

## Form 2: Daily Feed Log

### Use this form:

Each day in the study from randomisation until this infant is on full milk feeds (tolerating 150 ml/kg/day for 3 consecutive days), and until no longer on parenteral nutrition

***Before starting the daily log, please ensure Section A is complete***

*Use your normal 24 hour feeding period*



Speed of increasing milk feeds

Infant's surname: \_\_\_\_\_

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

Infant's date of birth:

/   /



## Section A: Milk feed increase

**Allocation:** Fast milk feed increase (30 ml/kg/day)  Slow milk feed increase (18 ml/kg/day)

**Date and time of fast/slow milk feed increase commencement:**   /   /     :      
 (i.e. when the feeds are first increased after randomisation) 24hr

## Section B: Feeds

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"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Current working weight (g)									

### Enteral Feeds

Total milk feed volume received per day (ml)									
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**Tick if this feed volume included (tick all that apply):**

Mother's breast milk	<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"/>
Donated breast milk	<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"/>
Breast milk fortifier	<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"/>
Term formula milk	<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"/>
Preterm formula milk	<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"/>

Tick if infant received parenteral nutrition on this day	<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"/>
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**Please complete a Form 3: Late-Onset Invasive Infection if 5 consecutive boxes are ticked in the following row or if this infant died from suspected late-onset infection**

Tick if antibiotics / antifungals were given on this day	<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"/>
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**Please complete a Form 4: Gut Signs if 5 consecutive boxes are ticked in the following row or if this infant died from suspected NEC**

Tick if feeds were stopped or withheld for more than 4 hours	<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"/>
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### Definitions:

Parenteral nutrition: solutions containing a mix of any of the following; essential and non-essential amino acids, glucose, fat, and micronutrients

Suspected NEC: sufficient concern about the abdomen that feeds are stopped or withheld for more than 4 hours

**Details of person completing form**

Name: \_\_\_\_\_

Hospital: \_\_\_\_\_

Date:   /   /   Signature: \_\_\_\_\_

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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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<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"/>
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**When this form has been completed**  
 Please return to the SIFT Coordinating Centre using the FREEPOST envelope provided



Speed of increasing milk feeds

## Contact Details

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