TOAST

Daily Dosing Log

TOAST study number: ☐☐☐☐

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

Infant's name and surname: _____

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

Daily Dosing

Please use this log to document a TOAST participant's medication packs and administration.

The decision of whether to give the TOAST medication intravenously or enterally will be at the discretion of the clinical team guided by the infant's tolerance of enteral feed.

- IV TOAST medication should be given if infants are not able to feed enterally
- Enteral TOAST medication if they are able to feed enterally

If giving enteral medication, please check that it has been reconstituted within the last 28 days and that it has been stored in the fridge at 2–8ºC.

Details of usage and/or disposal of all bottles and vials for the IV and the enteral packs must be recorded at the end of the dosing log.

Use supplemental daily dosing log pages if required to record further days of medication administration for the packs allocated on this dosing log.

If the infant is allocated another pack, please record administration, usage and disposal for that pack on a new paper dosing log.

Please continue filling out the dosing log until the infant leaves the hospital or unless they **permanently** discontinue the TOAST medication. (Permanent discontinuation should be recorded on the Discontinuation of Medication eCRF.)

Completed paper dosing logs (including any supplementary sheets) should be added to the Investigator Site File and the data entered onto OpenClinica.

Pack IDs	IV: ☐☐☐☐☐	Enteral: ☐☐☐☐☐					
Date (DD/MM/YY)	**TOAST medication given?**	**Reason for not giving medication (see key*) if not given:**	**ID of pack used:** (If not one of those at top of form, complete incident form, then continue completing this log)	**Medication administered**			**Name & Signature**
				Route: Intravenous or enteral medication given? (IV and Enteral have different pack IDs)	**Infant's working weight (in kg):**	**Volume (mls):**	
Reason for not giving medication: 1 = Clinician decision, 2 = Pack availability, 3 = Other. If Other, give details							
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			

Pack IDs	IV: ☐☐☐☐☐	Enteral: ☐☐☐☐☐					

Date (DD/MM/YY)	TOAST medication given?	Reason for not giving medication (see key*) if not given:	ID of pack used: (If not one of those at top of form, complete incident form, then continue completing this log)	Medication administered Route: Intravenous or enteral medication given? (IV and Enteral have different pack IDs)	Infant's working weight (in kg):	Volume (mls):	Name & Signature
*Reason for not giving medication: 1 = Clinician decision, 2 = Pack availability, 3 = Other. If Other, give details							
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			

Pack IDs	IV: ☐☐☐☐☐	Enteral: ☐☐☐☐☐					

Date (DD/MM/YY)	TOAST medication given?	Reason for not giving medication (see key*) if not given:	ID of pack used: (If not one of those at top of form, complete incident form, then continue completing this log)	Medication administered		Infant's working weight (in kg):	Volume (mls):	Name & Signature
				Route: Intravenous or enteral medication given? (IV and Enteral have different pack IDs)				

*Reason for not giving medication: 1 = Clinician decision, 2 = Pack availability, 3 = Other. If Other, give details

Date	TOAST given?	Reason	Pack ID	Route	Weight	Volume	Name & Signature
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			
D D / M M / Y Y	Yes ☐ No ☐		Pack ID ☐☐☐☐☐	IV ☐ Enteral ☐			

IV medication pack ID: ☐☐☐☐☐

Each vial to be administered intravenously as soon as possible after reconstitution and within 2 hours and the remainder to be disposed of. Complete this table for any vials not administered.
All vials must remain in the cardboard blinding shroud during disposal.

Vial number		Date disposed of:	Disposed of by:
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____
	☐ Full vial disposed of (not needed) ☐ Damaged	D D / M M / Y Y	Name: _____ Signature: _____

Enteral Medication Pack ID: ☐☐☐☐

Number of bottles in pack (6 or fewer): ☐

Reconstituted bottles must be disposed of after 28 days or when the infant is transferred/discharged

Please complete below for each bottle from this pack

Bottle number	If NOT reconstituted	If reconstituted:	For non-empty bottles:
	☐ Transferred with infant to other hospital ☐ Sent home with discharged infant ☐ Not needed* ☐ Batch expired *If "Not needed" / "Batch expired":* Date disposed of: DD / MM / YY Disposed of by: Signature: _____	Stored in fridge at 2 – 8°C ☐ REC**: DD / MM / YY DIS***: DD / MM / YY ☐ Empty (used up) ☐ No longer needed* ☐ Passed discard date ☐ Damaged ☐ Batch expired	Date disposed of: DD / MM / YY Disposed of by: Signature: _____
	☐ Transferred with infant to other hospital ☐ Sent home with discharged infant ☐ Not needed* ☐ Batch expired *If "Not needed" / "Batch expired":* Date disposed of: DD / MM / YY Disposed of by: Signature: _____	Stored in fridge at 2 – 8°C ☐ REC**: DD / MM / YY DIS***: DD / MM / YY ☐ Empty (used up) ☐ No longer needed* ☐ Passed discard date ☐ Damaged ☐ Batch expired	Date disposed of: DD / MM / YY Disposed of by: Signature: _____
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*E.g medication permanently discontinued, or (for reconstituted bottles) infant left this hospital

** REC: date of reconstitution = Day 1   ***DIS: date to discard = Day 28

Enteral Medication Pack ID: [_ _ _ _]

Number of bottles in pack (6 or fewer): [ ]

Reconstituted bottles must be disposed of after 28 days or when the infant is transferred/discharged
Please complete below for each bottle from this pack

Bottle number	If NOT reconstituted	If reconstituted
	☐ Transferred with infant to other hospital ☐ Sent home with discharged infant ☐ Not needed* ☐ Batch expired *If "Not needed" / "Batch expired":* Date disposed of: DD / MM / YY Disposed of by: _____ Signature: _____	REC**: DD / MM / YY DIS***: DD / MM / YY Stored in fridge at 2 – 8°C ☐ ☐ Empty (used up) ☐ No longer needed* ☐ Passed discard date ☐ Damaged ☐ Batch expired *For non-empty bottles:* Date disposed of: DD / MM / YY Disposed of by: _____ Signature: _____
	☐ Transferred with infant to other hospital ☐ Sent home with discharged infant ☐ Not needed* ☐ Batch expired *If "Not needed" / "Batch expired":* Date disposed of: DD / MM / YY Disposed of by: _____ Signature: _____	REC**: DD / MM / YY DIS***: DD / MM / YY Stored in fridge at 2 – 8°C ☐ ☐ Empty (used up) ☐ No longer needed* ☐ Passed discard date ☐ Damaged ☐ Batch expired *For non-empty bottles:* Date disposed of: DD / MM / YY Disposed of by: _____ Signature: _____

*E.g medication permanently discontinued, or (for reconstituted bottles) infant left this hospital

** REC: date of reconstitution = Day 1   ***DIS: date to discard = Day 28

National Perinatal Epidemiology Unit
Nuffield Department of Population Health
University of Oxford, Old Road Campus, Headington, Oxford, OX3 7LF
+44 (0)1865 289278   toast@npeu.ox.ac.uk   www.npeu.ox.ac.uk/toast

tofs · Evelina London · UNIVERSITY OF LIVERPOOL · UNIVERSITY OF Southampton
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