

# neoGASTRIC

## Daily Feed Log 2 (Days 15 – 71)

Baby's date of birth:   /   /

Baby's date of randomisation:   /   /

Name of hospital (where this form is completed): \_\_\_\_\_

### How to use this form:

This Daily Feed Log must be completed each **consecutive** day in the study from randomisation **until**:

- The baby has reached full feeds for three consecutive days
- Or the baby is 44<sup>+0</sup> gestational weeks<sup>+days</sup>

Complete the feeding log for each calendar day (24 hours from 00:00).

Once the baby has reached **150 ml/kg/day (at least 145 ml/kg/day) for three consecutive days** there is no further need to fill in the feed log.

Complete the question on the last page when the baby has reached full feeds.

Each baby **must** have a Daily Feed Log 1 (Days 1 – 14) completed (recording data for the first 14 complete days after randomisation) before starting to use this Daily Feed Log.

#### Definitions

**Clinical indication or concern:** e.g. abdominal tenderness, abdominal distension, abdominal discolouration, bloody stool, clinical deterioration, bilious/bloody vomiting, perioperative care, or free drainage after surgery

**Full feeds:** defined as tolerating 150 ml/kg/day (at least 145 ml/kg/day) or including breastfeeding where total milk is considered equivalent to full enteral feeds

## Allocation

- No routine measurement of gastric residual volumes  
 Routine measurement of gastric residual volumes

Study number: 

	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
1. Date (dd/mm)	<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"/>
2. Weight (g) used to calculate the volume of fluids/feeds given							
3. Has the baby reached full feeds today? (see definition)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
4. Does the baby have a gastric tube in situ today? <i>This includes days where a baby has a gastric tube in place for any part of the day</i>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Enteral Feeds</b>							
5. Total milk feed volume received per day (ml)							
6. Was the baby breastfed (sucking at the breast) today?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please complete a Late-Onset Infection and Gut Signs Form if 5 consecutive Y boxes are ticked in the following row more than 3 days after birth, or if this baby died from suspected late-onset infection. Answer No if antibiotics / antifungals given for prophylaxis							
7. Were antibiotics / antifungals given on this day for treatment of suspected or proven infection?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please review guidance and consider completing a Late-Onset Infection and Gut Signs form if 5 consecutive Y boxes are ticked in the following row. (This form <u>must</u> be completed if the baby died from suspected NEC or focal intestinal perforation).							
8. Was the baby nil by mouth at any point today with the intention that this was for 4 or more hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Gastric residual volume measurements</b>							
9. How many times were gastric residual volumes measured today?							
10. Were any of these measured for a clinical indication or concern (see definition)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
11. If any <b>were measured for a clinical indication or concern, please state how many:</b>							
12. <b>If the baby is on the routine measurement arm and has had &lt;4 GRV measurements today:</b> Is the baby establishing oral feeds today (e.g. breastfeeding or bottle feeding as well)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
13. Initial here if you have completed any of the log for this day							

When you have completed this feed log, please enter it on to OpenClinica.

If the baby has not yet reached full feeds, please continue recording data on Daily Feed Log 3 (Days 72 – 167).

If the baby has reached full feeds, please complete the question on page 8.

Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28	Day 29	Day 30	Day 31	Day 32	Day 33
<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"/>	<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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## Allocation

- No routine measurement of gastric residual volumes  
 Routine measurement of gastric residual volumes

Study number: 

	Day 34	Day 35	Day 36	Day 37	Day 38	Day 39	Day 40
1. Date (dd/mm)	<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"/>
2. Weight (g) used to calculate the volume of fluids/feeds given							
3. Has the baby reached full feeds today? (see definition)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
4. Does the baby have a gastric tube in situ today? <i>This includes days where a baby has a gastric tube in place for any part of the day</i>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Enteral Feeds</b>							
5. Total milk feed volume received per day (ml)							
6. Was the baby breast fed today?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please complete a Late-Onset Infection and Gut Signs Form if 5 consecutive Y boxes are ticked in the following row more than 3 days after birth, or if this baby died from suspected late-onset infection. Answer No if antibiotics / antifungals given for prophylaxis							
7. Were antibiotics / antifungals given on this day for treatment of suspected or proven infection?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
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8. Was the baby nil by mouth at any point today with the intention that this was for 4 or more hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Gastric residual volume measurements</b>							
9. How many times were gastric residual volumes measured today?							
10. Were any of these measured for a clinical indication or concern (see definition)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
11. If any <b>were measured for a clinical indication or concern, please state how many:</b>							
12. <b>If the baby is on the routine measurement arm and has had &lt;4 GRV measurements today:</b> Is the baby establishing oral feeds today (e.g. breastfeeding or bottle feeding as well)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
13. Initial here if you have completed any of the log for this day							

When you have completed this feed log, please enter it on to OpenClinica.

If the baby has not yet reached full feeds, please continue recording data on Daily Feed Log 3 (Days 72 – 167).

If the baby has reached full feeds, please complete the question on page 8.

Day 41	Day 42	Day 43	Day 44	Day 45	Day 46	Day 47	Day 48	Day 49	Day 50	Day 51	Day 52
<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"/>	<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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## Allocation

- No routine measurement of gastric residual volumes  
 Routine measurement of gastric residual volumes

Study number: 

	Day 53	Day 54	Day 55	Day 56	Day 57	Day 58	Day 59
1. Date (dd/mm)	<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"/>
2. Weight (g) used to calculate the volume of fluids/feeds given							
3. Has the baby reached full feeds today? (see definition)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
4. Does the baby have a gastric tube in situ today? <i>This includes days where a baby has a gastric tube in place for any part of the day</i>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Enteral Feeds</b>							
5. Total milk feed volume received per day (ml)							
6. Was the baby breast fed today?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please complete a Late-Onset Infection and Gut Signs Form if 5 consecutive Y boxes are ticked in the following row more than 3 days after birth, or if this baby died from suspected late-onset infection. Answer No if antibiotics / antifungals given for prophylaxis							
7. Were antibiotics / antifungals given on this day for treatment of suspected or proven infection?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Please review guidance and consider completing a Late-Onset Infection and Gut Signs form if 5 consecutive Y boxes are ticked in the following row. (This form <u>must</u> be completed if the baby died from suspected NEC or focal intestinal perforation).							
8. Was the baby nil by mouth at any point today with the intention that this was for 4 or more hours?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Gastric residual volume measurements</b>							
9. How many times were gastric residual volumes measured today?							
10. Were any of these measured for a clinical indication or concern (see definition)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
11. If any <b>were measured for a clinical indication or concern, please state how many:</b>							
12. <b>If the baby is on the routine measurement arm and has had &lt;4 GRV measurements today:</b> Is the baby establishing oral feeds today (e.g. breastfeeding or bottle feeding as well)?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
13. Initial here if you have completed any of the log for this day							

When you have completed this feed log, please enter it on to OpenClinica.

If the baby has not yet reached full feeds, please continue recording data on Daily Feed Log 3 (Days 72 – 167).

If the baby has reached full feeds, please complete the question on page 8.

Day 60	Day 61	Day 62	Day 63	Day 64	Day 65	Day 66	Day 67	Day 68	Day 69	Day 70	Day 71
<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"/>	<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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**When the baby has reached full feeds:**

**Which of the following did the baby receive before getting to full feeds, up to and including the third day of full feeds?** *(Please choose all that apply)*

- Mother's breast milk
- Donated breast milk
- Breast milk fortifier (any)
- Term formula
- Preterm formula
- Other formula

**If Other**, please specify: \_\_\_\_\_

**Now that the baby has reached full feeds, we would like them to remain on their allocated trial arm if at all possible until gastric feeding tube is no longer required or the infant is discharged home or reaches 44<sup>+0</sup> gestational weeks<sup>+days</sup>**

**Is the intention for this baby to remain on their allocated trial arm?**

*(Intention = your plan at **this** point for **this** baby)*

Yes  No

**If No:**

What is the intention?

- Move to no routine measurement of gastric residual volumes
- Move to routine, up to six-hourly, measurement of gastric residual volumes
- Other

**If you have answered Other**, please specify: \_\_\_\_\_

\_\_\_\_\_

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

**Signature:** \_\_\_\_\_

**Date of completion:**   /   /

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