

MALAYSIAN NATIONAL NEONATAL REGISTRY (READMISSION FORM)

Centre Name: _____ _____ _____ Date of Admission: <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yy)	<input type="checkbox"/> Discharge from : _____ MNNR No. (Office use): <input type="text"/> <input type="text"/> Centre: <input type="text"/>
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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:	Myocard: <input type="text"/> - <input type="text"/> - <input type="text"/>		
	Other ID document No: <input type="text"/>		
	Specify document type (if others): <input type="radio"/> Passport <input type="radio"/> Armed Force ID <input type="radio"/> Driver's License <input type="radio"/> Old IC <input type="radio"/> Hospital RN <input type="radio"/> Father's I/C <input type="radio"/> Work Permit number <input type="radio"/> Police ID Card <input type="radio"/> Immigration permit <input type="radio"/> Other, specify:.....		
4b. Baby's Mykid number:	<input type="text"/> - <input type="text"/> - <input type="text"/>		
*5. Date of birth of baby: (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>		
*6a. Birth weight:	<input type="text"/> (grams)	*6b. Gestation at birth:	<input type="text"/> (weeks)

SECTION 2 : PARTICULARS OF THIS ADMISSION

*7. Date of first discharge: (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>		
*8. Age at readmission:	<input type="text"/> (days) (autocalculate)		
*9. Weight at this readmission:	<input type="text"/> (grams)		
*10. Reason for readmission:	<input type="checkbox"/> Apnoea <input type="checkbox"/> LRTI <input type="checkbox"/> Confirmed sepsis <input type="checkbox"/> Others, Specify:..... <input type="checkbox"/> Fever <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Jaundice <input type="checkbox"/> URTI <input type="checkbox"/> Cyanosis due to sucking / swallowing incoordination		
*11. Ventilated:	<input type="radio"/> Yes → (fill in main CRF section 3&4) <input type="radio"/> No		

SECTION 5: OUTCOME

*48a. Date of discharge / transfer/ death: (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>	48b. Time of Death: (24 hour format) (mandatory for death cases)	<input type="text"/> (enter the best estimated time of death if the exact time is unknown)
*49. Weight and growth status on discharge:	a) Weight:	<input type="text"/> (grams)	
	b) Growth status:	<input type="radio"/> SGA <input type="radio"/> AGA <input type="radio"/> LGA	
*50. Feeding at discharge / death:	<input type="radio"/> Never fed <input type="radio"/> Human milk only <input type="radio"/> Formula only <input type="radio"/> Human milk with formula		
*51. Total duration of hospital stay (neonatal/ peds care):	<input type="text"/> (in completed days) (autocalculate)		
*52. Outcome:			

<input type="radio"/> Alive →	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="background-color: #00FFFF;">Place discharged to:</td> </tr> <tr> <td colspan="2"> <input type="radio"/> Home <input type="radio"/> Social welfare home <input type="radio"/> Other non Paeds ward <input type="radio"/> Still hospitalized as of 1st birthday <input type="radio"/> Transfer to other hospitals → </td> </tr> <tr> <td style="width: 30%; background-color: #00FFFF;">a) Name of hospital:</td> <td><input type="text"/></td> </tr> <tr> <td style="background-color: #00FFFF;">b) Reason for transfer:</td> <td> <input type="radio"/> Growth/ stepdown care <input type="radio"/> Acute medical/ <input type="radio"/> Social/ Logistic reason <input type="radio"/> Lack of NICU bed <input type="radio"/> diagnostic services <input type="radio"/> Other, specify: <input type="radio"/> Chronic/ Palliative care <input type="radio"/> Surgery </td> </tr> <tr> <td style="background-color: #00FFFF;">c) Post transfer disposition: <small>(Please fill this section if place transferred is not part of the NNR Network)</small></td> <td> <input type="radio"/> Home <input type="radio"/> Transferred again to another hospital <input type="radio"/> Death <input type="radio"/> Readmitted to your hospital </td> </tr> </table>	Place discharged to:		<input type="radio"/> Home <input type="radio"/> Social welfare home <input type="radio"/> Other non Paeds ward <input type="radio"/> Still hospitalized as of 1st birthday <input type="radio"/> Transfer to other hospitals →		a) Name of hospital:	<input type="text"/>	b) Reason for transfer:	<input type="radio"/> Growth/ stepdown care <input type="radio"/> Acute medical/ <input type="radio"/> Social/ Logistic reason <input type="radio"/> Lack of NICU bed <input type="radio"/> diagnostic services <input type="radio"/> Other, specify: <input type="radio"/> Chronic/ Palliative care <input type="radio"/> Surgery	c) Post transfer disposition: <small>(Please fill this section if place transferred is not part of the NNR Network)</small>	<input type="radio"/> Home <input type="radio"/> Transferred again to another hospital <input type="radio"/> Death <input type="radio"/> Readmitted to your hospital
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Name : _____ Signature: _____ Date: (dd/mm/yy)