

neoGASTRIC

Daily Feed Log (Days 1 - 14)

Baby's date of birth: / / Baby's date of randomisation: / /

Name of hospital (where this form is completed): _____

How to use this form:

The Daily Feed Log must be completed each **consecutive** day in the study from randomisation **until**:

- The baby has reached full feeds for three consecutive days
- Or the baby no longer requires a gastric feeding tube
- Or the baby is 44⁺⁰ gestational weeks^{+days}

Complete this feed log for 14 complete days from randomisation. After 14 days, if none of the above criteria are met, please complete a **Daily Feed Log (Day 15 onwards)** until one of them is reached.

Complete the feeding log for each calendar day (24 hours from 00:00).

Complete the question on the last page when the baby has reached full feeds.

Definitions

Serious clinical concerns: abdominal tenderness, abdominal discolouration, bloody stool, clinical deterioration, bilious/bloody vomiting

Full feeds: defined as tolerating 150 ml/kg/day (at least 145 ml/kg/day) or including breastfeeding where total milk is considered equivalent to full enteral feeds

Allocation

- No routine measurement of gastric residual volumes
 Routine measurement of gastric residual volumes

Study number:

	Day 0 (randomisation)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
1. Date (dd/mm)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<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. Weight (g) used to calculate the volume of fluids/feeds given							
3. Has the baby reached full feeds today? (see definition)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
4. Does the baby have a gastric tube in situ today? <i>This includes days where a baby has a gastric tube in place for any part of the day</i>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Enteral Feeds							
5. Total milk feed volume received per day (ml)							
6. Was the baby breastfed (sucking at the breast) today?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Withheld feeds							
7. Were the baby's feeds withheld for any length of time on this day?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
8. If withheld: How long were feeds withheld today (in hours)? e.g. if a baby is on 2-hourly feeds and a feed is delayed by 1 hour, this equates to feeds withheld for 1 hour.							
9. If withheld: Were the baby's feeds withheld due to vomiting on this day?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
10. If withheld: Was this around transfusion as part of the WHEAT trial?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please complete a Late-Onset Infection and Gut Signs Form if 5 consecutive boxes are ticked in the following row more than 3 days after birth, or if this baby died from suspected late-onset infection.							
11. Were antibiotics / antifungals given on this day for treatment of suspected or proven infection?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please review guidance and consider completing a Late-Onset Infection and Gut Signs form if 5 consecutive boxes are ticked in the following row.							
12. Was the baby nil by mouth at any point today with the intention that this was for 4 or more hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Gastric residual volume measurements							
13. How many times were gastric residual volumes measured today?							
14. Were any of these measured for serious clinical concerns (see definition)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
15. If any were measured for serious clinical concerns, please state how many:							
16. If the baby is on the routine measurement arm and has had <4 GRV measurements today: Is the baby establishing oral feeds today (e.g. breastfeeding or bottle feeding as well)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
17. Initial here if you have completed any of the log for this day							

Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
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Answer No if antibiotics / antifungals given for prophylaxis							
Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
(This form <u>must</u> be completed if the baby died from suspected NEC or focal intorction.)							
Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
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Complete the feeding log for each calendar day (24 hours from 00:00).

When you have completed this feed log, please enter it on to OpenClinica.

If the baby has not yet reached full feeds, please continue recording data on the **Daily Feed Log (Day 15 onwards)**.

If the baby has reached full feeds, please complete the question on the next page.

When the baby has reached full feeds:

Which of the following did the baby receive before getting to full feeds? (Please choose all that apply)

- Mother's breast milk
- Donated breast milk
- Breast milk fortifier (any)
- Term formula
- Preterm formula
- Other formula

If Other, please specify: _____

Name: _____

Signature: _____

Date of completion: / /

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