Study number: | | | | | | |

neoGASTRIC

Hospital Transfer/Discharge form

To be used at continuing care sites in the UK only

Use this form if a baby:

- Is discharged home
- Has transferred to another hospital
- Has died
- Is still an inpatient at your hospital and has reached 44^{+0} gestational weeks^{+days}

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

Please answer all questions unless stated otherwise.

Section 1: Details of stay

1.1 **Name of this hospital:** _____

1.2 **Date of admission to this hospital:** D D / M M / Y Y

1.3 **From this hospital, the baby** *(choose one only)*:

- Was discharged home. . . . . ☐
- Was transferred to another hospital . . . . . ☐
- Died. . . . . ☐
- Reached 44^{+0} gestational weeks^{+days} . . . . . ☐

If this baby was discharged home:

1.3.1 **Date of discharge from this hospital:** D D / M M / Y Y

If this baby was transferred:

1.3.1 **Name of hospital baby is being transferred to:** _____

1.3.2 **Date of transfer:** D D / M M / Y Y

If this baby died:

1.3.1 **Date of death:** D D / M M / Y Y

If the FIT-05 or FIT-PIV trials are recruiting at this hospital:

1.4 **Has the baby been randomised to either of these trials during this admission?**

Yes, to FIT-05 ☐ Yes, to FIT-PIV ☐

No ☐ N/A (these trials are not recruiting at this hospital) ☐

Section 2: Clinical outcomes

2.1 **Were any of the following diagnosed during the baby's stay in <u>this hospital</u> (prior to discharge or the baby reaching 44^{+0} gestational weeks^{+days})?**

Intraventricular haemorrhage (Grade 3 or Grade 4, Papile): Yes ☐ No ☐

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

- Grade 3 Intraventricular haemorrhage . . . . . ☐
- Grade 4 Intraventricular haemorrhage . . . . . ☐

Cystic periventricular leukomalacia: Yes ☐ No ☐

Microbiologically-confirmed or clinically-suspected late-onset infection: Yes ☐ No ☐

If the answer is Yes, <u>Please complete a Late-onset Infection and Gut Signs form, if one was not already completed for this instance of infection.</u>

Necrotising enterocolitis (NEC): Yes ☐ No ☐

If the answer is Yes, <u>Please complete a Late-onset Infection and Gut Signs form, if one was not already completed for this instance of NEC.</u>

Chronic Lung Disease: receiving oxygen or respiratory support at 36^{+0} weeks^{+days} corrected gestation:

Yes ☐

No ☐

N/A *(baby did not reach 36^{+0} weeks^{+days} corrected gestation during this admission and/or was not born at less than 32 weeks gestation)* ☐

Retinopathy of prematurity treated with intraocular medication, cryotherapy or laser surgery:

Yes ☐

No ☐

N/A *(baby was not born at less than 31 weeks gestation or did not weigh less than 1501g at birth)* ☐

If this baby has transferred to another hospital or has died, there are no further questions to answer. Please sign and date the form on the last page.

Section 3: Further details

Section 3 only needs to be completed if the baby has been discharged home or is still an inpatient and has reached 44^{+0} gestational weeks^{+days}.

If this baby was discharged home

3.1 **Method of feeding at discharge** *(choose all that apply)*:

Breast ☐

Bottle ☐

Gastric, jejunal or gastrostomy tube ☐

Other (please specify): _____

3.2 **Type of feeding at discharge** *(choose all that apply)*:

Mother's breast milk ☐

Donated breast milk ☐

Breast milk fortifier (any) ☐

Term formula ☐

Preterm formula ☐

Other formula (please specify): _____

3.3 **Weight at discharge home:** ☐☐☐☐ *g*

3.4 **Head circumference at discharge home:** ☐☐.☐ **cm**

(please provide the measurement taken closest to discharge home, up to a week prior to discharge home)

3.5 **<u>If this baby is not yet 36 weeks gestational age:</u>**

Is this baby being discharged home on respiratory support?

Yes ☐ No ☐ N/A (Baby is 36 weeks gestational age or over) ☐

If this baby is still an inpatient at your hospital and has reached 44+0 gestational weeks+days:

3.1 Method of feeding at 44+0 gestational weeks+days *(choose all that apply)*:

- Breast ☐
- Bottle ☐
- Gastric, jejunal or gastrostomy tube ☐
- Other (please specify): _____

3.2 Type of feeding at 44+0 gestational weeks+days *(choose all that apply)*:

- Mother's breast milk ☐
- Donated breast milk ☐
- Breast milk fortifier (any) ☐
- Term formula ☐
- Preterm formula ☐
- Other formula (please specify): _____

3.3 Weight at 44+0 gestational weeks+days: ☐☐☐☐ *g*

3.4 Head circumference at 44+0 gestational weeks+days:
(please provide the measurement taken closest to when the baby reached 44+0 gestational weeks+days, up to a week prior to this point) ☐☐.☐ *cm*

Details of person completing form:

Name: _____

Role: _____

Signature: _____

Date: D D / M M / Y Y

Principal Investigator signature: _____

Date: D D / M M / Y Y

When this form has been completed:

Please scan and return to the baby's recruiting site via secure email.

neoGASTRIC Study Team

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NHMRC-NIHR Collaborative Research Grant Scheme. The views expressed are those of the author(s) and not necessarily those of the NIHR, NHMRC or the Department of Health and Social Care.

FUNDED BY NIHR | National Institute for Health and Care Research