

SECTION 5 – INITIAL DIAGNOSES AND MANAGEMENT (cont'd)

5.3 Feeding diagnosis (check all that apply):

Delayed gastric emptying ___ Poor intestinal transport ___ Constipation ___

Gastro-esophageal reflux ___ Necrotizing enterocolitis ___ Unknown ___

Other, please specify: _____

5.4 Feeding therapy: Normal oral feeding ___

If multiple therapies, please specify temporal order:

Type	Approximate duration	Order	Current
Naso-gastric tube feeding	_____	_____	_____
Gastrostomy/jejunostomy tube feeding	_____	_____	_____
Total parenteral nutrition	_____	_____	_____
Prokinetic agent: (type: _____)	_____	_____	_____
Surgery: Fundoplication ___ Other ___ (type: _____)			

5.5 Other complications

CNS: Seizures ___ Apnea ___ Intraventricular hemorrhage ___ Ventriculomegaly ___

MRI patterns of hypoxic ischemic encephalopathy ___

Cardiac: Structural abnormality ___ Dysrhythmia ___ Hypotension ___

Infections: Sepsis ___ Meningitis ___ Urinary tract infection ___

Other, please specify: _____

SECTION 6 – OUTCOME

6.1 Hospital stay: Total number of days: _____ Days in intensive care unit: _____

6.2 Still in hospital ___ Home ___ Transfer to another facility, please specify: _____

6.3 Age at last follow-up: _____ months / years

6.4 Medical complications as of last follow-up: _____

6.5 Deceased: ___

If yes: Age at time of death _____ (weeks / months)

Duration of hospitalization prior to death: _____ (weeks / months / years)

Cause of death: _____

Withdrawal of life support: No ___ Yes ___

If yes, please specify reason: _____

SECTION 7 – REPORTING PHYSICIAN

First name _____ Surname _____

Address _____

City _____ Province _____ Postal code _____

Telephone number _____ Fax number _____

E-mail _____ Date completed _____

Thank you for completing this form.