ELFIN study number: ☐☐☐☐☐

Form 5: Hospital Transfer/Discharge

enteral lactoferrin in neonates

Only for NPEU office use

	Date	Initials
Logged	D D / M M / Y Y	
1st entry	D D / M M / Y Y	
2nd entry	D D / M M / Y Y	

Use this form:

If this infant is discharged home, is transferred to another unit, or has died

Infant's surname: _____

Infant's first name: *(enter unknown if applicable)* _____

Infant's date of birth: D D / M M / Y Y

Section A: Details of stay *(Please see of level of care definitions on page 4)*

A.1 Name of hospital: _____

A.2 Name of unit: _____

A.3 Date of this admission: D D / M M / Y Y

A.4 Date of discharge for this admission: D D / M M / Y Y

A.5 While in this unit during this admission, how many days did this infant receive:

Level 1 (intensive) care ☐☐

Level 2 (high dependency) care ☐☐

Level 3 (special) care ☐☐

Parenteral nutrition ☐☐

(please do not count previous days from transferring hospitals)

A.6 While in this unit, did this infant receive probiotics? Yes ☐ No ☐

Section B: Clinical outcomes *(please see definitions on page 3)*

Were any of the following diagnosed during this infant's stay in <u>this</u> unit?

B.1 Retinopathy of prematurity treated medically or surgically: Yes ☐ No ☐

If Yes: Laser ☐ Cryotherapy ☐ Injection ☐

B.2 Bronchopulmonary dysplasia; mechanical ventilator support via endotracheal tube or nasal CPAP at 36 weeks PMA; or supplemental oxygen at 36 weeks PMA: Yes ☐ No ☐

B.3 Pulmonary haemorrhage: Yes ☐ No ☐

B.4 Intracranial abnormality: Yes ☐ No ☐

If Yes, please specify grade (*please tick all that apply*)

Grade 1 IVH / Germinal Matrix Haemorrhage ☐ Grade 2 IVH ☐

Grade 3 IVH (distension) ☐ Grade 4 IVH (parenchymal involvement) ☐

B.5 Periventricular leukomalacia: Yes ☐ No ☐

B.6 Shunt for hydrocephalus: Yes ☐ No ☐

B.7 Patent ductus arteriosus treated with NSAID or surgery: Yes ☐ No ☐

B.8 Microbiologically-confirmed or clinically-suspected late-onset invasive infection Yes ☐ No ☐

If Yes, *please complete a Form 3 - Late-Onset Invasive Infection*

B.9 Necrotising enterocolitis (Bell stage 2 or 3) Yes ☐ No ☐

If Yes, *please complete a Form 4 - Gut Signs*

Please complete one section only: C, D or E

Section C: Discharged home

Discharged home:

C.1 Date of discharge: D D / M M / Y Y

C.2 Weight at discharge: ☐☐☐☐ g

C.3 Head circumference at discharge: ☐☐.☐ cm

C.4 Modes of feeding at discharge: *(please tick all that apply)*

- Breast ☐
- Bottle ☐
- Nasogastric or gastrostomy tube ☐

C.5 Type of feeding at discharge: *(please tick all that apply)*

- Mother's breast milk ☐
- Donated breast milk ☐
- Breast milk fortifier ☐
- Term formula milk ☐
- Preterm formula milk ☐

Section D: Transferred to another hospital

Transferred to another hospital:

D.1 Name and town of new hospital: _____

D.2 Name of receiving consultant *(if known)*: _____

D.3 Date of transfer: D D / M M / Y Y

Section E: Death

Death:

E.1 Date of death: D D / M M / Y Y

Section F: Form details

Details of person completing form

Name: _____

Role: _____

Date: D D / M M / Y Y **Signature:** _____

Section G: Contact details *(please complete only when infant discharged home)*

Contact details: Mother

Surname: _____ **First name:** _____

NHS number: ☐☐☐☐☐☐☐☐☐☐

Postal address: _____

_____

_____

Mobile number: ☐☐☐☐☐☐☐☐☐☐☐

Landline number: ☐☐☐☐☐☐☐☐☐☐☐

Email address: _____

GP name: _____

GP landline number: ☐☐☐☐☐☐☐☐☐☐☐

GP postal address: _____

Other family member

Tick if address is same as Mother ☐

Address: _____

_____

_____

_____

Postcode: ☐☐☐☐☐☐☐

Telephone: ☐☐☐☐☐☐☐☐☐☐☐

Mobile ☐☐☐☐☐☐☐☐☐☐☐

Relationship to baby:

Father ☐ Grandparent ☐

Other relative ☐ Family friend ☐

Neighbour ☐

Other ☐ _____

Please specify

Other

Tick if address is same as Mother ☐

Address: _____

_____

_____

_____

Postcode: ☐☐☐☐☐☐☐

Telephone: ☐☐☐☐☐☐☐☐☐☐☐

Mobile ☐☐☐☐☐☐☐☐☐☐☐

Relationship to baby:

Father ☐ Grandparent ☐

Other relative ☐ Family friend ☐

Neighbour ☐

Other ☐ _____

Please specify

Definitions:

Retinopathy of Prematurity:

Retinopathy of Prematurity treated by laser, cryotherapy or injection

Pulmonary haemorrhage: copious bloody secretions with clinical deterioration requiring change(s) in ventilator management

Intracranial abnormality: haemorrhage, parenchymal infarction, or focal white matter damage on cranial ultrasound scan or other imaging

Level 1 (intensive) care:

1. receiving any respiratory support via a tracheal tube and in the first 24 hours after its withdrawal
2. receiving NCPAP for any part of the day and less than five days old
3. below 1000g current weight and receiving NCPAP for any part of the day and for 24 hours after withdrawal
4. less than 29 weeks gestational age and less than 48 hours old
5. requiring major emergency surgery, for the pre-operative period and post-operatively for 24 hours
6. requiring complex clinical procedures:
   - full exchange transfusion
   - peritoneal dialysis
   - infusion of an inotrope, pulmonary vasodilator or prostaglandin and for 24 hours afterwards
7. any other very unstable baby considered by the nurse-in-charge to need 1:1 nursing
8. a baby on the day of death

Level 2 (high dependency) care:

1. receiving NCPAP for any part of the day and not fulfilling any of the criteria for intensive care
2. below 1000g current weight and not fulfilling any of the criteria for intensive care
3. receiving parenteral nutrition
4. having convulsions
5. receiving oxygen therapy and below 1500g current weight
6. requiring treatment for neonatal abstinence syndrome
7. requiring specified procedures that do not fulfil any criteria for intensive care:
   - care of an intra-arterial catheter or chest drain
   - partial exchange transfusion
   - tracheostomy care until supervised by a parent
8. requiring frequent stimulation for severe apnoea

Level 3 (special) care:

Special care is provided for all other babies who could not reasonably be expected to be looked after at home by their mother.

When this form has been completed

Please return to the ELFIN Coordinating Centre using the FREEPOST envelope provided

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