Neonatal History Form (NH)

Chronic Kidney Disease in Children Cohort Study (CKiD)

SECTION A: GENERAL INFORMATION

A1. PARTICIPANT ID: ENTER NUMBER ONLY IF LABEL IS NOT AVAILABLE

|__| - |__|__| - |__|__|__|

A2. Last CKiD Visit #: ___ ___ ___

A3. FORM VERSION: 1 2 / 0 1 / 2 1

A4. DATE OF THIS REPORT: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

A5. FORM COMPLETED BY (INITIALS) ___ ___ ___

Email the completed form to your respective CCC.
Midwest CCC: Christine Smith at casmith@cmh.edu;
cc: Leah Haddadi at lshaddadi@cmh.edu
East Coast CCC: Shumei Shang at ShangS@email.chop.edu

SECTION B: Birth History

B1. Are medical records available and accessible that provide information on the first 90 Days of Life?

Yes..... 1 ○
No..... 2 **(END FORM)** ○

B2. Birth Weight: ___ ___ ___ ___ (grams)

B3. Birth Head Circumference (HC): ___ ___ . ___ (cm)

B4. Birth Length: ___ . ___ (cm)

B5. Gestational Age (choose one):

<24 weeks.....	1 ○	33-34 weeks.....	7 ○
24 weeks.....	2 ○	35-36 weeks.....	8 ○
25-26 weeks.....	3 ○	37-39 weeks.....	9 ○
27-28 weeks.....	4 ○	40-42 weeks.....	10 ○
29-30 weeks.....	5 ○	>42 weeks.....	11 ○
31-32 weeks.....	6 ○	Unknown.....	-8 ○

B6. APGAR Score

a.	1 min: ___ ___	Unknown or Not Assigned.....	-8 ○
b.	5 min: ___ ___	Unknown or Not Assigned.....	-8 ○
c.	10 min: ___ ___	Unknown or Not Assigned.....	-8 ○
d.	15 min: ___ ___	Unknown or Not Assigned.....	-8 ○
e.	20 min: ___ ___	Unknown or Not Assigned.....	-8 ○

SECTION C: Prenatal History

C1. Congenital Anomalies Were Diagnosed Prenatally

Yes..... 1 ○
No..... 2 ○
Unknown..... -8 ○

C2. Fetal Antenatal Conditions

Yes..... 1 ○
No..... 2 **(Skip to D1)** ○
Unknown..... -8 **(Skip to D1)** ○

Please circle "Yes" or "No" for EACH of the following.	Yes	No
a. Fetal anomaly unspecified (CNS, Abdominal, cardiovascular, renal, respiratory).....	1 ○	2 ○
b. Fetal distress.....	1 ○	2 ○
c. Intrauterine Growth Restriction (IUGR).....	1 ○	2 ○
d. Other fetal/placental condition.....	1 ○	2 ○

SECTION D: NICU

D1. Was NICU stay required within First 90 Days of Life?

Yes..... 1 ○
No..... 2 **(Skip to E1)** ○
Unknown..... -8 **(Skip to E1)** ○

D2. Respiratory Support on Admission to NICU

None..... 1 ○
Hood/NC (Nasal Cannula) or O (Oxygen).... 2 ○
NCPAP (CPAP)..... 3 ○
EET (Endotracheal Tube) or V (Ventilation).. 4 ○
Unknown..... -8 ○

D3. Blood Pressure on Admission to NICU

a.Systolic (0-140) ___ ___ ___
Unknown..... -8 ○

b.Diastolic (0-100) ___ ___ ___
Unknown..... -8 ○

c.Mean (0-100) (If recorded in chart note) ___ ___ ___
Unknown..... -8 ○

D4. Was treatment required during transport or during first hour of Admission?

Yes..... 1 ◯
No..... 2 **(Skip to D5)** ◯
Unknown..... -8 **(Skip to D5)** ◯

Please circle "Yes" or "No" for EACH of the following.	Yes	No
a. Inhaled Nitric Oxide (iNO)	1 ◯	2 ◯
b. Intubated and ventilated (through ETT, Trach or LMA).....	1 ◯	2 ◯
c. Continuous Vasoactive agents (Pressors).....	1 ◯	2 ◯
d. Paralysis by neuromuscular blockade.....	1 ◯	2 ◯

D5. Initial NICU Discharge Disposition

Discharged from NICU to Home ..... 1 **(Skip to E1)** ◯
Transferred out of NICU to another NICU at another Institution..... 2 ◯
Transferred out of NICU to Nursery or other inpatient setting..... 3 **(Skip to E1)** ◯

D6. Date Transferred out of NICU to another NICU at another Institution: ___ ___/ ___ ___/ ___ ___ ___ ___ (M M D D Y Y Y Y)

SECTION E: First 90 Days of Life

E1. Problems on Admission to NICU, Nursery, or within First 90 Days of Life

Please circle "Yes", "No" or "Unknown" for EACH of the following.

		Yes	No	Unknown
a.	Acute Kidney Injury (AKI).....	1 ◯	2 ◯	-8 ◯
b.	Anomalies or Syndrome, including renal anomalies.....	1 ◯	2 ◯	-8 ◯
c.	Cardiac.....	1 ◯	2 ◯	-8 ◯
d.	Failure to Thrive (FTT)/feeding problems.....	1 ◯	2 ◯	-8 ◯
e.	Kidney anomalies.....	1 ◯	2 ◯	-8 ◯
f.	Hematologic or Oncologic.....	1 ◯	2 ◯	-8 ◯
g.	Hyperbilirubinemia.....	1 ◯	2 ◯	-8 ◯
h.	Hypoglycemia or Hypoglycemia Eval.....	1 ◯	2 ◯	-8 ◯
i.	Infection or R/O infection.....	1 ◯	2 ◯	-8 ◯
j.	Metabolic, other than Hypoglycemia.....	1 ◯	2 ◯	-8 ◯
k.	Neurologic, including hypoxic-ischemic encephalopathy (HIE) and Intraventricular hemorrhage (IVH).....	1 ◯	2 ◯	-8 ◯
l.	Preterm Birth without other co-morbidities.....	1 ◯	2 ◯	-8 ◯
m.	Respiratory.....	1 ◯	2 ◯	-8 ◯
n.	Surgical or surgical evaluation (Does not include retinopathy of prematurity (ROP), patent ductus arteriosus (PDA), Ventriculoperitoneal (VP) shunt, Cardiac surgery or trach/trach eval).....	1 ◯	2 ◯	-8 ◯
o.	Vascular Access.....	1 ◯	2 ◯	-8 ◯
p.	Other.....	1 ◯	2 ◯ **(Skip to E2)**	-8 ◯ **(Skip to E2)**

1. Specify Other: _____

E2. Respiratory Diagnosis and Treatment within First 90 Days of Life (Including NICU and Nursery Stay)

Yes..... 1 ◯
No..... 2 **(Skip to E3)** ◯
Unknown..... -8 **(Skip to E3)** ◯

Please circle "Yes" or "No" for EACH of the following.	Yes	No
a. Endotracheal Tube/Ventilation.....	1 ◯	2 ◯
b. Epinephrine.....	1 ◯	2 ◯
c. Cardiac compressions.....	1 ◯	2 ◯

E3. Seizures During the First 90 Days of Life

No seizures..... 1 ◯
Seizures confirmed by EEG or aEEG..... 2 ◯
Seizures suspected clinically, not confirmed by EEG or aEEG..... 3 ◯
Unknown..... -8 ◯

E4. Sepsis (i.e. Positive Blood Culture) in NICU, Nursery Stay, or within First 90 Days of Life

Yes..... 1 ◯
No..... 2 ◯
Unknown..... -8 ◯

SECTION F: Growth and Nutrition

F1. Is growth and nutrition information available for birth Admission to NICU or Nursery?

Yes..... 1 ◯
No..... 2 **(Skip to F2)** ◯

a. Date at ADM: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Weight at ADM: ___ ___ ___ ___ (grams)

c. Head Circumference at ADM: ___ ___ . ___ (cm)

d. Length at ADM: ___ ___ . ___ (cm)

e. Nutrition at ADM:

Enteral..... 1 ◯
Parenteral..... 2 **(Skip to F2)** ◯
No Feeds\TPN..... 3 **(Skip to F2)** ◯

f. Route of Feeds at ADM:

Oral..... 1 ◯
Gastric (NG/GT)..... 2 ◯
Transpyloric (NJ/GJ)..... 3 ◯

F2. Is growth and nutrition information available 2 Weeks after birth Admission?

Yes..... 1 ○
No..... 2 **(Skip to F3)** ○

a. Date at 2 Weeks: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Weight at 2 Weeks: ___ ___ ___ ___ (grams)

c. Head Circumference at 2 Weeks: ___ ___ . ___ (cm)

d. Length at 2 Weeks: ___ ___ . ___ (cm)

e. Nutrition at 2 Weeks:

Enteral ..... 1 ○
Parenteral ..... 2 **(Skip to F3)** ○
No Feeds\TPN..... 3 **(Skip to F3)** ○

f. Route of Feeds at 2 Weeks:

Oral..... 1 ○
Gastric (NG/GT)..... 2 ○
Transpyloric (NJ/GJ)..... 3 ○

F3. Is growth and nutrition information available 3 Months after birth Admission?

Yes..... 1 ○
No..... 2 **(Skip to G1)** ○

a. Date at 3 Months: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Weight at 3 Months: ___ ___ ___ ___ (grams)

c. Head Circumference at 3 Months: ___ ___ . ___ (cm)

d. Length at 3 Months: ___ ___ . ___ (cm)

e. Nutrition at 3 Months:

Enteral..... 1 ○
Parenteral..... 2 **(Skip to G1)** ○
No Feeds\TPN..... 3 **(Skip to G1)** ○

f. Route of Feeds at 3 Months:

Oral..... 1 ○
Gastric (NG/GT)..... 2 ○
Transpyloric (NJ/GJ)..... 3 ○

SECTION G: Imaging

G1. Neonatal Imaging within First 90 Days of Life

Yes..... 1 ○
No..... 2 **(Skip to H1)** ○
Unknown..... 3 **(Skip to H1)** ○

G2. Did the patient have a Renal or Bladder ultrasound?

Yes, normal..... 1 ○
Yes, abnormal..... 2 ○
No..... 3 **(Skip to G3)** ○

a. Date ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

G3. Did the patient have a Head ultrasound or Head CT Scan?

Yes, normal..... 1 ○
Yes, abnormal..... 2 ○
No..... 3 ○

G4. Did the patient have an Initial Head MRI during first 90 days of life?

Yes, normal..... 1 ○
Yes, abnormal..... 2 ○
No..... 3 **(Skip to H1)** ○

a. Date of First MRI ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

G5. Did the patient have a Final Head MRI during first 90 days of life?

Yes, normal..... 1 ○
Yes, abnormal..... 2 ○
No..... 3 **(Skip to H1)** ○

a. Date of Last MRI ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

SECTION H: Surgery

H1. Did patient have any surgeries within the First 90 Days of Life?

Yes..... 1 ○
No..... 2 **(Skip to I1)** ○
Unknown..... 3 **(Skip to I1)** ○

a. Date of Surgery 1: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Organ System of Surgery 1: _____

c. Surgery Procedure of Surgery 1: _____

d. Surgery Approach of Surgery 1: _____

H2. Did patient have 2 or more surgeries within the First 90 Days of Life?

Yes..... 1 ○
No..... 2 **(Skip to I1)** ○

a. Date of Surgery 2: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Organ System of Surgery 2: _____

c. Surgery Procedure of Surgery 2: _____

d. Surgery Approach of Surgery 2: _____

H3. Did patient have 3 or more surgeries within the First 90 Days of Life?

Yes..... 1 ○
No..... 2 **(Skip to I1)** ○

a. Date of Surgery 3: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

b. Organ System of Surgery 3: _____

c. Surgery Procedure of Surgery 3: _____

d. Surgery Approach of Surgery 3: _____

SECTION I: Discharge

I1. Initial Home Discharge Date: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

I2. Discharge Weight: ___ ___ ___ ___ (grams)

I3. Discharge Head Circumference: ___ ___ . ___ (cm)

I4. Discharge Length: ___ ___ . ___ (cm)

I5. Are laboratory results within the First 90 Days of Life, nearest to Discharge Date, available?

Yes..... 1 ○
No..... 2 **(Skip to J1)** ○

I6. Serum Creatinine : ___ . ___ ___ (mg/dL)

I7. Urea Nitrogen (BUN): ___ ___ ___ (mg/dL)

I8. Date of Labs (nearest to discharge date): ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

Section J: Maternal History

J1. Maternal Age (at childbirth): ___ ___

J2. Assisted Reproductive Technology (Includes fertility meds and/or procedures)

Yes..... 1 ○
No..... 2 ○
Unknown..... -8 ○

J3. Pre-Natal Care

Yes..... 1 ○
No..... 2 ○
Unknown..... -8 ○

J4. Maternal Substance Use History

Yes..... 1 ○
No..... 2 **(Skip to J5)** ○
Unknown..... -8 **(Skip to J5)** ○

Please circle "Yes", "No" or "Unknown" for EACH of the following.

		Yes	No	Unknown
a.	Amphetamines	1 ○	2 ○	-8 ○
b.	Cocaine	1 ○	2 ○	-8 ○
c.	Opiates	1 ○	2 ○	-8 ○
d.	Other	1 ○	2 ○	-8 ○

1. Specify Other _____

J5. Maternal Antenatal Conditions

Yes..... 1 ○
No..... 2 **(END FORM)** ○
Unknown..... -8 **(END FORM)** ○

Please circle "Yes", "No" or "Unknown" for EACH of the following.

		Yes	No	Unknown
a.	Chorioamnionitis	1 ○	2 ○	-8 ○
b.	Diabetes	1 ○	2 ○	-8 ○
c.	Pre-eclampsia/eclampsia/HELLP	1 ○	2 ○	-8 ○
d.	Other Infection	1 ○	2 ○	-8 ○
e.	Previous Cesarean	1 ○	2 ○	-8 ○
f.	Pre-existing Maternal Hypertension	1 ○	2 ○	-8 ○
g.	Other Maternal Condition	1 ○	2 ○	-8 ○

1. Specify Other _____