

MALAYSIAN NATIONAL NEONATAL REGISTRY (CRF 09)

Centre Name: _____	<input type="radio"/> Stillbirth <input type="radio"/> Livebirth	MNNR No. (Office use): <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
Date of Admission: <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (dd/mm/yy)	<input type="radio"/> New Case <input type="radio"/> Readmission <input type="radio"/> Transfer from, if relevant: _____	Centre: _____
Admitted to neonatal ward: <input type="radio"/> Yes → (Proceed to complete all sections in this CRF) <input type="radio"/> No → (Proceed to complete [Sections 1, 2, 4(No. 45) and 5])		
<i>Instruction: Where check boxes <input type="checkbox"/> are provided, check (✓) one or more boxes. Where radio buttons <input type="radio"/> are provided, check (✓) one box only.</i>		

SECTION 1 : PATIENT PARTICULARS & MATERNAL HISTORY

1. Name of mother: *	_____		
2. Name of baby (optional):	_____		
3. RN of baby: *	_____		
4. Mother's I/C number: *	MyKad: <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	Other ID document No: _____	
	Specify document type (if others): <input type="radio"/> Passport <input type="radio"/> Father's I/C <input type="radio"/> Armed Force ID <input type="radio"/> Work Permit number <input type="radio"/> Others		

5. Date of birth of baby: *	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (dd/mm/yyyy)		
6. Ethnic group of mother: *	<input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Bumiputra Sabah, specify: _____ <input type="radio"/> Other Malaysian <input type="radio"/> Chinese <input type="radio"/> Orang Asli <input type="radio"/> Bumiputra Sarawak, specify: _____ <input type="radio"/> Non-citizen		
7. Maternal age: *	<input style="width: 20px;" type="text"/> (years)		
8. GPA: * (current pregnancy before delivery of this child)	Gravida: _____	Parity: _____	Abortion: _____
9. Maternal diabetes (including gestational diabetes): *	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
10. Maternal hypertension, chronic pregnancy induced: *	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
11. Maternal chorioamnionitis: *	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		

SECTION 2 : BIRTH HISTORY

12. Antenatal steroid: *	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
13. Intrapartum antibiotic: *	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
14. Birth weight: *	<input style="width: 20px;" type="text"/> (grams)		
15. Gestation: *	<input style="width: 20px;" type="text"/> (weeks)		
16. Growth status: *	<input type="radio"/> SGA <input type="radio"/> AGA <input type="radio"/> LGA		
17. Gender: *	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate		
18. Place of birth: *	<input type="radio"/> Inborn <input type="radio"/> University hospital <input type="radio"/> District hospital with specialist <input type="radio"/> Home <input type="radio"/> Outborn → <input type="radio"/> General hospital <input type="radio"/> District hospital without specialist <input type="radio"/> Others, specify: _____ <input type="radio"/> Private hospital <input type="radio"/> Private maternity home		

19. Multiplicity: *	<input type="radio"/> Singleton <input type="radio"/> Twin <input type="radio"/> Triplet <input type="radio"/> Others, specify: _____		
20. Final mode of delivery: *	<input type="radio"/> Vaginal delivery → <input type="radio"/> SVD <input type="radio"/> Ventouse <input type="radio"/> Forceps <input type="radio"/> Breech <input type="radio"/> Caesarean section <input type="radio"/> Unknown		

21. Apgar score at 1 min and 5 min (1-10) : *	a) Score at 1 min: <input style="width: 20px;" type="text"/> <input type="checkbox"/> Unknown	b) Score at 5 min: <input style="width: 20px;" type="text"/> <input type="checkbox"/> Unknown (Please score even if the baby is intubated)	
	a) Oxygen: <input type="radio"/> Yes <input type="radio"/> No	d) Cardiac compression: <input type="radio"/> Yes <input type="radio"/> No	
22. Initial resuscitation : *	b) Bag-mask vent: <input type="radio"/> Yes <input type="radio"/> No	e) Adrenaline: <input type="radio"/> Yes <input type="radio"/> No	
	c) Endotracheal tube vent: <input type="radio"/> Yes <input type="radio"/> No		
23. Admission temperature: *	<input style="width: 20px;" type="text"/> (°C)		

SECTION 3 : NEONATAL EVENT

24. Respiratory support:	<input type="radio"/> Yes → <input type="checkbox"/> CPAP <input type="checkbox"/> Conventional ventilation <input type="checkbox"/> HFOV <input type="checkbox"/> Nitric oxide <div style="border: 1px dashed black; padding: 2px; display: inline-block;"> <input checked="" type="radio"/> Nasal CPAP before ETT ventilation: <input type="radio"/> Yes <input type="radio"/> No </div>
	<input type="radio"/> No
25. Total duration of ventilatory support: (Do not count the days on CPAP only)	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (days)
26. Surfactant:	<input type="radio"/> Yes → <input type="radio"/> < 1 hr <input type="radio"/> 1- 2 hrs <input type="radio"/> > 2 hrs <input type="radio"/> No
27. Post natal steroid for CLD:	<input type="radio"/> Yes <input type="radio"/> No
28. Parenteral nutrition:	<input type="radio"/> Yes <input type="radio"/> No

SECTION 4 : PROBLEMS / DIAGNOSES

29. Respiratory :	<input type="checkbox"/> Meconium aspiration syndrome <input type="checkbox"/> Pulmonary haemorrhage <input type="checkbox"/> Pneumonia <input type="checkbox"/> Transient tachypnoea of newborn <input type="checkbox"/> Pulmonary interstitial emphysema <input type="checkbox"/> Unknown						
30. RDS:	<input type="radio"/> Yes <input type="radio"/> No						
31. Pneumothorax:	<input type="radio"/> Yes → <div style="border: 1px dashed black; padding: 2px; display: inline-block;"> Pneumothorax developed during mechanical ventilation: <input type="radio"/> Yes <input type="radio"/> No </div> <input type="radio"/> No						
32. Supplemental oxygen at:	a) Day 28: <input type="radio"/> Yes <input type="radio"/> No b) 36 weeks corrected age : <input type="radio"/> Yes <input type="radio"/> No						
33. Cardiovascular:	PPHN: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown						
34. PDA:	<input type="radio"/> Yes → <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">a) ECHO done:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td>b) Indomethacin/Ibuprofen:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td>c) Ligation:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> </table> <input type="radio"/> No	a) ECHO done:	<input type="radio"/> Yes <input type="radio"/> No	b) Indomethacin/Ibuprofen:	<input type="radio"/> Yes <input type="radio"/> No	c) Ligation:	<input type="radio"/> Yes <input type="radio"/> No
a) ECHO done:	<input type="radio"/> Yes <input type="radio"/> No						
b) Indomethacin/Ibuprofen:	<input type="radio"/> Yes <input type="radio"/> No						
c) Ligation:	<input type="radio"/> Yes <input type="radio"/> No						
35. NEC (Stage 2 and above):	<input type="radio"/> Yes → <div style="border: 1px dashed black; padding: 2px; display: inline-block;"> Surgical treatment: <input type="radio"/> Yes <input type="radio"/> No </div> <input type="radio"/> No						
36. ROP: Retinal Exam Done:	<input type="radio"/> Yes (If yes, worst stage of ROP): → <input type="radio"/> Stage 0 <input type="radio"/> Stage 1 <input type="radio"/> Stage 2 <input type="radio"/> Stage 3 <input type="radio"/> Stage 4 <input type="radio"/> Stage 5 <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">a) Laser therapy:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td>b) Cryotherapy:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td>c) Vitrectomy:</td> <td><input type="radio"/> Yes <input type="radio"/> No</td> </tr> </table> <input type="radio"/> No → <div style="border: 1px dashed black; padding: 2px; display: inline-block;"> Appointment given: <input type="radio"/> Yes <input type="radio"/> No </div> <input type="radio"/> Not applicable	a) Laser therapy:	<input type="radio"/> Yes <input type="radio"/> No	b) Cryotherapy:	<input type="radio"/> Yes <input type="radio"/> No	c) Vitrectomy:	<input type="radio"/> Yes <input type="radio"/> No
a) Laser therapy:	<input type="radio"/> Yes <input type="radio"/> No						
b) Cryotherapy:	<input type="radio"/> Yes <input type="radio"/> No						
c) Vitrectomy:	<input type="radio"/> Yes <input type="radio"/> No						
37. IVH:	<input type="radio"/> Yes <i>If yes, worst grade :</i> → <input type="radio"/> Grade 1 <input type="radio"/> Grade 2 <input type="radio"/> Grade 3 <input type="radio"/> Grade 4 <div style="border: 1px dashed black; padding: 2px; display: inline-block; width: 100%;"> <input type="checkbox"/> VP shunt / reservoir insertion </div> <input type="radio"/> No <input type="radio"/> Not applicable (term infant) <div style="border: 1px dashed black; padding: 2px; display: inline-block; width: 100%;"> <input type="checkbox"/> Ultrasound not done </div>						
38. Central venous line:	<input type="radio"/> Yes <input type="radio"/> No						
39. Catheter associated infection:	<input type="radio"/> Yes <input type="radio"/> No						
40. Catheter associated ischaemic event:	<input type="radio"/> Yes → <input type="radio"/> Vasospasm <input type="radio"/> Gangrene <input type="radio"/> Organ dysfunction <input type="radio"/> No						

SECTION 4 : PROBLEMS / DIAGNOSES (cont.)

41. Seizures:	<input type="radio"/> Yes		<input type="radio"/> No	
42. Infection: (Clinical or Confirmed)	<input type="radio"/> Yes →	<input type="radio"/> Clinical sepsis	I) For first episode of confirmed sepsis:	
	<input type="radio"/> No	<input type="radio"/> Confirmed sepsis →	<input type="radio"/> On or before day 3 of life <input type="radio"/> After day 3 of life	
			II) For confirmed sepsis: <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Fungal <input type="checkbox"/> Acinetobacter <input type="checkbox"/> MRSA <input type="checkbox"/> Staphylococcus aureus <input type="checkbox"/> Others, specify: <input type="checkbox"/> CONS <input type="checkbox"/> Klebsiella <input type="checkbox"/> ESBL organisms <input type="checkbox"/> Pseudomonas	
43. Neonatal meningitis:	<input type="radio"/> Yes		<input type="radio"/> No	
44. HIE (≥ 36 weeks):	<input type="radio"/> None		<input type="radio"/> Mild	<input type="radio"/> Moderate
45. Congenital anomalies:				
45a. Major congenital anomalies:				
<input type="radio"/> Yes → <input type="radio"/> No → (Proceed to No.46):				
<input type="radio"/> Syndrome (known)		<input type="checkbox"/> Down <input type="checkbox"/> Edward <input type="checkbox"/> Patau <input type="checkbox"/> Others, specify (Please refer to ICD 10): <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
<input type="radio"/> Not a recognised syndrome <input type="radio"/> Isolated major abnormality		45b. Types of abnormalities (Check all that are present. Applies to all including 'known syndromes', 'not a recognised syndrome' or 'isolated major abnormality')		
		<input type="checkbox"/> CVS → <input type="radio"/> Cyanotic <input type="radio"/> Acyanotic <input type="checkbox"/> Skeletal dysplasia <input type="checkbox"/> CNS → <input type="checkbox"/> ECHO done <input type="checkbox"/> Respiratory <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> GIT <input type="checkbox"/> Hydrancephaly <input type="checkbox"/> Hydrops <input type="checkbox"/> Holoprosencephaly <input type="checkbox"/> Renal <input type="checkbox"/> Others (Refer to ICD 10): <input type="checkbox"/> Neural Tube Defect → <input type="checkbox"/> Spina bifida <input type="checkbox"/> Cleft → <input type="radio"/> Lip <input type="radio"/> Palate <input type="radio"/> Lip and palate: <input type="checkbox"/> Anencephaly <input type="checkbox"/> Others, specify: <input type="checkbox"/> Encephalocele <input type="checkbox"/> None of the above <input type="checkbox"/> Others (Refer to ICD 10):		
46. Inborn Errors of Metabolism (IEM):	<input type="radio"/> Yes →		a) Clinical diagnosis? <input type="radio"/> Yes <input type="radio"/> No b) Confirmed diagnosis? <input type="radio"/> Yes, specify → <input type="text"/> <input type="radio"/> No	
	<input type="radio"/> No			

SECTION 5 : OUTCOME

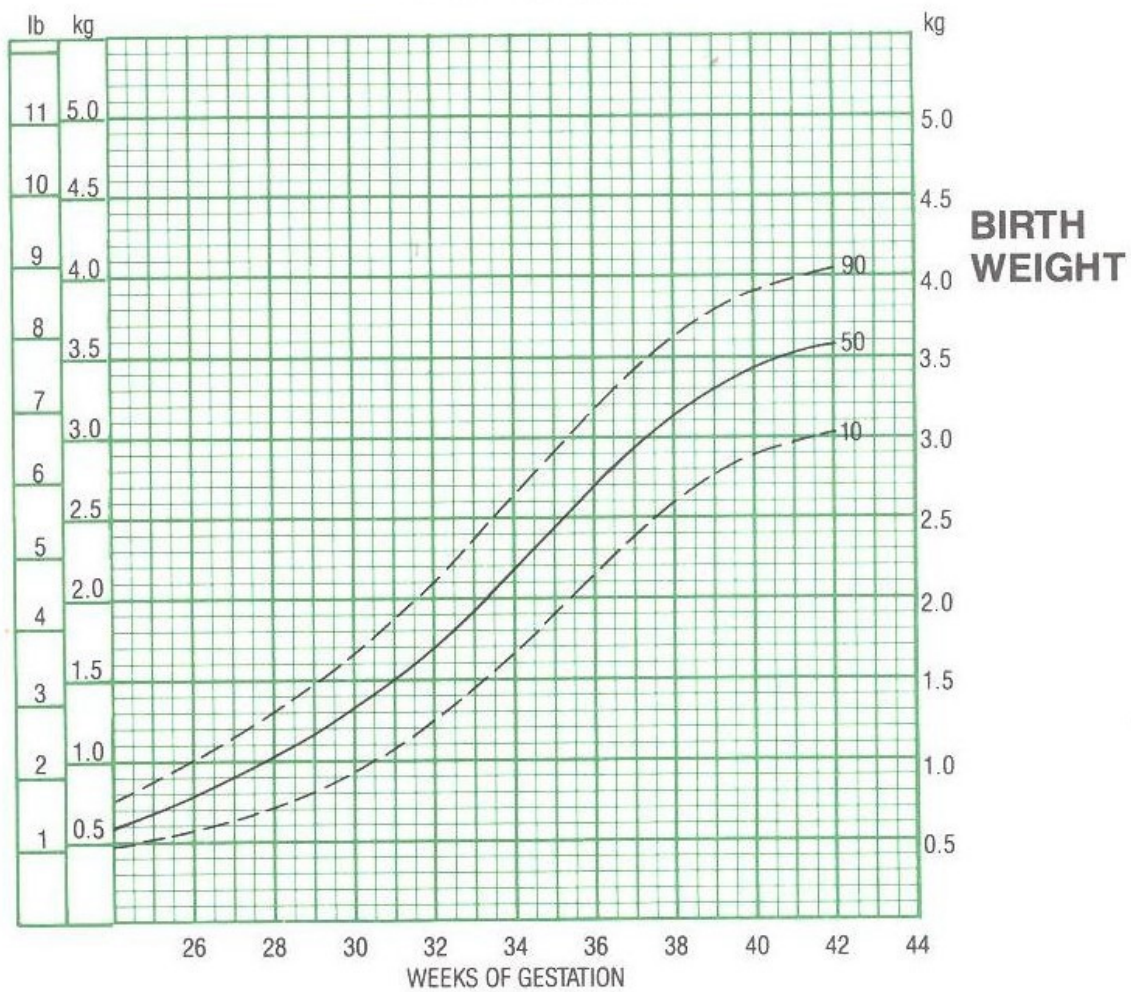
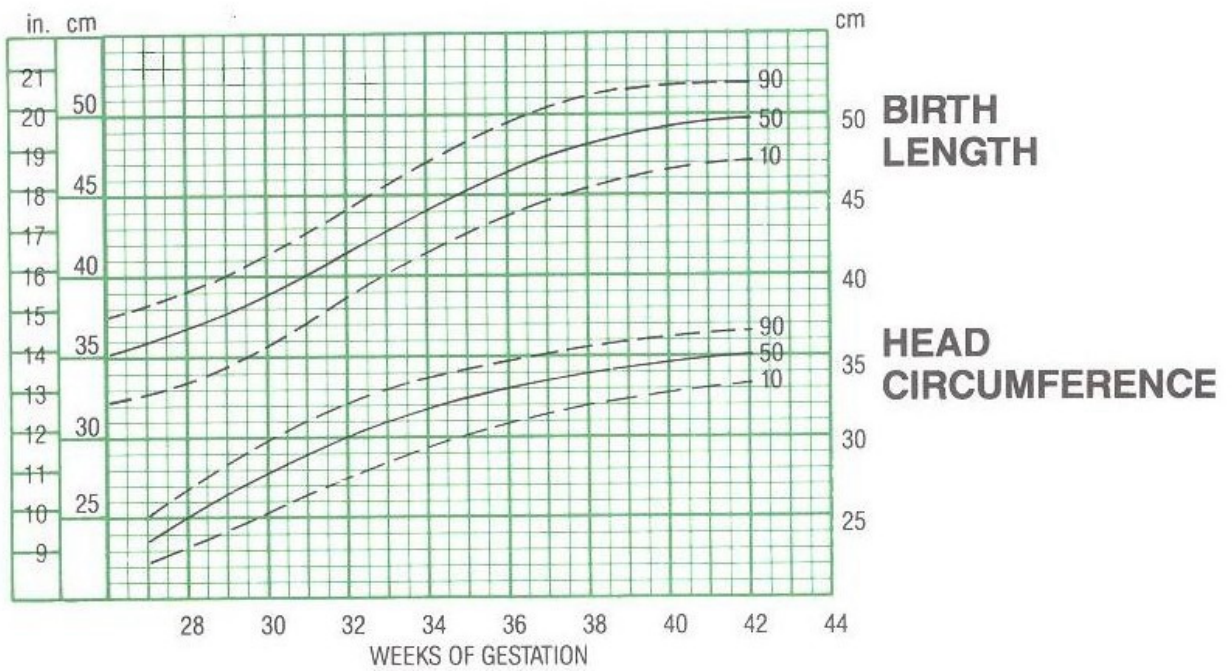
1. Date of discharge / transfer:	<input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yy)														
2. Weight and growth status on discharge / death:	2a) Weight:	<input type="text"/> <input type="text"/> <input type="text"/> (grams)													
	2b) Growth status:	<input type="radio"/> SGA <input type="radio"/> AGA <input type="radio"/> LGA													
3. Feeding at discharge / death:	<input type="radio"/> Never fed <input type="radio"/> Formula only <input type="radio"/> No data / Unknown <input type="radio"/> Human milk only <input type="radio"/> Human milk with formula														
4. Total duration of hospital stay (Neonatal / Paeds Care):	<input type="text"/> <input type="text"/> <input type="text"/> (in completed days)														
5. Outcome:															
<input type="radio"/> Alive →	Place discharged to: <input type="radio"/> Home <input type="radio"/> Social welfare home <input type="radio"/> Other non Paeds Ward <input type="radio"/> Still hospitalized as of 1st birthday <input type="radio"/> Transfer to other hospitals →														
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">a) Name of hospital:</td> <td colspan="3"><input type="text"/></td> </tr> <tr> <td>b) Reason for transfer:</td> <td colspan="3"> <input type="radio"/> Growth / Stepdown care <input type="radio"/> Acute medical / diagnostic services <input type="radio"/> Social/ Logistic reason <input type="radio"/> Lack of NICU bed <input type="radio"/> Others, specify: <input type="radio"/> Chronic/Palliative care <input type="radio"/> Surgery </td> </tr> <tr> <td>c) Post transfer disposition: (Please fill this section if place transferred is not part of the NNR Network)</td> <td colspan="3"> <input type="radio"/> Home <input type="radio"/> Transferred again to another hospital <input type="radio"/> Death <input type="radio"/> Readmitted to your hospital </td> </tr> </table>			a) Name of hospital:	<input type="text"/>			b) Reason for transfer:	<input type="radio"/> Growth / Stepdown care <input type="radio"/> Acute medical / diagnostic services <input type="radio"/> Social/ Logistic reason <input type="radio"/> Lack of NICU bed <input type="radio"/> Others, specify: <input type="radio"/> Chronic/Palliative care <input type="radio"/> Surgery			c) Post transfer disposition: (Please fill this section if place transferred is not part of the NNR Network)	<input type="radio"/> Home <input type="radio"/> Transferred again to another hospital <input type="radio"/> Death <input type="radio"/> Readmitted to your hospital		
a) Name of hospital:	<input type="text"/>														
b) Reason for transfer:	<input type="radio"/> Growth / Stepdown care <input type="radio"/> Acute medical / diagnostic services <input type="radio"/> Social/ Logistic reason <input type="radio"/> Lack of NICU bed <input type="radio"/> Others, specify: <input type="radio"/> Chronic/Palliative care <input type="radio"/> Surgery														
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<input type="radio"/> Dead →	Died within 12 Hours of admission: <input type="radio"/> Yes <input type="radio"/> No Place of death: <input type="radio"/> Labour room/OT <input type="radio"/> Neonatal unit <input type="radio"/> In transit <input type="radio"/> Others, specify: <input type="text"/>														

Name : _____

Signature : _____

Date: / / (dd/mm/yy)

INTRAUTERINE GROWTH CURVES (COMPOSITE MALE / FEMALE) (APPENDIX 2)



Data Source: W.H. Kitchen et al Revised intrauterine growth curves for an Australian hospital population. Aust. Paediatr. J. (1983) 19:157-161.