/> ⁰²	<input type="text"/>	<input type="text"/>
- Acquired: (first episode)	<input type="text"/> ⁰¹	<input type="text"/> ⁰²	<input type="text"/>	<input type="text"/>
C. Congenital viral syndrome	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Specify: _____				
D. Pulmonary Interstitial Emphysema				
	Right			<input type="text"/>
	Left			<input type="text"/>
	Yes	No		
Chest Tube Inserted	<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
	Right			
	Left			
E. Pneumothorax - Unilateral	Month	Day	Year	
1st episode				
	Right			<input type="text"/>
	Left			<input type="text"/>
Recurrent <input type="text"/>				
	Yes	No		
Chest Tube Inserted	<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
	Right			
	Left			

Ventilation
Support at
Time of
Diagnosis
(CMV=1,
HFV=2,
None=3)

15. Major Diagnoses: (continued)

Condition		Date of Diagnosis			
		Month	Day	Year	
2nd episode	Right	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Recurrent	<input type="checkbox"/>				
Chest Tube Inserted	Right	<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
	Left	<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
Pneumothorax - Bilateral		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Recurrent	<input type="checkbox"/>			
Chest Tube Inserted		<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
		<input type="text"/> ⁰¹	<input type="text"/> ⁰²		
F. Pneumomediastinum:		Month	Day	Year	
1st episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2nd episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3rd episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
G. Pneumopericardium:		Month	Day	Year	
1st episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2nd episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3rd episode		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Ventilation
Support at
Time of
Diagnosis
(CMV=1,
HFV=2,
None=3)

15. Major Diagnoses: (continued)

Condition	Date of Diagnosis			
	Month	Day	Year	
H. Pneumoperitoneum: Secondary to Pulmonary Causes				
1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specify: _____				

I. Pulmonary Venous Air Embolism	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
J. Respiratory Distress (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
K. Persistent Fetal Circulation/ Persistent Pulmonary Hypertension	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
L. Bronchopulmonary Dysplasia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M. Necrotizing Tracheobronchitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
N. Tracheostomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indication: _____				
O. Post Extubation Atelectasis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
P. Apnea	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Q. Necrotizing Enterocolitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
R. Jaundice Requiring Exchange Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Ventilation
Support at
Time of
Diagnosis
(CMV=1,
HFV=2,
None=3)

15. Major Diagnoses: (continued)

Condition	Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	Month	Day	Year	
S. Congenital Heart Disease	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
T. Patent Ductus Arteriosus	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U. Retinopathy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

16. If PDA diagnosed:

Was congestive heart failure present? Yes 01 No 02

Were the following treatments given?

	Date First Treated		
	Month	Day	Year
<input type="checkbox"/> Fluid restriction or diuretics	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Indomethacin	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ligation	<input type="text"/>	<input type="text"/>	<input type="text"/>

17. Periventricular Leukomalacia (PVL) 01 02

18. IVH 01 02

If YES, when first detected? Month Day Year

How? (check all that apply)

01 02 03 04
 Ultrasound Catscan Clinical Autopsy

Most severe grade during hospital course:
 1, 2, 3, 4

	Yes	No
19. Post hemorrhagic hydrocephalus	01 <input type="checkbox"/>	02 <input type="checkbox"/>
Shunt	01 <input type="checkbox"/>	02 <input type="checkbox"/>
Repeat Lumbar Puncture	01 <input type="checkbox"/>	02 <input type="checkbox"/>
Ventricular Drainage	01 <input type="checkbox"/>	02 <input type="checkbox"/>
20. Seizures	01 <input type="checkbox"/>	02 <input type="checkbox"/>

If YES, date of onset

Month	Day	Year
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Number of Episodes: 1 episode

More than 1 episode

EEG Results:

Not done

Normal

Abnormal

	Yes	No
21. Culture proven infections?	01 <input type="checkbox"/>	02 <input type="checkbox"/>

If YES, write the date of first positive culture in the box which indicates site of culture.

	Spinal		Blood		Endotracheal		Other	
	Month	Day	Month	Day	Month	Day	Month	Day
A. Pneumonia	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
B. Meningitis	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
C. Sepsis	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
D. Other	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Specify: _____

22. Highest Bilirubin

SIU

mg %

Month

Day

Year

A. Highest Total

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B. Highest Direct

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		•	
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23. Medications:

Starting Date

Duration of Therapy

Month

Day

Year

(days)

A. Antibiotics

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B. Methylxanthines

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Indications

C. Bronchodilators

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D. Muscle Relaxants

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E. Sedation

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F. Anti-seizure medications

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G. Volume Expansion

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H. Vasodilators

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I. Vasopressor Agents

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J. Diuretics

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K. Steroids

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L. Bicarbonates

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M. Other

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--	--

--	--	--

Specify _____

24. Technique of entotracheal tube suctioning:

A. Hand ventilation with suctioning

Yes 01 No 02

B. (for HFV only) Machine sigh after suctioning

01 02

25. Study Outcome:

A. Crossover

01 02

1. If YES, date of first crossover ..
Month Day Year

B. Days on assigned ventilation days

C. Date first weaned to CPAP
Month Day Year Time

D. Extubated

1) Days on endotracheal tube CPAP days

E. Days on nasal or pharyngeal CPAP days

F. Days on O₂ Therapy:
> 40% days

22 - 40% days

G. Room air date
Month Day Year

H. Need for supplemental oxygen at the 28th day

01 02

I. Enteral Feeding date
Month Day Year

J. Date on which 90 cal/kg reached

K. Radiographic changes consistent with BPD on
day 28 ± 7 days

Yes 01 No 02 Don't Know 94

26. Patient Disposition:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

A. Infant still in hospital at 28 days

	Yes	No
In O ₂	<input type="checkbox"/> 01	<input type="checkbox"/> 02
On ventilator	<input type="checkbox"/> 01	<input type="checkbox"/> 02

B. Discharged to home

	Yes	No
In O ₂	<input type="checkbox"/> 01	<input type="checkbox"/> 02
On ventilator	<input type="checkbox"/> 01	<input type="checkbox"/> 02

C. Discharged to other hospital

	Yes	No
In O ₂	<input type="checkbox"/> 01	<input type="checkbox"/> 02
On ventilator	<input type="checkbox"/> 01	<input type="checkbox"/> 02

D. Died

	Yes	No
If died, autopsy done?	<input type="checkbox"/> 01	<input type="checkbox"/> 02

Month	Day	Year
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

INFANT ENTRY AND HOSPITAL FORM

1. Infant ID

2. Date of Birth Month Day Year

3. Sex Male⁰¹ Female⁰²

4. Birth Order (for twins only)

5. Ventilator Assigned CMV⁰¹ HFV⁰²

A. Make, Model and Serial Number of assigned ventilator:

6. Date and time of initiation of infant on study ventilator Month Day Year Time

***** FETAL AND PERINATAL DATA *****

7. Complications (check all that apply): Yes⁰¹ No⁰² Don't Know⁹⁴

A. Placenta previa

B. Abruptio placentae

C. Cord prolapse

D. Other (specify) _____ ..

8. a. Was a test of fetal lung maturity done on amniotic fluid within 24 hours prior to birth?

b. If YES, which tests were done? (check all that apply)

1) L/S Ratio ⁰¹ 4) Shake Test ⁰⁴

2) Phosphatidyl Glycerol ⁰² 5) Foam Stability Index ⁰⁵

3) Disaturated PC ⁰³ 6) Other ⁰⁶

c. Result: Mature ⁰¹ Immature ⁰²

9. Was fetal distress present?

A. Fetal scalp pH?

If YES, lowest pH

B. Meconium stained amniotic fluid

10. Delivery Data:

- A. Presentation: Vertex ⁰¹ Breech (other compound) ⁰²
- B. Route: Vaginal ⁰¹ Caesarean ⁰²
- If vaginal: Forceps? ⁰¹ Spontaneous? ⁰²

11. Apgar Scores:

- One minute Not Recorded ⁰¹
- Five minutes Not Recorded ⁰¹

12. Infant resuscitated at birth? ⁰¹ Yes ⁰² No

A. If YES, how? (check all that apply)

- 1. Oxygen ⁰¹
- 2. Bag and Mask Ventilation ⁰²
- 3. Intubation ⁰³
- 4. Cardiac Massage ⁰⁴
- 5. Drugs/Fluids ⁰⁵

13. Physical Measurements at Randomization:

- A. Weight gm
- B. Length (to the nearest 0.5 cm) cm
- C. Head Circumference (to the nearest 0.5 cm) cm

14. Ultrasound Data:

A. Ultrasound at Randomization ⁰¹ Yes ⁰² No

If YES, date and time of ultrasound:

Month	Day	Year	Time
<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"/> <input type="text"/>

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade:

Grade 1	Grade 2	Grade 3	Grade 4
<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²	<input type="checkbox"/> ⁰³	<input type="checkbox"/> ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

B. Ultrasound at Day 1 Yes 01 No 02

If YES, date and time of ultrasound:

Month Day Year Time

1. IVH Yes 01 No 02

If YES, indicate grade:

Grade 1 01 Grade 2 02 Grade 3 03 Grade 4 04

2. PVL Yes 01 No 02

Ultrasound at Day 2 Yes 01 No 02

Month Day Year Time

1. IVH Yes 01 No 02

If YES, indicate grade:

Grade 1 01 Grade 2 02 Grade 3 03 Grade 4 04

2. PVL Yes 01 No 02

Ultrasound at Day 3 Yes 01 No 02

Month Day Year Time

1. IVH Yes 01 No 02

If YES, indicate grade:

Grade 1 01 Grade 2 02 Grade 3 03 Grade 4 04

2. PVL Yes 01 No 02

Ultrasound at Day 4 Yes ⁰¹ No ⁰²

Month Day Year Time

1. IVH Yes ⁰¹ No ⁰²

If YES, indicate grade:

Grade 1 ⁰¹ Grade 2 ⁰² Grade 3 ⁰³ Grade 4 ⁰⁴

2. PVL Yes ⁰¹ No ⁰²

Ultrasound at Day 5 Yes ⁰¹ No ⁰²

Month Day Year Time

1. IVH Yes ⁰¹ No ⁰²

If YES, indicate grade:

Grade 1 ⁰¹ Grade 2 ⁰² Grade 3 ⁰³ Grade 4 ⁰⁴

2. PVL Yes ⁰¹ No ⁰²

Ultrasound at Day 6 Yes ⁰¹ No ⁰²

Month Day Year Time

1. IVH Yes ⁰¹ No ⁰²

If YES, indicate grade:

Grade 1 ⁰¹ Grade 2 ⁰² Grade 3 ⁰³ Grade 4 ⁰⁴

2. PVL Yes ⁰¹ No ⁰²

Ultrasound at Day 7 ⁰¹ Yes ⁰² No

Month Day Year Time

1. IVH ⁰¹ Yes ⁰² No

If YES, indicate grade:

Grade 1 ⁰¹ Grade 2 ⁰² Grade 3 ⁰³ Grade 4 ⁰⁴

2. PVL ⁰¹ Yes ⁰² No

***** HOSPITAL COURSE *****

15. Major Diagnoses: Condition	Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	Month	Day	Year	
A. Respiratory Distress Syndrome	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
B. Pneumonia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
-Congenital:	<input type="checkbox"/> ⁰¹ Proven	<input type="checkbox"/> ⁰² Suspected	<input type="text"/>	<input type="text"/>
-Acquired: (first episode)	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²	<input type="text"/>	<input type="text"/>
C. Congenital viral syndrome	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Specify: _____				
D. Pulmonary Interstitial Emphysema				
Right	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Chest Tube Inserted				
Right	<input type="checkbox"/> ⁰¹ Yes	<input type="checkbox"/> ⁰² No		
Left	<input type="checkbox"/> ⁰¹	<input type="checkbox"/> ⁰²		

Major
Diagnoses:
Condition

Date of Diagnosis
Month Day Year

Ventilation
Support at
Time of
Diagnosis
(CMV=1,
HFV=2,
None=3)

E. Pneumothorax
Unilateral

1st episode Right

Left

Recurrent

Chest Tube Inserted Right Yes ⁰¹ No ⁰²

Left Yes ⁰¹ No ⁰²

2nd episode Right

Left

Recurrent

Chest Tube Inserted Right Yes ⁰¹ No ⁰²

Left Yes ⁰¹ No ⁰²

Bilateral

Recurrent

Chest Tube Inserted Yes ⁰¹ No ⁰²

F. Pneumomediastinum

1st episode

2nd episode

3rd episode

G. Pneumopericardium

1st episode

2nd episode

3rd episode

Major Diagnoses: Condition	Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	Month	Day	Year	
H. Pneumoperitoneum: Secondary to Pulmonary Causes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Specify: _____				
<hr/>				
I. Pulmonary Venous Air Embolism	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
J. Respiratory Distress (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
K. Persistent Fetal Circulation/ Persistent Pulmonary Hypertension	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
L. Bronchopulmonary Dysplasia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
M. Necrotizing Tracheobronchitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
N. Tracheostomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Indication: _____				
O. Post Extubation Atelectasis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
P. Apnea	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Q. Necrotizing Enterocolitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
R. Jaundice Requiring Exchange Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
S. Congenital Heart Disease	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
T. Patent Ductus Arteriosus	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
U. Retinopathy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

16. If PDA diagnosed: Was congestive heart failure present? Yes ⁰¹ No ⁰²

Were The Following Treatments Given?

Date First Treated

	Month	Day	Year
<input type="checkbox"/> Fluid restriction or diuretics	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Indomethacin	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ligation	<input type="text"/>	<input type="text"/>	<input type="text"/>

17. Periventricular Leukomalacia (PVL) Yes ⁰¹ No ⁰²

18. IVH ⁰¹ ⁰²

If YES, when first detected? Month Day Year

How? (check all that apply)

Ultrasound ⁰¹ Catscan ⁰² Clinical ⁰³ Autopsy ⁰⁴

Most Severe Grade during hospital course 1, 2, 3, 4

19. Post hemorrhagic hydrocephalus Yes ⁰¹ No ⁰²

Shunt ⁰¹ ⁰²

Repeat Lumbar Puncture ⁰¹ ⁰²

Ventricular Drainage ⁰¹ ⁰²

20. Seizures ⁰¹ ⁰²

If YES, date of onset Month Day Year

Number of seizures ..

ECG Results ⁰¹ Not Done
⁰² Normal
⁰³ Abnormal

21. Culture proven infections? ⁰¹ ⁰² Yes No

If YES, write the date at first positive culture in the box which indicates site of culture.

	Spinal		Blood		Endotracheal		Other	
	Month	Day	Month	Day	Month	Day	Month	Day
A. Pneumonia								
B. Meningitis								
C. Sepsis								
D. Other								

Specify: _____

22. Highest Bilirubin:

	SIU	mg. %	Month	Day	Year
A. Highest Total					
B. Highest Direct ...					

23. Medications:

	Starting Date			Duration of Therapy (days)
	Month	Day	Year	
A. Antibiotics				
B. Methylxanthines ...				

Indications _____

C. Bronchodilators				
D. Muscle Relaxants ..				
E. Sedation				
F. Anti-seizure medications				
G. Volume Expansion ..				
H. Vasodilators				
I. Vasopressor Agents				
J. Diuretics				
K. Steroids				
L. Bicarbonates				
M. Other				

Specify: _____

24. Technique of entotracheal tube suctioning:

- A. Hand ventilation with suctioning Yes ⁰¹ No ⁰²
- B. (for HFV only) Machine sigh after suctioning ⁰¹ ⁰²

25. Study Outcome:

- A. Crossover ⁰¹ ⁰²

1. If YES, Date of first crossover Month Day Year

B. Days on assigned ventilation days

C. Date first weaned to CPAP Month Day Year Time

D. Extubated

E. Days on nasal or pharyngeal CPAP days

F. Days on O₂ therapy > 40% days

22 - 40% days

G. Room air date

H. Need for supplemental oxygen at the 28th day Yes ⁰¹ No ⁰²

I. Enteral Feeding date

J. Date on which 90 cal/kg reached

26. Patient Status at 28 Days:

A. Infant still in hospital Month Day Year

In O₂ Yes ⁰¹ No ⁰²

On Ventilator ⁰¹ ⁰²

B. Discharged to home

In O₂ Yes ⁰¹ No ⁰²

On Ventilator ⁰¹ ⁰²

		Month	Day	Year
C.	<input type="checkbox"/> Discharged to other hospital	<input type="text"/>	<input type="text"/>	<input type="text"/>
	In O ₂	Yes	No	
		<input type="checkbox"/> 01	<input type="checkbox"/> 02	
	On Ventilator	<input type="checkbox"/> 01	<input type="checkbox"/> 02	
D.	<input type="checkbox"/> Died	<input type="text"/>	<input type="text"/>	<input type="text"/>
	If died, autopsy done?	Yes	No	
		<input type="checkbox"/> 01	<input type="checkbox"/> 02	

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

INFANT ENTRY AND HOSPITAL FORM

1. Infant ID [] [] [] [] [] [] [] [] [] []

2. Date of Birth Month [] [] Day [] [] Year [] []

3. Sex Male ⁰¹ Female ⁰²

4. Birth Order (for twins only)

5. Ventilator Assigned CMV ⁰¹ HFV ⁰²

A. Make, Model and Serial Number of assigned ventilator:

6. Date and time of initiation of infant on study ventilator Month [] [] Day [] [] Year [] [] Time [] [] [] []

***** FETAL AND PERINATAL DATA *****

7. Complications (check all that apply):
A. Placenta previa Yes No ⁰¹ ⁰² Don't Know ⁹⁴
B. Abruptio placentae Yes No ⁰¹ ⁰² Don't Know ⁹⁴
C. Cord prolapse Yes No ⁰¹ ⁰² Don't Know ⁹⁴
D. Other (specify) Yes No ⁰¹ ⁰² Don't Know ⁹⁴

8. a. Was a test of fetal lung maturity done on amniotic fluid within 24 hours prior to birth? Yes No ⁰¹ ⁰² Don't Know ⁹⁴

b. If YES, which tests were done? (check all that apply)

1) L/S Ratio ⁰¹ 4) Shake Test ⁰⁴
2) Phosphatidyl Glycerol ⁰² 5) Foam Stability Index ⁰⁵
3) Disaturated PC ⁰³ 6) Other ⁰⁶

c. Result: Mature ⁰¹ Immature ⁰²

9. Was fetal distress present? Yes No ⁰¹ ⁰² Don't Know ⁹⁴

A. Fetal scalp pH? Yes No ⁰¹ ⁰²

If YES, lowest pH [] . [] []

B. Meconium stained amniotic fluid Yes No ⁰¹ ⁰² Don't Know ⁹⁴

10. Delivery Data:

A. Presentation: Vertex 01 Breech (other compound) 02

B. Route: Vaginal 01 Caesarean 02

If vaginal: Forceps? 01 Spontaneous? 02

11. Apgar Scores:

One minute Not Recorded 01

Five minutes Not Recorded 01

12. Infant resuscitated at birth? Yes No
 01 02

A. If YES, how? (check all that apply)

1. Oxygen 01

2. Bag and Mask Ventilation 02

3. Intubation 03

4. Cardiac Massage 04

5. Drugs/Fluids 05

13. Physical Measurements at Randomization:

A. Weight gm

B. Length (to the nearest 0.5 cm) cm

C. Head Circumference (to the nearest 0.5 cm) cm

***** HOSPITAL COURSE *****

14. Major Diagnoses: Condition		Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
		Month	Day	Year	
A.	Respiratory Distress Syndrome	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
B.	Pneumonia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	Proven Suspected				
	-Congenital: <input type="checkbox"/> 01 <input type="checkbox"/> 02	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	-Acquired: <input type="checkbox"/> 01 <input type="checkbox"/> 02 (first episode)	<input type="text"/>	<input type="text"/>	<input type="text"/>	
C.	Congenital viral syndrome	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	Specify: _____				
<hr/>					
D.	Pulmonary Interstitial Emphysema	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
		<input type="text"/>	<input type="text"/>	<input type="text"/>	
E.	Pneumothorax				
	Unilateral	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	Bilateral	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	Recurrent	<input type="checkbox"/>			
F.	Pneumomediastinum	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

R L
L L

Major Diagnoses: <u>Condition</u>	Date of Diagnosis			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	<u>Month</u>	<u>Day</u>	<u>Year</u>	
G. Pneumopericardium	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
H. Pneumoperitoneum: Secondary to Pulmonary Causes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
1st episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
2nd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
3rd episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Specify: _____				

I. Pulmonary Venous Air Embolism	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
J. Respiratory Distress (other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
K. Persistent Fetal Circulation/ Persistent Pulmonary Hypertension	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
L. Bronchopulmonary Dysplasia	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
M. Necrotizing Tracheobronchitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
N. Tracheostomy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Indication: _____				
O. Post Extubation Atelectasis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
P. Apnea	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Q. Necrotizing Enterocolitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
R. Jaundice Requiring Exchange Transfusion	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Major Diagnoses: <u>Condition</u>	<u>Date of Diagnosis</u>			Ventilation Support at Time of Diagnosis (CMV=1, HFV=2, None=3)
	<u>Month</u>	<u>Day</u>	<u>Year</u>	

- | | | | | |
|-----------------------------|----------------------|----------------------|----------------------|--------------------------|
| S. Congenital Heart Disease | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| T. Patent Ductus Arteriosus | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| U. Retinopathy | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |

15. If PDA diagnosed: Yes 01 No 02
 Was congestive heart failure present?

<u>Were The Following Treatments Given?</u>	<u>Date First Treated</u>		
	<u>Month</u>	<u>Day</u>	<u>Year</u>
<input type="checkbox"/> Fluid restriction or diuretics	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Indomethacin	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ligation	<input type="text"/>	<input type="text"/>	<input type="text"/>

16. Periventricular Leukomalacia (PVL) Yes 01 No 02

17. IVH Yes 01 No 02

If YES, when first detected? Month Day Year

How? (check all that apply)

Ultrasound 01 Catscan 02 Clinical 03 Autopsy 04

Most Severe Grade during hospital course 1, 2, 3, 4

18. Post hemorrhagic hydrocephalus Yes 01 No 02

Shunt 01 02

Repeat Lumbar Puncture 01 02

Ventricular Drainage 01 02

19. Culture proven infections? Yes No 01 02

If YES, write the date at first positive culture in the box which indicates site of culture.

	Spinal		Blood		Endotracheal		Other	
	Month	Day	Month	Day	Month	Day	Month	Day
A. Pneumonia			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Meningitis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
C. Sepsis	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Specify: _____

20. Highest Bilirubin:

	SIU	mg. %	Month	Day	Year
A. Highest Total	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Highest Direct ...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

21. Medications:

	Starting Date			Duration of Therapy
	Month	Day	Year	(days)
A. Antibiotics	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Methylxanthines ...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Indications _____

C. Bronchodilators	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D. Muscle Relaxants ..	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E. Sedation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
F. Anti-seizure medications	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
G. Volume Expansion ..	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
H. Vasodilators	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
I. Vasopressor Agents	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
J. Diuretics	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
K. Steroids	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
L. Bicarbonates	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M. Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Specify: _____

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

CROSS-OVER FORM

1. Infant ID
2. Date of Birth Month Day Year
3. Sex Male ⁰¹ Female ⁰²
4. Original Ventilator Assignment CMV HFV
5. Date and Time Infant Qualified for Cross-Over:
- Month Day Year Time
-
6. Qualifying Blood Gases for Cross-Over and Ventilator Settings:
- Ventilator Type: CMV ⁰¹ HFV ⁰²

		First			Second		
		Month	Day	Year	Month	Day	Year
A.	Blood Gases						
	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Time (24-hour clock)	<input type="text"/>			<input type="text"/>		
	Source:						
	(arterial=1;	<input type="checkbox"/>			<input type="checkbox"/>		
	transcutaneous=2;						
	capillary=3)						
	PaO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
	PaCO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
	pH	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
B.	% O ₂ :	<input type="text"/>			<input type="text"/>		
C.	Ventilator Variables:						
	1. <u>High Frequency Ventilator</u>						
	Ventilator Rate (Hz)	<input type="text"/>			<input type="text"/>		
	Stroke Volume (ml)	<input type="text"/> . <input type="checkbox"/>			<input type="text"/> . <input type="checkbox"/>		
	Amplitude (cmH ₂ O)	<input type="text"/>			<input type="text"/>		
	PIP (Peak)(cm H ₂ O)	<input type="text"/>			<input type="text"/>		
	\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
	Flow Rate (lpm)	<input type="text"/>			<input type="text"/>		
	2. <u>Conventional Ventilator</u>						
	Ventilator Rate	<input type="text"/> cpm			<input type="text"/> cpm		
	Inspiratory Time (sec.)	<input type="text"/> . <input type="checkbox"/>			<input type="text"/> . <input type="checkbox"/>		
	PEEP (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
	PIP (cm H ₂ O)	<input type="text"/> . <input type="checkbox"/>			<input type="text"/> . <input type="checkbox"/>		
	\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> . <input type="checkbox"/>			<input type="text"/> . <input type="checkbox"/>		
	Flow Rate (lpm)	<input type="text"/>			<input type="text"/>		

D. Sigh Data

Machine Rate	<input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> cpm
Manual Rate	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cph	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cph
Inspiratory Time (sec.)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
PIP (Peak) (cm H ₂ O)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>

E. Medications:

Sodium Bicarbonate/THAM	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type & dose:	_____		_____	
Vasopressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____	
Volume expanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____	
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Was The Baby Switched Yes 01 No 02

If no, why not? _____

***** Post Cross-Over Data *****

8. Make and Model of the New Ventilator:

9. Post Cross-Over Blood Gases and Ventilator Settings:

Time Since Cross-Over	First	Second	6 Hours			
	Month	Day	Month	Day	Month	Day
A. Blood Gases Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(arterial=1; transcutaneous=2; capillary=3)		
PaO ₂ (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PaCO ₂ (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
pH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. % O ₂ :	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. Ventilator Variables:						
1. High Frequency Ventilator						
Ventilator Rate (Hz)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke Volume (ml)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amplitude (cmH ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (Peak)(cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow Rate (lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Conventional Ventilator

Ventilator Rate	<input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> cpm
Inspiratory Time (sec.)	<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"/>
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<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"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>
Flow Rate (lpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

D. Sigh Data

Machine Rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Manual Rate (cph)	<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"/> <input type="text"/> <input type="text"/> . <input type="text"/>
Inspiratory Time (sec.)	<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"/>
PIP (Peak)(cm H ₂ O)	<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"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>

E. Medications:

Sodium Bicarbonate/THAM	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type & dose:	_____		_____		_____	
Vasopressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____		_____	
Volume expanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____		_____	
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Was the Baby's Condition on This New Ventilator:

⁰¹ Same, ⁰² Better, ⁰³ Worse

11. Was the Baby Maintained on This New Ventilator? ⁰¹ Yes ⁰² No

If no, why? _____

If YES to Q.11, record blood gases and ventilator data.

Time Since Cross-Over	9 Hours		12 Hours		18 Hours	
	Month	Day	Month	Day	Month	Day
A. Blood Gases Date						
Time						
Source	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
(arterial=1; transcutaneous=2; capillary=3)						
PaO ₂ (mm Hg)						
PaCO ₂ (mm Hg)						
pH						
B. % O ₂ :						
C. Ventilator Variables:						
1. <u>High Frequency Ventilator</u>						
Ventilator Rate (Hz)						
Stroke Volume (ml)						
Amplitude (cmH ₂ O)						
PIP (Peak)(cm H ₂ O)						
\bar{P}_{aw} (cm H ₂ O)						
Flow Rate (lpm)						
2. <u>Conventional Ventilator</u>						
Ventilator Rate						
Inspiratory Time (sec.)						
PEEP (cm H ₂ O)						
PIP (cm H ₂ O)						
\bar{P}_{aw} (cm H ₂ O)						
Flow Rate (lpm)						

D. Sigh Data

Machine Rate (cpm)

Manual Rate (cph)

Inspiratory Time
(sec.) . . .

PIP (Peak) (cm H₂O) . . .

\bar{P}_{aw} (cm H₂O) . . .

E. Medications:

	Yes	No	Yes	No	Yes	No
Sodium Bicarbonate/THAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____		_____	
Vasopressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____		_____	
Volume expanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____		_____	
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Time Since Cross-Over	24 Hours			48 Hours		
A. Blood Gases	Month	Day	Year	Month	Day	Year
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time (24-hour clock)	<input type="text"/>			<input type="text"/>		
Source: (arterial=1; transcutaneous=2; capillary=3)	<input type="checkbox"/>			<input type="checkbox"/>		
PaO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
PaCO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
pH	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
B. % O ₂ :	<input type="text"/>			<input type="text"/>		
C. Ventilator Variables:						
1. <u>High Frequency Ventilator</u>						
Ventilator Rate (Hz)	<input type="text"/>			<input type="text"/>		
Stroke Volume (ml)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
Amplitude (cmH ₂ O)	<input type="text"/>			<input type="text"/>		
PIP (Peak)(cm H ₂ O)	<input type="text"/>			<input type="text"/>		
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
Flow Rate (lpm)	<input type="text"/>			<input type="text"/>		
2. <u>Conventional Ventilator</u>						
Ventilator Rate	<input type="text"/>	cpm		<input type="text"/>	cpm	
Inspiratory Time (sec.)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
PEEP (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
PIP (cm H ₂ O)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
Flow Rate (lpm)	<input type="text"/>			<input type="text"/>		

D. Sigh Data

Machine Rate	<input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> cpm
Manual Rate	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cph	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cph
Inspiratory Time (sec.)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
PIP (Peak) (cm H ₂ O)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>

E. Medications:

Sodium Bicarbonate/THAM	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Type & dose:	_____		_____	
Vasopressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____	
Volume expanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type & dose:	_____		_____	
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Adjunctive Therapy In Use At The Time Cross-Over Criteria Were Met:

- Muscle Relaxants 01
- Vasodilators 02
- Vasopressors 03
- Diuretics 04
- Steroids 05
- Sedatives 06
- Anticonvulsants 07

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____

CROSS-OVER FORM

(This form must be completed if (1) the cross-over criteria are met, or (2) infant is crossed over, or (3) failed in attempts to initiate the infant on the assigned ventilator.)

1. Infant ID

2. Date of birth
Month Day Year

3. Sex Male 01 Female 02

4. Reasons for completing this form (Check all that apply):

- A. Cross-over criteria met 01
- B. Infant crossed over 02
- C. Other (Specify) 03

5. If cross-over criteria were met:

A. Date and time
Month Day Year Time

B. Was the infant crossed over? 01 02
Yes No

If NO, why not? _____

6. If the infant was crossed over:

Date and Time
Month Day Year Time

If the infant was switched without meeting the cross-over criteria, please explain reasons for crossing over.

7. Qualifying blood gases for cross-over/blood gases during attempts to initiate infant on the assigned ventilator and ventilator settings:

Ventilator type CMV 01 HFV 02

	FIRST			SECOND		
A. Blood Gases:	Month	Day	Year	Month	Day	Year
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time (24-hr clock)	<input type="text"/>			<input type="text"/>		
Source (arterial = 1; transcutaneous = 2; capillary = 3; venous = 4)						
	Source			Source		
PaO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
PaCO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
pH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1. O ₂ Saturation % (pulse oximeter)	<input type="text"/>			<input type="text"/>		
B. % O ₂ (22-100%)	<input type="text"/>			<input type="text"/>		
Nasal cannula (mL/min of 100% O ₂)	<input type="text"/>			<input type="text"/>		
C. HFV						
1. Ventilator Variables:						
Ventilator rate (Hz)	<input type="text"/>			<input type="text"/>		
Stroke volume (mL)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amplitude (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
PIP (peak) (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
\bar{P} aw (cm H ₂ O)	<input type="text"/>			<input type="text"/>		
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Machine Sigh Data:						
Machine rate	<input type="text"/> cpm			<input type="text"/> cpm		
Machine rate	<input type="text"/> cph			<input type="text"/> cph		
Inspiratory time (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>			<input type="text"/>		

FIRST

SECOND

3. IHFO:

HFO rate cpm
 HFO rate cph
 Duration (sec)

cpm
 cph

D. Conventional Ventilator:

Ventilator rate cpm
 Inspiratory time (sec) •
 PEEP (cm H₂O)
 PIP (peak) (cm H₂O)
 P_{aw} (cm H₂O) •
 Flow rate (Lmp) •

cpm
 •

 •
 •

E. Medications:

Yes

Sodium bicarbonate/THAM 01

Type and dose: _____

Vasopressors 01

Type and dose: _____

Volume expanders 01

Type and dose: _____

Muscle relaxants 01

Type and dose: _____

Yes

01

01

01

01

8. Adjunctive therapy in use at the time cross-over criteria were met:

Muscle relaxants 01
 Vasodilators 02
 Vasopressors 03
 Diuretics 04
 Steroids 05
 Sedatives 06
 Anticonvulsants 07

9. Was an ultrasound done prior to cross-over? ^{Yes} 01 ^{No} 02

If YES, date and time of ultrasound ^{Month} ^{Day} ^{Year} ^{Time}

IVH ^{Yes} 01 ^{No} 02

If YES, indicate grade ^{Grade 1} 01 ^{Grade 2} 02 ^{Grade 3} 03 ^{Grade 4} 04

POST CROSS-OVER DATA

Questions 10 through 14 need to be completed only if the infant was crossed over.

10. Make and model of the new ventilator:

11. Post cross-over blood gases and ventilator settings:

Time Since Cross-Over:

FIRST

SECOND

THIRD

A. Blood Gases Data:

	Month	Day	Month	Day	Month	Day
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Source (arterial = 1;
transcutaneous = 2;
capillary = 3; venous = 4)

Source

Source

Source

PaO ₂ (mm Hg)	<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"/>
PaCO ₂ (mm Hg)	<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"/>
pH	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
1. O ₂ Saturation % (pulse oximeter)	<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"/>

B. % O₂ (22-100%)

Nasal cannula (mL/min of 100% O ₂)	<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"/>
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C. HFV

1. Ventilator Variables:

Ventilator rate (Hz)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke volume (mL)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>

2. Machine Sigh Data:

Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

	FIRST	SECOND	THIRD
3. IHFO:			
HFO rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
HFO rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Duration (sec)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
D. Conventional Ventilator:			
Ventilator rate (cpm)	<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"/>
Inspiratory time (sec) ..	<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"/>
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<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"/>

E. Medications:

	Yes	Yes	Yes
Sodium bicarbonate/THAM	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Vasopressors	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Volume expanders	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Muscle relaxants	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			

12. Was the baby's condition on this new ventilator

	Same	Better	Worse
	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03

13. Was the baby maintained on this new ventilator?

	Yes	No
	<input type="checkbox"/> 01	<input type="checkbox"/> 02

If NO, why? _____

If YES to Q.13, record blood gases and ventilator data.

Time Since Cross-Over:

	9 Hours		12 Hours		18 Hours	
	Month	Day	Month	Day	Month	Day
A. Blood Gases Data:						
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Source (arterial = 1; transcutaneous = 2; capillary = 3; venous = 4)						
		Source		Source		Source
PaO ₂ (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PaCO ₂ (mm Hg)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
pH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1. O ₂ Saturation % (pulse oximeter)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. % O₂ (22-100%)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nasal cannula (mL/min of 100% O ₂)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C. HFV						
1. Ventilator Variables:						
Ventilator rate (Hz)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stroke volume (mL)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Flow rate (Lpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Machine Sigh Data:						
Machine rate (cpm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Machine rate (cph)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Inspiratory time (sec)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

	9 Hours	12 Hours	18 Hours
3. IHFO:			
HFO rate (cpm)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
HFO rate (cph)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Duration (sec)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
D. Conventional Ventilator:			
Ventilator rate (cpm)	<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"/>
Inspiratory time (sec)	<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"/>
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<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"/>
Flow rate (Lpm)	<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"/>

E. Medications:	Yes	Yes	Yes
Sodium bicarbonate/THAM	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Vasopressors	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Volume expanders	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			
Muscle relaxants	<input type="checkbox"/> 01	<input type="checkbox"/> 01	<input type="checkbox"/> 01
Type and dose: _____			

24 Hours

48 Hours

A. Blood Gases:

Date

--	--

 /

--	--

 /

--	--

Date

--	--

 /

--	--

 /

--	--

Time (24-hr clock)

--	--	--	--

Time (24-hr clock)

--	--	--	--

Source (arterial = 1;
transcutaneous = 2; capillary = 3;
venous = 4)

Source

Source

PaO₂ (mm Hg)

--	--	--

--

PaO₂ (mm Hg)

--	--	--

--

PaCO₂ (mm Hg)

--	--	--

--

PaCO₂ (mm Hg)

--	--	--

--

pH

--

 .

--	--

--

pH

--

 .

--	--

--

1. O₂ Saturation % (pulse oximeter)

--	--	--

1. O₂ Saturation % (pulse oximeter)

--	--	--

B. % O₂ (22-100%)

--	--	--

% O₂ (22-100%)

--	--	--

Nasal cannula (mL/min of 100% O₂) ...

--	--	--	--

Nasal cannula (mL/min of 100% O₂) ...

--	--	--	--

C. HFV

1. Ventilator Variables:

Ventilator rate (Hz)

--	--

Ventilator rate (Hz)

--	--

Stroke volume (mL)

--	--

 .

--

Stroke volume (mL)

--	--

 .

--

Amplitude (cm H₂O)

--	--

Amplitude (cm H₂O)

--	--

PIP (peak) (cm H₂O)

--	--

PIP (peak) (cm H₂O)

--	--

P̄aw (cm H₂O)

--	--

P̄aw (cm H₂O)

--	--

Flow rate (Lpm)

--	--

 .

--

Flow rate (Lpm)

--	--

 .

--

2. Machine Sigh Data:

Machine rate

--	--

 cpm

Machine rate

--	--

 cpm

Machine rate

--	--

 cph

Machine rate

--	--

 cph

Inspiratory time (sec)

--	--

 .

--

Inspiratory time (sec)

--	--

 .

--

PIP (peak) (cm H₂O)

--	--

PIP (peak) (cm H₂O)

--	--

	24 Hours	48 Hours
3. IHFO:		
HFO rate	<input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> cpm
HFO rate	<input type="text"/> <input type="text"/> cph	<input type="text"/> <input type="text"/> cph
Duration (sec)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
D. Conventional Ventilator:		
Ventilator rate	<input type="text"/> <input type="text"/> <input type="text"/> cpm	<input type="text"/> <input type="text"/> <input type="text"/> cpm
Inspiratory time (sec)	<input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> . <input type="text"/> <input type="text"/>
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
PIP (peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
Flow rate (Lmp)	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>
E. Medications:	Yes	Yes
Sodium bicarbonate/THAM	<input type="text"/> 01	<input type="text"/> 01
Type and dose:	_____	_____
Vasopressors	<input type="text"/> 01	<input type="text"/> 01
Type and dose:	_____	_____
Volume expanders	<input type="text"/> 01	<input type="text"/> 01
Type and dose:	_____	_____
Muscle relaxants	<input type="text"/> 01	<input type="text"/> 01
Type and dose:	_____	_____

14. Was an ultrasound done after cross-over?

01 **Yes** 02 **No**

If YES, date and time of ultrasound

Month Day Year Time

IVH

01 **Yes** 02 **No**

If YES, indicate grade

Grade 1 **Grade 2** **Grade 3** **Grade 4**

01 02 03 04

Signature of clinical coordinator: _____ Date: _____

CROSS-OVER FORM

(This form must be completed if (1) the crossover criteria are met, or (2) infant is crossed over, or (3) failed in attempts to initiate the infant on the assigned ventilator.)

1. Infant ID

2. Date of Birth

3. Sex Male ⁰¹ Female ⁰²

4. Reasons for completing this form (CHECK ALL THAT APPLY):

A. Cross-over criteria met ⁰¹

B. Infant crossed over ⁰²

C. Other (SPECIFY) ⁰³

5. If cross-over criteria were met:

A. Date and Time:

Month Day Year Time

B. Was the infant crossed over? ⁰¹ Yes ⁰² No

If NO, why not? _____

6. If the infant was crossed over:

Date and Time:

Month Day Year Time

If the infant was switched without meeting the cross-over criteria, please explain reasons for crossing over.

7. Qualifying blood gases for cross-over/blood gases during attempts to initiate infant on the assigned ventilator and ventilator settings:

Ventilator Type: CMV ⁰¹ HFV ⁰²

A. <u>Blood Gases:</u>	First			Second		
	Month	Day	Year	Month	Day	Year
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time (24-Hr. Clock)	<input type="text"/>			<input type="text"/>		
Source: (arterial=1; transcutaneous=2; capillary=3)	<input type="text"/>			<input type="text"/>		
PaO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
PaCO ₂ (mm Hg)	<input type="text"/>			<input type="text"/>		
pH	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
B. % O ₂ :	<input type="text"/>			<input type="text"/>		

C. HFV

1. Ventilator Variables:

Ventilator Rate (Hz)	<input type="text"/>	<input type="text"/>	
Stroke Volume (ml)	<input type="text"/>	.	<input type="text"/>
Amplitude (cm H ₂ O)	<input type="text"/>	<input type="text"/>	
PIP (Peak) (cm H ₂ O)	<input type="text"/>	<input type="text"/>	
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/>	<input type="text"/>	
Flow Rate (lpm)	<input type="text"/>	<input type="text"/>	

2. Machine Sigh Data:

Machine Rate	<input type="text"/>	cpm	<input type="text"/>	cpm
Machine Rate	<input type="text"/>	cph	<input type="text"/>	cph

Inspiratory Time (sec.)

.

.

PIP (Peak) (cm H₂O)

.

.

3. IHFO:

HFO Rate

cpm

cpm

HFO Rate

cph

cph

Duration (sec.)

D. Conventional Ventilator:

Ventilator Rate

cpm

cpm

Inspiratory Time (sec.)

PEEP (cm H₂O)

PIP (Peak) (cm H₂O)

.

.

\bar{P}_{aw} (cm H₂O)

.

.

Flow Rate (lpm)

E. Medications:

Sodium Bicarbonate/THAM

Yes 01

No 02

Type & Dose: _____

Vasopressors

01

02

Type & Dose: _____

Volume Expanders

01

02

Type & Dose: _____

Muscle Relaxants

01

02

8. Adjunctive Therapy In Use At The Time Cross-Over Criteria Were Met:

- Muscle Relaxants 01
- Vasodilators 02
- Vasopressors 03
- Diuretics 04
- Steroids 05
- Sedatives 06
- Anticonvulsants 07

9. Was an ultrasound done prior to cross-over? Yes 01 No 02

If YES, date and time of ultrasound:

Month	Day	Year	Time
<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"/> <input type="text"/>

IVH 01 02

If YES, indicate grade:

Grade 1	Grade 2	Grade 3	Grade 4
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04

***** POST CROSS-OVER DATA *****
 Questions 10 through 14 need to be completed only if the infant was crossed over.

10. Make and Model of the New Ventilator:

11. Post Cross-Over Blood Gases and Ventilator Settings:

Time Since Cross-Over:

	First		Second		Third	
	Month	Day	Month	Day	Month	Day
A. <u>Blood Gases Date:</u>	<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"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Time	<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"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Source
(arterial=1;
transcutaneous = 2;
capillary=3)

PaO₂ (mm Hg)

PaCO₂ (mm Hg)

pH

B. % O₂:

C. HFV:

1. Ventilator Variables:

Ventilator Rate (Hz)

Stroke Volume (ml)

Amplitude (cm H₂O)

PIP (Peak) (cm H₂O)

\bar{P}_{aw} (cm H₂O)

Flow Rate (lpm)

2. Machine Sigh Data:

Machine Rate (cpm)

Machine Rate (cph)

Inspiratory Time
(sec.)

PIP (Peak)
(cm H₂O)

3. IHFV:

HFO Rate (cpm)

HFO Rate (cph)

Duration (sec.)

D. Conventional Ventilator:

Ventilator Rate

cpm

cpm

cpm

Inspiratory Time (sec)

PEEP (cm H₂O)

PIP (cm H₂O)

.

.

Paw (cm H₂O)

.

.

Flow Rate (lpm)

E. Medications:

Sodium Bicarbonate/
THAM

Yes

No

01

02

Yes

No

01

02

Yes

No

01

02

Type & Dose

Vasopressors

01

02

01

02

01

02

Type & Dose

Volume expanders

01

02

01

02

01

02

Type & Dose

Muscle relaxants

01

02

01

02

01

02

12. Was the Baby's Condition on This New Ventilator:

Same

01

Better

02

Worse

03

13. Was the Baby Maintained on This New Ventilator?

Yes

01

No

02

If NO, why?

If YES to Q13, record blood gases and ventilator data.

Time Since Cross-Over:

9 Hours

12 Hours

18 Hours

A. Blood Gases Date:

Month	Day	Month	Day	Month	Day
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Time

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Source

(arterial=1;
transcutaneous = 2;
capillary=3)

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

PaO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

PaCO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

pH

<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	---	----------------------	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

B. % O₂:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

C. HFV:

1. Ventilator Variables:

Ventilator Rate (Hz)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Stroke Volume (ml)

<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"/>
----------------------	----------------------	---	----------------------	----------------------	----------------------	---	----------------------	----------------------	----------------------	---	----------------------

Amplitude (cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

PIP (Peak) (cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

\bar{P}_{aw} (cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Flow Rate (lpm)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

2. Machine Sigh Data:

Machine Rate (cpm)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Machine Rate (cph)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Inspiratory Time (sec.) . . .

PIP (Peak) (cm H₂O) . . .

3. IHFO:

HFO Rate (cpm)

HFO Rate (cph)

Duration (sec.)

D. Conventional Ventilator:

Ventilator Rate cpm cpm cpm

Inspiratory Time (sec)

PEEP (cm H₂O)

PIP (cm H₂O) . . .

\bar{P}_{aw} (cm H₂O) . . .

Flow Rate (lpm)

E. Medications:

Sodium Bicarbonate/
THAM Yes No Yes No Yes No
 01 02 01 02 01 02

Type & Dose _____

Vasopressors 01 02 01 02 01 02

Type & Dose _____

Volume expanders 01 02 01 02 01 02

Type & Dose _____

Muscle relaxants 01 02 01 02 01 02

Time Since Cross-Over

A. Blood Gases:

Date

24 Hours			48 Hours		
Month	Day	Year	Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Time

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Source:
(arterial=1;
transcutaneous=2;
capillary=3)

<input type="text"/>	<input type="text"/>
----------------------	----------------------

PaO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

PaCO₂ (mm Hg)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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pH

<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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B. % O₂:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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C. HFV:

1. Ventilator Variables:

Ventilator
Rate (Hz)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Stroke Volume (ml)

<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Amplitude (cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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PIP (Peak)
(cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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\bar{P}_{aw} (cm H₂O)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Flow Rate (lpm)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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2. Machine Sigh Data:

Machine Rate

<input type="text"/>	<input type="text"/>	cpm	<input type="text"/>	<input type="text"/>	cpm
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Machine Rate

<input type="text"/>	<input type="text"/>	cph	<input type="text"/>	<input type="text"/>	cph
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Inspiratory
Time (sec.)

<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
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PIP (Peak)
(cm H₂O)

<input type="text"/>	<input type="text"/>	.	<input type="text"/>	<input type="text"/>	.	<input type="text"/>
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3. IHFO:

HFO Rate	<input type="text"/> <input type="text"/>	cpm	<input type="text"/> <input type="text"/>	cpm
HFO Rate	<input type="text"/> <input type="text"/>	cph	<input type="text"/> <input type="text"/>	cph
Duration (sec.)	<input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/>	

D. Conventional Ventilator:

Ventilator Rate	<input type="text"/> <input type="text"/> <input type="text"/>	cpm	<input type="text"/> <input type="text"/> <input type="text"/>	cpm
Inspiratory Time (sec.)	<input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/>	
PEEP (cm H ₂ O)	<input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/>	
PIP (Peak) (cm H ₂ O)	<input type="text"/> <input type="text"/>	•	<input type="text"/>	<input type="text"/> <input type="text"/>
\bar{P}_{aw} (cm H ₂ O)	<input type="text"/> <input type="text"/>	•	<input type="text"/>	<input type="text"/> <input type="text"/>
Flow Rate (lpm)	<input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/>	

E. Medications:

	Yes	No	Yes	No
Sodium Bicarbonate/THAM	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02

Dose & Type _____

Vasopressors	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
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Dose & Type _____

Volume expanders	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
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Dose & Type _____

Muscle Relaxants	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 01	<input type="checkbox"/> 02
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14. Was an ultrasound done after cross-over? Yes 01 No 02

If YES, date and time of ultrasound:

Month	Day	Year	Time
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

IVH Yes 01 No 02

If YES, indicate grade:

Grade 1	Grade 2	Grade 3	Grade 4
<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04

SIGNATURE OF CLINICAL COORDINATOR: _____

DATE: _____