Study number: | | | | | | |

neoGASTRIC

Hospital Transfer/Discharge form

To be used at continuing care sites in the UK only

Use this form if a baby:

- Is discharged home
- Has transferred to another hospital
- Has died
- Is still an inpatient at your hospital and has reached 44^{+0} gestational weeks^{+days}

Baby's date of birth: D D / M M / Y Y

Please answer all questions unless stated otherwise.

Section 1: Details of stay

1.1 **Name of this hospital:** _____

1.2 **Date of admission to this hospital:** D D / M M / Y Y

1.3 **From this hospital, the baby** *(choose one only)*:

- Was discharged home. . . . ☐
- Was transferred to another hospital . . . . ☐
- Died. . . . ☐
- Reached 44^{+0} gestational weeks^{+days} . . . . ☐

If this baby was discharged home:

1.3.1 **Date of discharge from this hospital:** D D / M M / Y Y

If this baby was transferred:

1.3.1 **Name of hospital baby is being transferred to:** _____

1.3.2 **Date of transfer:** D D / M M / Y Y

If this baby died:

1.3.1 **Date of death:** D D / M M / Y Y

1.4 **Has the baby been randomised to the FEED1 trial during this admission?** Yes ☐ No ☐

If Yes:

1.4.1 **What was the baby's FEED1 allocation?**

- Full feeds from Day 1 . . . . ☐
- Gradual advancement of feeds. . . . ☐

Section 2: Clinical outcomes

2.1 **Were any of the following diagnosed during the baby's stay in <u>this hospital</u> (prior to discharge or the baby reaching 44^{+0} gestational weeks^{+days})?**

Intraventricular haemorrhage (Grade 3 or Grade 4, Papile): Yes ☐ No ☐

If Yes, please specify grade *(choose all that apply)*:

- Grade 3 Intraventricular haemorrhage . . . . ☐
- Grade 4 Intraventricular haemorrhage . . . . ☐

Cystic periventricular leukomalacia: Yes ☐ No ☐

Microbiologically-confirmed or clinically-suspected late-onset infection: Yes ☐ No ☐

If the answer is Yes, <u>Please complete a Late-onset Infection and Gut Signs form, if one was not already completed for this instance of infection.</u>

Necrotising enterocolitis (NEC): Yes ☐ No ☐

If the answer is Yes, <u>Please complete a Late-onset Infection and Gut Signs form, if one was not already completed for this instance of NEC.</u>

Chronic Lung Disease: receiving oxygen or respiratory support at 36^{+0} weeks^{+days} corrected gestation:

Yes ☐

No ☐

N/A *(baby did not reach 36^{+0} weeks^{+days} corrected gestation during this admission and/or was not born at less than 32 weeks gestation)* ☐

Retinopathy of prematurity treated with intraocular medication, cryotherapy or laser surgery:

Yes ☐

No ☐

N/A *(baby was not born at less than 31 weeks gestation or did not weigh less than 1501g at birth)* ☐

If this baby has transferred to another hospital or has died, there are no further questions to answer. Please sign and date the form on the last page.

Section 3: Further details

Section 3 only needs to be completed if the baby has been discharged home or is still an inpatient and has reached 44^{+0} gestational weeks^{+days}.

If this baby was discharged home

3.1 **Method of feeding at discharge** *(choose all that apply)*:

Breast ☐

Bottle ☐

Gastric, jejunal or gastrostomy tube ☐

Other (please specify): _____

3.2 **Type of feeding at discharge** *(choose all that apply)*:

Mother's breast milk ☐

Donated breast milk ☐

Breast milk fortifier (any) ☐

Term formula ☐

Preterm formula ☐

Other formula (please specify): _____

3.3 **Weight at discharge home:** ☐☐☐☐ *g*

3.4 **Head circumference at discharge home:** ☐☐.☐ **cm**

(please provide the measurement taken closest to discharge home, up to a week prior to discharge home)

3.5 **<u>If this baby is not yet 36 weeks gestational age:</u>**

Is this baby being discharged home on respiratory support?

Yes ☐ No ☐ N/A (Baby is 36 weeks gestational age or over) ☐

If this baby is still an inpatient at your hospital and has reached 44+0 gestational weeks+days:

3.1 Method of feeding at 44+0 gestational weeks+days *(choose all that apply)*:

- Breast ☐
- Bottle ☐
- Gastric, jejunal or gastrostomy tube ☐
- Other (please specify): _____

3.2 Type of feeding at 44+0 gestational weeks+days *(choose all that apply)*:

- Mother's breast milk ☐
- Donated breast milk ☐
- Breast milk fortifier (any) ☐
- Term formula ☐
- Preterm formula ☐
- Other formula (please specify): _____

3.3 Weight at 44+0 gestational weeks+days: ☐☐☐☐ *g*

3.4 Head circumference at 44+0 gestational weeks+days:
(please provide the measurement taken closest to when the baby reached 44+0 gestational weeks+days, up to a week prior to this point) ☐☐.☐ *cm*

Details of person completing form:

Name: _____

Role: _____

Signature: _____

Date: D D / M M / Y Y

Principal Investigator signature: _____

Date: D D / M M / Y Y

When this form has been completed:

Please scan and return to the baby's recruiting site via secure email.

neoGASTRIC Study Team

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