

DISCHARGE FORM

CONFIDENTIAL

Study number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Infant initials	<input type="text"/>	<input type="text"/>	<input type="text"/>		

Name of nurse completing this questionnaire	<input style="width: 100%;" type="text"/>						
	<i>Please print name</i>						
Signed	<input style="width: 100%;" type="text"/>						
Date	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y
D	D	M	M	Y	Y		

Notes for completing this form

Explanatory text and instructions for completion of the questions are in italics in a separate box before each set of questions. All questions in the grey boxes should be completed. Unless stated otherwise, please complete all questions on the form. In certain circumstances some questions may not be applicable and where this is the case there are instructions on exactly what information may be missed.

Please complete the information in the required format (as specified in the form). For questions with a Yes/No answer, please mark the relevant Yes/No box with a 'X' (i.e. if the answer to a question is 'yes', the yes box should be crossed and the no box should be left blank)

1. Admission information

Please complete the following table with the information from child's arrival in ED/AAA/ARU. Date and time of arrival in hospital must be completed in full. When recording medications, please record full start date for medications (DD/MM/YY) where possible. If a date is not known, please mark as NK (for example, if medication started on an unknown day in June 2011, please record as NK/06/11).

Date of arrival in hospital

D	D	M	M	Y	Y
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Time of arrival in hospital

hh:mm

Measurements taken on arrival in hospital

Heart rate beats/min

Respiratory rate per min

SpO2 in air %

Please record oxygen supplementation on arrival in hospital by mode of delivery (i.e. if oxygen supplementation was given by nasal cannula please record the details in the nasal cannula row)

Nasal cannula

Flow l/min

Face mask

Flow l/min

Medication

Please complete details for all medications that infant was receiving at time of arrival in hospital

Antibiotics Y N

Co-Amoxiclav Y N

Date started

D	D	M	M	Y	Y
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Amoxicillin Y N

Date started

D	D	M	M	Y	Y
---	---	---	---	---	---

Clarithromycin Y N

Date started

D	D	M	M	Y	Y
---	---	---	---	---	---

Erythromycin Y N

Date started

D	D	M	M	Y	Y
---	---	---	---	---	---

Bronchodilator Y N

Salbutamol Y N

Date started

D	D	M	M	Y	Y
---	---	---	---	---	---

Ipratropium bromide Y N

Date started

D	D	M	M	Y	Y
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Inhaled corticosteroids Y N

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Montelukast Y N

Other	<input type="checkbox"/> Y	<input type="checkbox"/> N	<i>Please list all other medication(s) below</i>
			<input type="text"/>
			<input type="text"/>

2. Admission to ward for supportive care

Please complete the following table with the details for the admission to the ward for supportive care.

Date	<input type="text"/> D	<input type="text"/> D	<input type="text"/> M	<input type="text"/> M	<input type="text"/> Y	<input type="text"/> Y	Time	<input type="text"/> hh:mm
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3. Investigations

Please record if the child has had any of the following investigations while in hospital. Please record the total number of investigations during the entire hospital stay in each category. For example, if 3 separate laboratory virology tests were please mark the laboratory virology testing box with a '3'. If investigations were not done, please mark the box as '0'.

<i>Please identify results of testing below</i>							
Laboratory virology testing	<input type="text"/>	RSV positive	<input type="checkbox"/> Y	<input type="checkbox"/> N	RSV negative	<input type="checkbox"/> Y	<input type="checkbox"/> N
		Other virus positive	<input type="checkbox"/> Y	<input type="checkbox"/> N			
<i>Please identify results of testing below</i>							
NPT virology testing	<input type="text"/>	RSV positive	<input type="checkbox"/> Y	<input type="checkbox"/> N	RSV negative	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood culture	<input type="text"/>						
Urine culture	<input type="text"/>						
Chest x-ray	<input type="text"/>						

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4. Treatment

Please identify which of the following treatments the child has had during hospital stay from the following list. If treatments have been stopped then restarted during admission, please record the start date of the first treatment and the end date of the last treatment. Please do not leave start/end time of treatment blank or mark as NK. If the exact time is not known please record best estimate based on information from the medical notes.

			Start date					Start time	End date					End time		
Supplemental oxygen	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm
IV fluids	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm
NG feeding	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm

5. Continuing medication

Please refer to the prescription chart and record if the child has been prescribed any of the following medications during hospital stay. If child was receiving antibiotics or salbutamol inhaler as they came into hospital please record start/end dates as normal but identify this by crossing the last box in the row.

			Start date					Start time	End date					End time	Continued from admission?	
Antibiotics	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
	<i>(expected end date if scheduled to finish after discharge)</i>															
Salbutamol inhaler	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> hh:mm	<input type="checkbox"/> D	<input type="checkbox"/> D	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y
	<i>(expected end date if scheduled to finish after discharge)</i>															

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6. Eight hourly observations

Please complete the following table with the heart and respiratory rates measured during hospital stay. The first entry in the table should be the first heart and respiratory rate measured on the ward and the subsequent rows should be completed for measurements at 8 hour intervals from that initial measurement. For example, if the child was admitted to the ward at 9am, the measurements at 9am should be recorded in row 1 **the next available measurement** after 5pm (i.e. an 8 hour interval) should be recorded in row 2 and so on. If the child is admitted to HDU during hospital stay please continue to record heart and respiratory rate during HDU stay.

Date						Time	Heart rate	Respiratory rate
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min
D	D	M	M	Y	Y	hh:mm	beats/min	/min

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Date	Time	Heart rate	Respiratory rate
D D M M Y Y	hh:mm	beats/min	/min
D D M M Y Y	hh:mm	beats/min	/min
D D M M Y Y	hh:mm	beats/min	/min
D D M M Y Y	hh:mm	beats/min	/min
D D M M Y Y	hh:mm	beats/min	/min

If additional measurements to be recorded, please complete an additional observations data collection form and return with the discharge form

7. Transfer to HDU

The following section should only be completed if the child was transferred to the HDU during hospital admission. If the child was not admitted to the HDU, please cross the first question as 'No' and score through the remaining questions within this section.

Was the child admitted to HDU?

 Y

 N

If yes, please complete a BIDS SAE form and fax to ECTU on 0131 537 3851

Date study oximeter removed for admission to HDU

Time study oximeter removed for admission to HDU

Date study oximeter reapplied after discharge from HDU

Time study oximeter reapplied after discharge from HDU

D D M M Y Y

hh:mm

D D M M Y Y

hh:mm

Please record the study oximeter reapplied to the child after discharge from HDU:

M					
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8. Discharge

Please complete the following table with discharge details. Please do not leave time blank or mark as NK. If the exact time is not known, please record best estimate based on available information in the medical notes.

Discharge criteria

			Date						Time
Feeding returned to normal ($\geq 75\%$ normal)	<input type="checkbox"/> Y	<input type="checkbox"/> N	D	D	M	M	Y	Y	hh:mm
Stable continuously monitored oxygen saturation in air $\geq 94\%$ (for 4 hours including a period of sleep)	<input type="checkbox"/> Y	<input type="checkbox"/> N	D	D	M	M	Y	Y	hh:mm

Was infant admitted with apnoea?

(if yes, please complete the following details for infants admitted with apnoea ONLY*)

*Period of observation for at least 12 hours following last witnessed apnoea	<input type="checkbox"/> Y	<input type="checkbox"/> N	D	D	M	M	Y	Y	hh:mm
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Please complete following details for discharge criteria for ALL infants

Date and time discharge criteria met	D	D	M	M	Y	Y	hh:mm
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Date and time of actual discharge	D	D	M	M	Y	Y	hh:mm
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Please photocopy the completed form and send the copy back to:

Fiona Sloan
BIDS Trial Manager
Edinburgh Clinical Trials Unit (ECTU)
OPD 2, 2nd Floor
Western General Hospital
Crewe Road South
Edinburgh
EH4 2XU

Tel: 0131 537 2516

The original questionnaire should be retained in the BIDS participant file

To be completed by ECTU only

Data entered by (initials)

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Date

D	D	M	M	Y	Y
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