Delivery Hospital Code ___ ____ ___ ___

Mother's Last Name _____

Mother's First Name _____

Mother's Maiden Name _____

Mother's SS# ___ ___ ___- ___ ___- ___ ___ ___ ___

Mother's Race

___ White ___ Black ___Asian ___Hispanic ___Mixed Race ___Other

Payment Method

___Insurance ___WV Medicaid ___Self-Pay ___Other ___ Unknown

Street Address _____

City_____ **State** _____ **Zip** _____

Birthweight: _____ Grams	<1500 (6) 1501-2000 (5) 2000-2500 (4) 2500-3000 (3) >3000 (0)	
Maternal Age _____	<24 (2) ≥24 (0)	
No. Previous Pregnancy	≥1 (4) 0 (0)	
Maternal Education	<10 (8) 10 to 11 (6) 12 (4) >12 (0)	
Tobacco Use	Yes (7) No (0)	
Congenital Abnormality	Yes (15) No (0)	
5 Min. APGAR	<8 (12) ≥8 (0)	
No. PNC Visits	<10 (4) ≥10 (0)	
Intrauterine Substance Exposure	Yes (3) No (0)	
Gestational Age _____	Extremely <28 (25) Very 28 to 32 (17) Moderate 32 to < 37 (10) ≥ = 37 (0)	
TOTAL SCORE	**(High ≥ 17)**	

Newborn Hearing Screening Date: _____ /_____ /_____
Type of Test: ____ ABR ____ OAE
Left Ear __Pass ___Fail ___Not Screened
Right Ear __Pass ___Fail ___Not Screened
Rescreen Date: _____ /_____ /_____
Left Ear __Pass ___Fail ___Not Screened
Right Ear __Pass ___Fail ___Not Screened
Reason if Not Screened:
___ Infant Death ___Parent Refusal ___Equipment Failure ___Other

Infant Last Name _____

Infant First Name _____

Infant's DOB _____ /_____ /_____ **Infant's Gender** ___ Girl ___ Boy

Infant's Discharge Date: _____ /_____ /_____

Parent Phone __ __ __- __ __ __ - __ __ __

Primary Care Physician/Clinic _____

City, State, Zip _____, _____, _____

Office Phone ___ ___ ___- ___ ___ ___ - ___ ___ ___

Transferred to NICU: ___ Yes ___ No

___ Cabell Huntington ___ WVU ___ CAMC ___ Other

CCHD Screening: ____ Yes ____ No

1st reading: Rt. Hand ____ Rt. Foot ____ Age (hours) ____
2nd reading: Rt. Hand ____ Rt. Foot ____ Age (hours) ____
3rd reading: Rt. Hand ____ Rt. Foot ____ Age (hours) ____

If Yes to Intrauterine Substance Exposure, check all that apply:
__Self-reported
__Documented in prenatal record
__Positive maternal drug test
__Unknown/Other

If Yes to Intrauterine Substance Exposure, check all that apply:

__Opioids
__Sedatives/Hypnotics
__Cannabinoids
__Alcohol
__Unknown
__Stimulants
__Phencyclidine- PCP
__Gabapentin
__Antidepressants

Infant Diagnosed with NAS: ___Yes ___No

Maternal Hepatitis C ___Yes ___No ___ Unknown

Mother's feeding intention: ___ Breast only ___ Bottle or Both

Was the infant fed breast milk exclusively prior to discharge?

___ Yes ___ No

Was the infant removed from mother's care? ___ Yes ___ No

<u>Questions for Mother</u>

Have you ever been diagnosed by a physician with the following conditions?

___ Type I diabetes (juvenile type) ___ Type II diabetes (adult onset)
___ Gestational diabetes (pregnancy related)
___ No, I have not been diagnosed with diabetes

Mother's Height _____ feet _____ _____ inches

Mother's Weight (Pre-Delivery Admission Weight) _____ lbs.