MALAYSIAN NATIONAL NEONATAL REGISTRY (READMISSION FORM)

Centre Name:_____

Date of Admission: ☐☐ ☐☐ ☐☐ **(dd/mm/yy)**

MNNR No. (Office use): ☐☐☐☐☐☐ / ☐☐☐☐

SECTION 1 : PATIENT PARTICULARS & MATERNAL HISTORY

*** 1. Name of mother:**	
2. Name of baby (Optional):	
*** 3. RN of baby:**	
*** 4a. Mother's I/C number:**	MyKad: ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Other ID document No: ☐☐☐☐☐☐☐☐☐☐☐☐ Specify document type (if others): ◯Passport ◯Armed Force ID ◯Driver's License ◯Old IC ◯Hospital RN ◯Father's I/C ◯Work Permit number ◯Police ID Card ◯Immigration permit ◯Other, specify:……
4b. Baby's MyKid number:	☐☐☐☐☐☐ – ☐☐ – ☐☐☐☐
*** 5. Date of birth of baby:** (dd/mm/yy)	☐☐ / ☐☐ / ☐☐☐☐
*** 6a. Birth weight:** ☐☐☐☐ (grams)	***6b. Gestation at birth:** ☐☐ (weeks)

SECTION 2 : PARTICULARS OF THIS ADMISSION

*** 7. Date of first discharge:** (dd/mm/yy)	☐☐ / ☐☐ / ☐☐☐☐
*** 8. Age at readmission:**	☐☐☐ (days) (autocalculate)
*** 9. Weight at this readmission:**	☐☐☐☐ (grams)
*** 10. Reason for readmission:**	◯Apnoea ◯Aspiration ◯Cardiac surgery ◯Confirmed sepsis ◯Cyanosis due to sucking / swallowing incoordination ◯Fever ◯Hernia operation ◯Jaundice ◯Nearer to home ◯LRTI ◯Poor weight gain ◯Post-op care ◯ROP laser ◯Step down care ◯URTI ◯Others, Specify:……
***11. Ventilated:**	◯ Yes (fill in main CRF section 3&4) ◯ No

SECTION 5: OUTCOME

***48a. Date of discharge / transfer/ death:** (dd/mm/yy)	☐☐ / ☐☐ / ☐☐	**48b. Time of Death:** (24 hour format) (mandatory for death cases)	☐☐☐☐ (enter the best estimated time of death if the exact time is unknown)
***49. Weight and growth status on discharge:** a) **Weight:**	☐☐☐☐ (grams)		
b) **Growth status:**	◯ SGA ◯ AGA ◯ LGA		
***50. Feeding at discharge / death:**	◯ Never fed ◯ Human milk only ◯ Formula only ◯Human milk with formula ◯ No data / Unknown		
***51. Total duration of hospital stay (neonatal/ peads care):**	☐☐☐ (in completed days) (autocalculate)		

***52. Outcome:**

◯ Alive →

Place discharged to:

- ◯ Home
- ◯ Social welfare home
- ◯ Other non Paeds ward
- ◯ Still hospitalized as of 1st birthday
- ◯ Transfer to other hospitals →

a) Name of hospital:	
b) Reason for transfer:	◯Growth/ stepdown care ◯Acute medical/ diagnostic services ◯Social/ Logistic reason ◯Lack of NICU bed ◯Other, specify: …… ◯Chronic/ Palliative care ◯Surgery
c) Post transfer disposition: (Please fill this section if place transferred is not part of the NNR Network)	◯ Home ◯ Transferred again to another hospital ◯ Death ◯ Readmitted to your hospital ◯ Still in ward

◯ Dead →

Place of death:	◯ Labour room / OT ◯ Neonatal unit ◯ In transit ◯ Others, specify: ……

Name : _____ **Signature:**_____ **Date:** ☐☐ ☐☐ ☐☐ **(dd/mm/yy)**