
THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
SCRIPTA
MANET
★ 1934 ★

NINCDS COLLABORATIVE
PERINATAL PROJECT
A User's Guide to the Project and Data

Volume II: Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part E: Neonatal Exams and Observations

December 1983

Prepared for
the National Institute of Neurological
and Communicative Disorders and Stroke
under Contract 2311105150

Battelle
Pacific Northwest Laboratories

LEGAL NOTICE

This report was prepared by Battelle as an account of sponsored research activities. Neither Sponsor nor Battelle nor any person acting on behalf of either:

MAKES ANY WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED, with respect to the accuracy, completeness, or usefulness of the information contained in this report, or that the use of any information, apparatus, process, or composition disclosed in this report may not infringe privately owned rights; or

Assumes any liabilities with respect to the use of, or for damages resulting from the use of, any information, apparatus, process, or composition disclosed in this report.

NINCDS COLLABORATIVE PERINATAL PROJECT: A USER'S GUIDE TO THE PROJECT AND DATA

Volume II. Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File

Part E. Neonatal Exams and Observations

NR Hinds
A Brix
JS Littlefield
CR Watson

December 1983

Prepared for
National Institute of Neurological
and Communicative Disorders and Stroke
under Contract 2311105150

Battelle
Pacific Northwest Laboratories
Richland, Washington 99352

INTRODUCTION

DOCUMENT OBJECTIVES AND READER ASSUMPTIONS

Volume II, Project Study Forms and Documentation of Transfer to Computerized Data Items in Master File, provides researchers with detailed documentation for how data were collected, coded and stored on the data base. Volume II will help investigators decide: if data were collected in a suitable way for addressing particular research questions; if revision of forms affected the collection of specific data items; if data were coded on master, variable or work files, or are available only on microfilm. The reader is assumed to be the principal investigator for a project in which data from the data base will be used.

DOCUMENT STRUCTURE

Because of its size, this volume is divided into ten separate parts, each containing material on a group of forms related by subject. Each part groups together similar study forms. Generally, a part covers a single time period. The parts do not correspond exactly to the hierarchical classification structure described in Volume I. The parts of Volume II include:

A. Prenatal Record and Medical History
B. Labor and Delivery
C. Pathological Exams and Autopsies
D. Family and Socioeconomic History
E. Neonatal Exams and Observations
F. Pediatric and Neurological Exams, Four Months - One Year
G. Pediatric Neurological Exams, Seven Years
H. Psychological Exams, Eight Months
I. Psychological Exams, Four Years and Seven Years
J. Speech, Language and Hearing Exams, Three Years and Eight Years (Final)

This part of Volume II contains Part E: Neonatal Exams and Observations and includes Forms PED-1, PED-2, PED-3, PED-4 (ADM-44), PED-5, PED-6, PED-7 and PED-8.

To allow easy access to the data as they appear on the master file, all documentation for each form or form grouping representing a card series on the master file is identified by form number appearing at the bottom of each page. Forms are arranged in what may appear to be illogical numerical order in some cases, but the arrangement presented here ties forms and their revisions together and allows an investigator to trace an item through all revision cycles. Thus, in Part A of Volume II, OB-42 follows OB-9 and OB-10 appears next to OB-44 and OB-45. (For an explanation of how the master file was organized to result in this ordering, see the next section of the Introduction.)

All material related to a form is organized as a single unit within each part of Volume II. The material included for each form is given below in the order it appears:

- Descriptive Summary of Form. Includes purpose of form, history of use, revisions and location of records stored on Master File. A table is provided for each form (except those on microfilm only) showing the number of records available for each revision.
- Data Items Referencing Form. A list of all data items in computer files originating from form. List ordered by data item identification with reference to item number on form.
- Form. Copy of last revision of form.
- Form item numbers linked to data items. A list organized by form item numbers of all computerized data items originating from the form.
- Definition of codes. Coding instructions detailing the codes assigned to each computerized data item from the form.
- Master File Card Image. Illustrates transfer of data on form to Master File card.
- Instructions for Completing Form. The instructions used by study personnel to complete the form for each case.
- Earlier Forms or Manuals. Copies of earlier versions of forms or manuals that were used during the study.

MASTER FILE ORGANIZATION AND REVISION OF FORMS

Some understanding of how the master file was organized should aid investigators who want to trace the entry of data into computerized study files. The numbering system used both on forms and cards provides information on how data may be retrieved from the master file.

Forms

The first forms used in the study were the OB forms; as a consequence, this group of forms underwent the most revision. At first glance, it appears that forms disappear from the file and reappear in strange or bewildering places. In actuality, revisions were made according to a specific method.

Two types of revision and subsequent recodes appear in the master file, both of which appear in the OB series. In the first type of revision, radical changes in the concept of a form created a need for new coding in the computer file. Form OB-9, for example, was replaced by forms OB-40 (an optional form retained by the institution), OB-42, and OB-43 in April 1962. Data for earlier patients were recorded on OB-9 and entered on cards 1309, 2309, 3309 and 4309 of the master file; after April 1962, data was recorded on OB-42 and OB-43 and were entered on cards 0342, 1343 and 2343 of the master file.

In the second type of revision, the Collaborative Perinatal Task Force considered revisions important enough to warrant the distinction of a new form number, but considered the data for both forms to be similar enough to allow combining of data from both the old and new forms on the same card series. An example of this type of revision is form OB-35, replaced by OB-57 in April 1962. Records for both OB-35 and OB-57 are entered on cards 0357, 1357, 2357, 3357, 4357, and 5357 in the master file.

In assigning numbers to forms and their revisions, designers of the study followed a plan: prenatal records, history, and summaries of the prenatal period received numbers 1 through 15; when revised, these forms were assigned numbers in the forties. Labor and hospital records appeared on the 30 series of forms. When these forms were revised, they were assigned numbers in the fifties. Some OB data in the master file were abstracted by NINCDS staff members from forms filled out at the hospital. Cards derived from this procedure were designated as coming from forms ADm-49, 50 and 51 (which were actually ABSTRACT SHEETS). Autopsy protocol and laboratory exams of the placenta were recorded on forms PATH-1, PATH-2 and PATH-3.

Forms for recording family health history and genetic information during pregnancy also received a fair amount of revision. Early records appear on forms FHH-1,2,3 and 4. With revisions in April 1963, form SE-1 replaces part of FHH-1 and FHH-3; FHH-2, FHH-4 and parts of FHH-1 and FHH-3 were replaced by

forms GEN-5 through GEN-8 in May 1961. Form FHH-9, initiated in November 1965 for collection of socioeconomic data at time the child was seven years of age, was not replaced or revised.

The PED series of forms underwent little revision. Records for newborn babies appeared in PED-1 through PED-8; records for children up to age one and interval records were placed on PED-10 through PED-29. Seven year records were included in the series numbered PED-74 and up. Only one pediatrics form was radically revised: PED-7 was replaced by PED-8 in March 1963.

No replacements occur in the PS series, where results of psychological and speech, language and hearing tests were recorded. The PS forms are divided into distinct groups based on time of testing and subject of testing. Psychological testing occurred at 8 months, 4 years and 7 years; speech, language and hearing exams were administered at ages 3 and 8. Only the 8 month psychological examination underwent substantial revisions.

Master File Card Number and NINDB Case Number Rationale

Computer cards for each NCPP study form are numbered to reflect their origin and possible revisions. Card numbers are assigned to identify the type of data (subject), the presence of multiple cards in a series, NCPP study form and form revisions. The first five digits of each card on the master file are the card number. The study forms and card numbers are given in Figure 1.

The first fourteen columns of each master file computer card contain the master file card number and the NINDB case number. Table 1 identifies the function of each of these columns.

Column 1 identifies multiple cards in a series. It contains a zero for cards unique to a particular form (that is, no other cards are present), for example OB-3, or for cards where repetitive data are contained. Cards for OB-2 are an example of this second type; no new categories of information are included on successive cards, but previous births in excess of four must be recorded on an add-on card. For card series where data entered are unique to a card and more than one card is required to complete the series, a "1" is used to designate the first card, for example CD-5. OB-57, PATH-2 and PED-14 are exceptions to these rules.

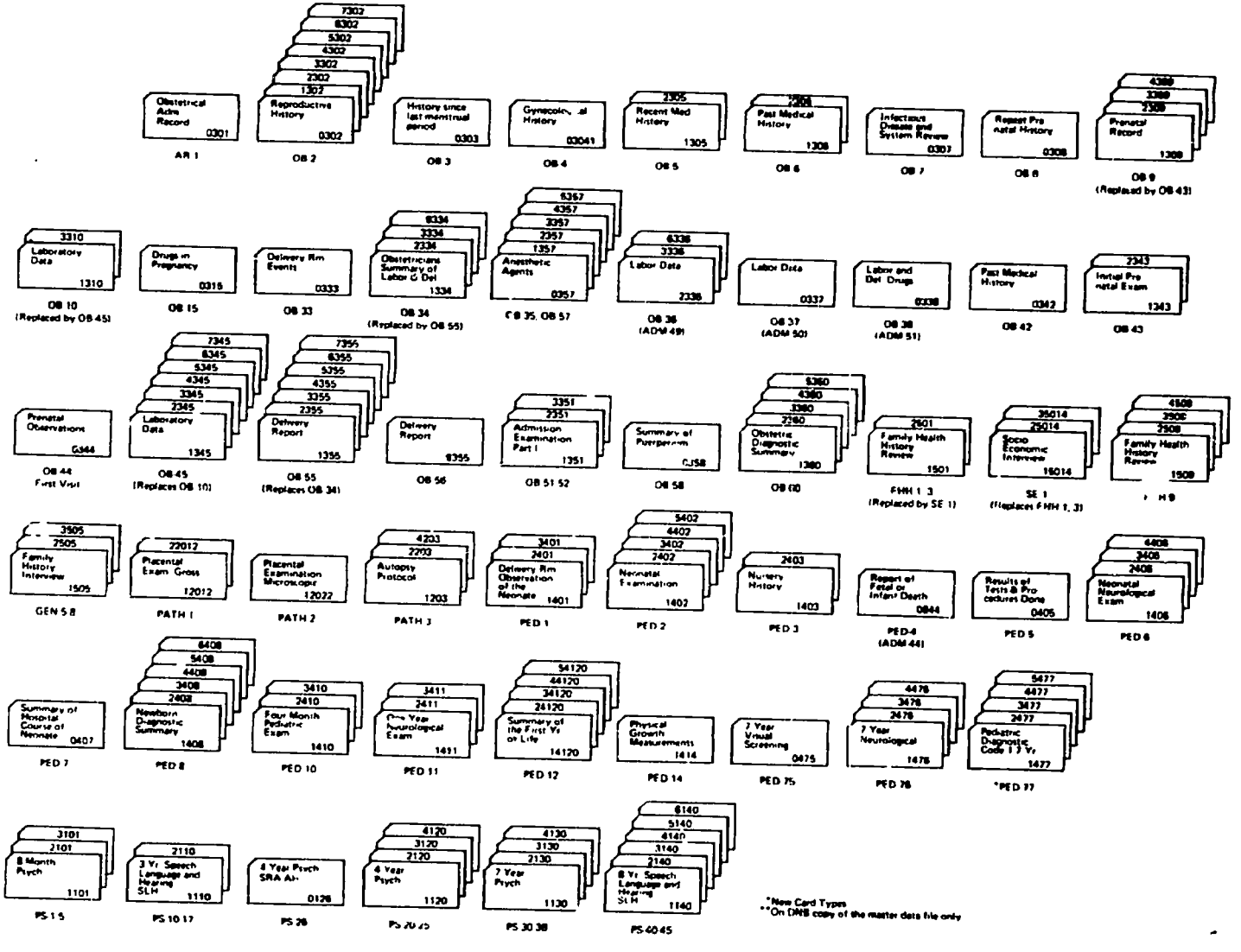


FIGURE 1. Cards on the Master Data File

TABLE 1. Derivation of Master File Card Number and NINDB Case Number.

Contents	Columns
Master File Card Number	
card identifier	1
general subject matter	2
form number	3-4
revision code	5
NINDB Case Number	
collaborating institution	6-7
type of patient selection	8
gravida identification number	9-12
order of the pregnancy	13
identifies child or gravida	14

The second digit on the card reveals the general subject matter covered by data on the card. All cards containing information pertaining to obstetrics, for example, are designated by a "3" in column 2; family histories are designated by a "5"; pathology with a "2"; pediatrics, with a "4"; and psychological testing with a "1".

Columns three and four reveal the form number. In the case of forms where old and new forms having different numbers are included together, the number of the latest form appears on the master file. This rule does not apply to data abstracted from several forms by NINCDS staff (ADM forms).

Column 5 of the card contains a revision code indicating which form or combination of forms was used in arriving at data on a particular card. A typical card will have one to three revision codes, with a zero indicating the first version of a form and "1", "2", and "3" indicating later revisions. As a rule, revision codes used on cards differ from card to card; investigators should check the definition of codes provided in Volume II to determine the meaning of revision codes used.

Each woman and child studied in the project received a unique case number (NINDB case number) composed of nine digits, recorded in columns 6 through 14 of all master file cards. The case number identified the institution, the mother and the child. The first two digits represented the collaborating institution (see Table 2). The third digit indicated the type of patient

selection. A "1" was used for patients selected for the central core study; a "6" indicated that a patient had been transferred from one institution to another, and a "7" indicated that the patient was part of a special study undertaken by the collaborating institution. The fourth through seventh digits were used to identify the gravida, while the eighth digit identified the order of the pregnancy of a given gravida in the project. The ninth digit was used to identify the gravida or child of the pregnancy; "9" indicated the gravida, "0" indicated the child of a single birth, "1" indicated the first child of a multiple birth, "2" indicated the second child of a multiple birth, etc.

TABLE 2. Collaborating Institutions and Their Code Number (Columns six and seven of all master file cards.)

05 - Boston, Massachusetts
Harvard Medical School
Boston Lying-In Hospital
Children's Hospital Medical Center

10 - Buffalo, New York
University of Buffalo
Children's Hospital

15 - New Orleans, Louisiana
Charity Hospital
Tulane University School of Medicine Medical Center
Louisiana State University

31 - New York, New York
Columbia University College of Physicians & Surgeons
Columbia-Presbyterian Medical Center

37 - Baltimore, Maryland
The Johns Hopkins University School of Medicine
The Johns Hopkins Hospital

45 - Richmond, Virginia
Virginia Commonwealth University
Medical College of Virginia

50 - Minneapolis, Minnesota
University of Minnesota Hospital
Health Sciences Center

55 - New York, New York
New York Medical College
Metropolitan Hospital

60 - Portland, Oregon
University of Oregon
Medical School

66 - Philadelphia, Pennsylvania
University of Pennsylvania
Pennsylvania Hospital
The Children's Hospital of Philadelphia

71 - Providence, Rhode Island
Brown University
Child Study Center

82 - Memphis, Tennessee
University of Tennessee College of Medicine
Gailor Hospital

Data Item Identification and Naming

The NCPP data base contains over 6700 different data items and blank filler locations on computer files. We have assigned each of these a unique identification and a terse, stylized name. Because names were chosen to facilitate use of this guide, they do not duplicate names used by NINDB during the active phase of the project. Users should consult appropriate documentation before using data items from the master, variable or work files (Volumes II, III and IV).

The data item identifiers consist of 11 characters. At the far left are four unique numbers that were assigned sequentially. The next character is always a period and is followed by up to six characters. For data items on the master file, these characters describe the data collection form from which a data item was derived; for data items on the variable (VAR) or work (WXX) files, these characters indicate the appropriate file. If the right side is less than six characters, periods are inserted as shown in these examples:

850..OB-34	an item from OB-34; on the master file
3650.PATH-3	an item from PATH-3; on the master file
5223....VAR	an item on the variable file
6340...W-10	an item on work file 10, Rupture of Membranes

We assigned the numbers sequentially as they appear in Volume V. For the master file, we followed the order in which the cards would be found within an NINDB case. All card columns are accounted for by one of our data item identifications. For the variable and work files, the numbers were assigned in the order that data items appear within a case.

We categorized each data item according to the person to whom the data refer, by the time of measurement and/or the time to which the item applies and by general type or subject area (Table 3). Then we assigned names to the data items using the following guidelines:

- The name and the three associated categories had to stand alone - they must describe the data item out of context.
- The first word in the data item name had to be an important or key word when all names were listed alphabetically as in Volumes VI and VII. Thus "cry, abnormal" was used rather than "abnormal cry" because a

researcher is more likely to look for this item under "C" than under "A" in an alphabetic list.

- Secondary key words were preceded with a semicolon to facilitate preparation of the permuted index. For example, "abruptio; placenta" will be found under both the "A" and "P" portion of Volume VI.

- Qualifying words are delimited by commas and will not appear as keywords in Volume VI. Thus "abruptio; placenta, degree" will not be found in the "D" section.

- If medical terminology or usage has changed since the study was conducted, modern terms may be included and will be enclosed in brackets. Thus "mongolism; [Down's syndrome]" will appear under both the "M" and "D" portions of Volume VI.

- If measurement units are associated with a data item name, they are enclosed in parentheses and placed at the end of the name as in "Birthdate (yr)."

- The categories (person, time and subject) are appended to the right of the data item name.

Definitions for each category used in naming data items are given in Table 4 at the end of this introduction. Additional information is found in Chapter 4 of Volume I.

Data item names thus assigned are terse and highly stylized; as we have already indicated, they are <u>not</u> the names used by NINDB during the active phase of the project. Our aim was to develop standardized names that would stand alone. These names are intended to facilitate a user's search for data items potentially useful in a research project. Before an item is used, a researcher should consult its complete description. For a data item from the master files, e.g., 850..OB-34, the data item should be traced to the appropriate study form, e.g., OB-34, located in Volume II. A variable file data item, e.g., 5223....VAR, is traced to Volume III, where it is defined and its original source given. A data item from a work file is traced to Volume IV for its description.

Some data items contained in the indexes may include the notation "DO NOT USE." These items are either inaccurate or an alternative data item is available that gives better information. Users will find more appropriate data items by consulting one of the indexes to the data items (Volumes, V, VI and VII).

Tables of Data Items: Column Headings

For each form, two sets of computer generated pages list all data items in either the master, variable or work files derived from this form. These lists enable a user to track form items to computerized data items listed in other volumes of the User's Guide and vice versa. The computer listings have the following information.

Column Heading	Description
DATA ITEM ID	A unique identifier for this data item. See Data Item Identification and Naming above for details.
ITEM ON FORM	An identifier used on the NCPP study form to identify the question or group of questions which was used to generate this data item.
CARD NUM	Identifies the master file card on which this data item is located. See Master File Card Number and NINDB Case Number Rationale above for a description of card number.
FROM	Beginning card column for this data item.
TO	Ending card column for this data item.
DATA ITEM NAME	Terse stylized name for this data item. See Data Item Identification and Naming above for details.

ASSOCIATED DOCUMENTS

By examining the tables provided for each, investigators will be able to determine which computer files contain data of interest. For data contained in the variable file, see Volume III of this guide; for data contained in work files, see Volume IV.

TABLE 3. Abbreviations for Person, Time and Subject Categories

Person	Time	Subject
Mother	General	Administrative
Father	Preconception	Anesthesia
Placenta	Registration	Clin. Impression
Fetus	Prenatal	Clinical Lab
Child	Admission	Current Pregnancy
M Surrogate	Intrapartum	Environ. Exposure
Family	Delivery	Events
Sibship	Post Partum	Hearing
	Neonatal	Hospitalizations
	Four month	Language
	Eight month	Linkage
	One year	Malformations
	Three year	Diag. & Cond.
	Four year	Med. History
	Seven year	Medications
	Eight year	Neurological Exam
		Observations
		Pathology
		Physical Exam
		Procedure
		Psych. Exam
		Reproductive Hist.
		Serology
		Socioecon. Info
		Speech
		Vision
		Work History
		X-ray
		Summary
		Gyn. History
		Special Studies
		Fam/Genetic Hist.
		SLH Exam

TABLE 4. Definition of Person, Time and Subject Categories

PERSON	DEFINITION
Mother	Study registrant bearing the "study pregnancy"; biologic mother of the "study child"; gravida.
Father	Biologic father of the study child or study pregnancy; in the case of socioeconomic data, this category may indicate either the "father of baby" (not necessarily husband of the mother) or the "husband" (not necessarily related biologically to the study child).
Placenta	The organ of metabolic and gaseous interchange between the fetus and mother; also included in this category are gross and microscopic pathologic data from examination of the umbilical cord.
Fetus	Conceptus; the product of conception including the embryonic stage, i.e., from conception to the moment of birth.
Child	Product of the study pregnancy from the moment of birth onward; study child.
M Surrogate	Person or persons substituting for the mother of a study child, e.g., adoptive parents, foster parents or guardian.
Family	Person or persons biologically related to the mother or father of the study child.
Sibship	Child or children having one or both of the same biologic parents as the study child; siblings; half siblings; full siblings.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

TIME	DEFINITION
General	Data with no pertinent time period or data pertaining to more than one time period.
Preconception	Data pertaining to the period prior to conception of the study pregnancy.
Registration	Data collected at the time of study mother's registration in the study.
Prenatal	Data pertaining to the period from conception of the study pregnancy to delivery of the study child.
Admission	Data collected at the time of study mother's admission to the hospital for delivery of the study child.
Intrapartum	Data pertaining to the period from admission for delivery or onset of labor to delivery of the study child.
Delivery	Data pertaining to the time period during which delivery of the study child occurred.
Post Partum	Data (pertaining to the study mother) collected during the period immediately following birth of the study child.
Neonatal	Data pertaining to the study child during the period from birth to one month of age; the majority of these data were collected prior to or at the time a study child was discharged from the hospital.
Four Month	Data collected at the time of the four month examination of the study child.
Eight Month	Data collected at the time of the eight month examination of the study child.
One Year	Data collected at the time of the one year examination of the study child.
Three Year	Data collected at the time of the three year examination of the study child.
Four Year	Data collected at the time of the four year examination of the study child.
Seven Year	Data collected at the time of the seven year examination of the study child.
Eight Year	Data collected at the time of the eight year examination of the study child.

TABLE 4. Definition of Person, Time and Subject Categories (Cont.)

SUBJECT	DEFINITION
Administrative	Data pertaining to the administrative aspects of the study.
Anesthesia	Data on medications and procedures used to obtain anesthesia.
Clin. Impression	Impression of abnormality or dysfunction gained by an examiner following evaluation of clinical signs and symptoms and including a subjective component.
Clinical Lab	Data obtained from laboratory examination of clinical specimens.
Current Pregnancy	Personal data and medically relevant information pertaining to the study pregnancy for which the mother is enrolled.
Environ. Exposure	Data on exposure to occupational or other environmental entities or hazards.
Events	Data related to a specific event, occurrence or incidence.
Hearing	Data obtained from examination and testing of hearing function.
Hospitalizations	Data on specific hospital admissions or the number of hospitalizations.
Language	Data obtained from examination and testing of language function.
Linkage	Data on the genetic relationships of family members to the study mother, father or child.
Malformations	Data on the conditions in which failure of normal development has resulted in abnormal physical traits existing at the time of birth.
Diag. & Cond.	Data on specific diagnoses or conditions obtained from past medical history or examination during the study.
Med. History	Data obtained from the study participant or medical records relevant to past or current medical diagnoses or conditions.
Medications	Data on drugs or medications used.
Neurological Exam	Data obtained from observation and physical examination of the central nervous system.
Observations	Data obtained from observations not categorized elsewhere.
Pathology	Data obtained from clinical and anatomical pathological examination.
Physical Exam	Data obtained from physical examination of the study participant.
Procedure	Data relating to specific procedures performed on the study participant prior to or during the period of enrollment in the study.
Psych. Exam	Data obtained from the psychological examinations and observations.

TABLE 4. Definition of Person, Time and Subject Categories. (Cont.)

SUBJECT	DEFINITION
Reproductive Hist.	Data pertaining to the outcome of pregnancies prior to and or during the period of enrollment in the study.
Serology	Data obtained from the laboratory examination of serum by specific immunologic methods.
Socioecon. Info	Data related to the social and economic characteristics and environment of the study participant.
Speech	Data obtained from examination and observation of speech function.
Vision	Data obtained from examination of the eyes.
Work History	Data pertaining to occupation and employment prior to and during the period of enrollment in the study.
X-Ray	Data on diagnostic x rays and diagnostic or therapeutic radiological procedures.
Summary	Data presented as a summary of data collected and recorded elsewhere.
Gyn. History	Medical history specifically related to the female genital tract, reproductive physiology and endocrinology.
Special Studies	Data pertaining to participation in other special organized studies conducted during the period of enrollment in the study.
Fam/Genetic Hist.	Data on the medical histories of family members genetically related to the study child.
SLH Exam	Data obtained from the speech, language and hearing examinations not specifically or exclusively related to one of these areas.

CONTENTS

PED-1 Delivery Room Observation of the Neonate

Form PED-1 was used in recording important delivery room events observed during birth. Observations included: the sequence of events in the establishment of circulation and respiration outside the uterus; information on the functional integrity of the infant immediately following birth; possible signs of perinatal stress that couldn't be observed elsewhere; birth; and certain measurements and facts about the child. The form was first implemented in January 1959 and underwent revisions in November 1959 and in January 1961. Some cards from the master file also came from a test revision dated November 1959. Only the test revision and final form were available for inclusion here. Data from PED-1 were punched onto three cards in the master file (Table PED-1.1).

TABLE PED-1.1 Cards and Data Records by Revision for Form PED-1

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-1: Delivery Observations	1401		
		0	6,401
		1	3,938
		2	1,841
		3	42,616
			54,796
PED-1: Apgar Score	2401		
		0	6,399
		1	3,935
		2	515
		3	42,628
			53,477
PED-1: Delivery Procedures	3401		
		0	6,392
		1	3,930
		2	514
		3	42,588
			53,424
	total for form		161,697

Data Items Referencing Form PED-1, Delivery Room Observations of Neonate

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
3726.....		1401	1	5	Card number (sequence, form type, form number, revision number)
3727.....		1401	6	14	NINDB case number
3728..PED-1	4	1401	15	16	Birth date (mo)
3729..PED-1	4	1401	17	18	Birth date (day)
3730..PED-1	4	1401	19	20	Birth date (yr)
3731..PED-1	32	1401	21	21	Sex
3732..PED-1	33	1401	22	23	Birth; weight (lbs)
3733..PED-1	33	1401	24	25	Birth; weight (oz)
3734..PED-1	5	1401	26	27	Birth time (hr)
3735..PED-1	5	1401	28	29	Birth time (min)
3736..PED-1	6	1401	30	30	Cord clamped, before or after delivery
3737..PED-1	6	1401	31	32	Cord clamped, time (min)
3738..PED-1	7	1401	33	33	Breath, first, before or after delivery
3739..PED-1	7	1401	34	35	Breath, first time (min)
3740..PED-1	8	1401	36	36	Cry, first, before or after delivery
3741..PED-1	8	1401	37	38	Cry, first time (min)
3742..PED-1	9	1401	39	39	Suction, DO NOT USE, see card 03401 column 30
3743..PED-1	9	1401	40	40	Drugs; medications, DO NOT USE, see card 03401 column 31
3744..PED-1	9	1401	41	41	Oxygen administered, DO NOT USE, see card 03401 column 32-41
3745..PED-1	9	1401	42	42	Resuscitation procedures, DO NOT USE, see card 03401 column 42-51
3746..PED-1	17	1401	43	44	Physical examination, time since birth (min)
3747..PED-1	20	1401	45	45	Respiration
3748..PED-1	21	1401	46	46	Motor activity; tone
3749..PED-1	22	1401	47	47	Neck; tone
3750..PED-1	23	1401	48	48	Molding; birth
3751..PED-1	24	1401	49	49	Forceps marks
3752..PED-1	25	1401	50	50	Cord, stained/unstained
3753..PED-1	26	1401	51	52	Cord, length on body (cm)
3754..PED-1	26	1401	53	54	Cord, length on placenta (cm)
3755..PED-1	26	1401	55	56	Cord, length other (cm)
3756..PED-1	26	1401	57	58	Cord, length total (cm)
3757..PED-1	27	1401	59	59	Skin color
3758..PED-1	28	1401	60	60	Cry
3759..PED-1	29	1401	61	61	Moro; reflex
3760..PED-1		1401	62	62	Motor activity
3761..PED-1		1401	63	63	Movements; body
3762..PED-1		1401	64	64	Edema
3763..PED-1		1401	65	65	Bleeding
3764..PED-1		1401	66	67	Respiration, sustained; breath, 10th (min)
3765..PED-1		1401	68	68	Observation by study personnel
3766.....		1401	69	77	Blank
3767..PED-1		1401	78	78	Card 14012, reason

Data Items Referencing Form PED-1, Delivery Room Observations of Neonate

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
3768.....		1401	79	80	Blank
3769.....		2401	1	5	Card number (sequence, form type, form number, revision number)
3770.....		2401	6	14	NTNDB case number
3771..PED-1	4	2401	15	16	Birth date (mo)
3772..PED-1	4	2401	17	18	Birth date (day)
3773..PED-1	4	2401	19	20	Birth date (yr)
3774..PED-1	32	2401	21	21	Sex
3775..PED-1	33	2401	22	23	Birth: weight (lbs)
3776..PED-1	33	2401	24	25	Birth: weight (oz)
3777..PED-1	5	2401	26	27	Birth time (hr)
3778..PED-1	5	2401	28	29	Birth time (min)
3779..PED-1	10	2401	30	30	Apgar, heart rate, 1 minute
3780..PED-1	10	2401	31	31	Apgar, respiratory effort, 1 minute
3781..PED-1	10	2401	32	32	Apgar, muscle tone, 1 minute
3782..PED-1	10	2401	33	33	Apgar, reflex irritability, 1 minute
3783..PED-1	10	2401	34	34	Apgar, color, 1 minute
3784..PED-1	10	2401	35	36	Apgar, total score, 1 minute
3785..PED-1	10	2401	37	37	Apgar, heart rate, 2 minute
3786..PED-1	10	2401	38	38	Apgar, respiratory effort, 2 minute
3787..PED-1	10	2401	39	39	Apgar, muscle tone, 2 minute
3788..PED-1	10	2401	40	40	Apgar, reflex irritability, 2 minute
3789..PED-1	10	2401	41	41	Apgar, color, 2 minute
3790..PED-1	10	2401	42	43	Apgar, total score, 2 minute
3791..PED-1	10	2401	44	44	Apgar, heart rate, 5 minute
3792..PED-1	10	2401	45	45	Apgar, respiratory effort, 5 minute
3793..PED-1	10	2401	46	46	Apgar, muscle tone, 5 minute
3794..PED-1	10	2401	47	47	Apgar, reflex irritability, 5 minute
3795..PED-1	10	2401	48	48	Apgar, color, 5 minute
3796..PED-1	10	2401	49	50	Apgar, total score, 5 minute
3797..PED-1	10	2401	51	51	Apgar, heart rate, 10 minute
3798..PED-1	10	2401	52	52	Apgar, respiratory effort, 10 minute
3799..PED-1	10	2401	53	53	Apgar, muscle tone, 10 minute
3800..PED-1	10	2401	54	54	Apgar, reflex irritability, 10 minute
3801..PED-1	10	2401	55	55	Apgar, color, 10 minute
3802..PED-1	10	2401	56	57	Apgar, total score, 10 minute
3803..PED-1	10	2401	58	58	Apgar, heart rate, 15 minute
3804..PED-1	10	2401	59	59	Apgar, respiratory effort, 15 minute
3805..PED-1	10	2401	60	60	Apgar, muscle tone, 15 minute
3806..PED-1	10	2401	61	61	Apgar, reflex irritability, 15 minute
3807..PED-1	10	2401	62	62	Apgar, color, 15 minute
3808..PED-1	10	2401	63	64	Apgar, total score, 15 minute
3809..PED-1	10	2401	65	65	Apgar, heart rate, 20 minute
3810..PED-1	10	2401	66	66	Apgar, respiratory effort, 20 minute

Data Items Referencing Form PED-1, Delivery Room Observations of Neonate

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
3811..PED-1	10	2401	67	67	Apgar, muscle tone, 20 minute
3812..PED-1	10	2401	68	68	Apgar, reflex irritability, 20 minute
3813..PED-1	10	2401	69	69	Apgar, color, 20 minute
3814..PED-1	10	2401	70	71	Apgar, total score, 20 minute
3815.....		2401	72	80	Blank
3816.....		3401	1	5	Card number (sequence, form type, form number, revision number)
3817.....		3401	6	14	NINDB case number
3818..PED-1	4	3401	15	16	Birth date (mo)
3819..PED-1	4	3401	17	18	Birth date (day)
3820..PED-1	4	3401	19	20	Birth date (yr)
3821..PED-1	32	3401	21	21	Sex
3822..PED-1	33	3401	22	23	Birth: weight (lbs)
3823..PED-1	33	3401	24	25	Birth: weight (oz)
3824..PED-1	5	3401	26	27	Birth time (hr)
3825..PED-1	5	3401	28	29	Birth time (min)
3826..PED-1	9	3401	30	30	Suction
3827..PED-1	9	3401	31	31	Drugs: medication
3828..PED-1	9	3401	32	32	Oxygen administered, open
3829..PED-1	9	3401	33	34	Oxygen administered, open, age begun (min)
3830..PED-1	9	3401	35	36	Oxygen administered, open, duration (min)
3831..PED-1	9	3401	37	37	Oxygen or air administered, positive pressure
3832..PED-1	9	3401	38	39	Oxygen or air administered, positive pressure, age begun (min)
3833..PED-1	9	3401	40	41	Oxygen or air administered, positive pressure, duration (min)
3834..PED-1	9	3401	42	42	Intubation
3835..PED-1	9	3401	43	44	Intubation, age begun (min)
3836..PED-1	9	3401	45	46	Intubation, duration (min)
3837..PED-1	9	3401	47	47	Procedures, other
3838..PED-1	9	3401	48	49	Procedures, other, age begun (min)
3839..PED-1	9	3401	50	51	Procedures, other, duration (min)
3840.....		3401	52	80	Blank
5382....VAR	6		546	548	Cord clamped, interval time (sec)
5383....VAR	26		549	550	Cord, length (cms)
5384....VAR	26		551	552	Cord, length, categorized
5385....VAR			553	553	Records present: pediatric
5386....VAR	32		554	554	Sex
5387....VAR	10		555	555	Apgar, heart rate, 1 minute
5388....VAR	10		556	556	Apgar, respiratory effort, 1 minute
5389....VAR	10		557	557	Apgar, muscle tone, 1 minute
5390....VAR	10		558	558	Apgar, reflex irritability, 1 minute
5391....VAR	10		559	559	Apgar, color, 1 minute
5392....VAR	10		560	561	Apgar, total, 1 minute
5393....VAR			562	562	Apgar, total, 1 minute, classified
5394....VAR	10		563	563	Apgar, heart rate, 5 minute

Data Items Referencing Form PED-1, Delivery Room Observations of Neonate

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5395....VAR	10		564	564	Apgar, respiratory effort, 5 minute
5396....VAR	10		565	565	Apgar, muscle tone, 5 minute
5397....VAR	10		566	566	Apgar, reflex irritability, 5 minute
5398....VAR	10		567	567	Apgar, color, 5 minute
5399....VAR	10		568	569	Apgar, total, 5 minute
5400....VAR			570	570	Apgar, total, 5 minute, classified
5401....VAR	9		571	571	Suction
5402....VAR	9		572	572	Drugs; medications administered
5403....VAR	9		573	573	Oxygen administered, open
5404....VAR	9		574	574	Oxygen or air administered, positive pressure
5405....VAR	9		575	575	Intubation
5406....VAR	9		576	576	Procedures, other
5916....VAR			1092	1093	Outcome of study pregnancy; deaths; survivors
5918....VAR	33		1095	1098	Birth; weight (gms)
5920....VAR	0		1101	1102	Gestation at delivery (wks)
5921....VAR	4		1103	1108	Birth date; date of birth or delivery (mo/day/yr)
5935....VAR	8		1122	1122	Cry, first, before or after delivery
5986....VAR	5		1218	1221	Birth time (hr/min)
5987....VAR	7		1222	1223	Breath, first, time before/after delivery (min)
5988....VAR	23		1224	1224	Molding; birth
5989....VAR	24		1225	1225	Forceps marks
5990....VAR	25		1226	1226	Cord, stained / unstained
5993....VAR	10		1231	1231	Apgar heart rate, 10 minute
5994....VAR	10		1232	1232	Apgar respiratory effort, 10 minute
5995....VAR	10		1233	1233	Apgar muscle tone, 10 minute
5996....VAR	10		1234	1234	Apgar reflex irritability, 10 minute
5997....VAR	10		1235	1235	Apgar color, 10 minute
5998....VAR	10		1236	1237	Apgar total, 10 minute
5999....VAR			1238	1238	Apgar total, 10 minute, classified
6000....VAR	10		1239	1239	Apgar heart rate, 15 minute
6001....VAR	10		1240	1240	Apgar respiratory effort, 15 minute
6002....VAR	10		1241	1241	Apgar muscle tone, 15 minute
6003....VAR	10		1242	1242	Apgar reflex irritability, 15 minute
6004....VAR	10		1243	1243	Apgar color, 15 minute
6005....VAR			1244	1245	Apgar total, 15 minute
6006....VAR			1245	1245	Apgar total, 15 minute, classified
6007....VAR	10		1247	1247	Apgar heart rate, 20 minute
6008....VAR	10		1248	1248	Apgar respiratory effort, 20 minute
6009....VAR	10		1249	1249	Apgar muscle tone, 20 minute
6010....VAR	10		1250	1250	Apgar reflex irritability, 20 minute
6011....VAR	10		1251	1251	Apgar color, 20 minute
6012....VAR	10		1252	1253	Apgar total, 20 minute
6013....VAR			1254	1254	Apgar total, 20 minute, classified

Data Items Referencing Form PED-1, Delivery Room Observations of Neonate

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
6014....VAR	21		1255	1255	Motor activity; tone (revision 3)
6015....VAR	27		1256	1256	Skin color
6016....VAR	28		1257	1257	Cry, present / absent / abnormal / unknown
6017....VAR	27		1258	1258	Motor Activity, neonate
6035....VAR	8		1279	1280	Cry, first, before or after delivery, time (mins)
6162....VAR	4-5		1457	1460	Rupture of membranes, interval; INACCURATE DO NOT USE
6330...W-10	4		12	17	Birth date (mo/day/yr)
6331...W-10	5		18	20	Birth time (hr/min)

REV. 1/61

DELIVERY ROOM OBSERVATION OF THE NEONATE

2. OBSERVED BY | 3. TITLE OR POSITION

4. DATE OF BIRTH Mo. | Day | Year | 5. TIME OF BIRTH (24-hr clock)

Time all events below as age before or after delivery

		Age Began	Age Ended
6. CORD CLAMPED (Age) Min. Sec. ☐ Before Delivery ☐ After Delivery	9. PROCEDURES (Omit uncomplicated oral-pharyngeal suction) ☐ 0 None ☐ 1 Gastric Suction ☐ 2 Tracheal Suction ☐ 3 Drugs (Give type & Dose) ☐ 4 Open Oxygen ☐ 5 Positive Pressure Oxygen or Air ☐ 6 Intubation ☐ 9 Other (Specify)	Min.	Min.
7. FIRST BREATH (Age) Min. Sec. ☐ Before Delivery ☐ After Delivery		Min.	Min.
8. FIRST CRY (Age) Min. Sec. ☐ Before Delivery ☐ After Delivery		Min.	Min.

10. APGAR SCORE (*Score infant at 1, 2 and 5 minutes of age. If score of 8 is not attained, score at 10, 15 and 20 minutes.*)

				11.	12.	13.	14.	15.	16.
			1) AGE AT TIME OF SCORING	Min. Sec.	Min. Sec.	Min. Sec.	Min. Sec.	Min. Sec.	Min. Sec.
2) HEART RATE	0 – Absent	1 – Slow – Less Than 100	2 – 100 or over						
3) RESPIRATORY EFFORT	0 – Absent	1 – Weak Cry, Hypoventilation	2 – Crying Lustily						
4) MUSCLE TONE	0 – Flaccid	1 – Some Flexion Extremities	2 – Well Flexed						
5) REFLEX IRRITABILITY	0 – No Response	1 – Some Motion	2 – Cry						
6) COLOR	0 – Blue Pale	1 – Blue Hands and Feet	2 – Entirely Pink						
			7) TOTAL						

PHYSICAL EXAMINATION

17. Begun at _____ min. of age | 18. EXAMINED BY | 19. TITLE OR POSITION

20. RESPIRATION ☐ 0 Normal ☐ 9 Other

21. MOTOR ACTIVITY AND TONE ☐ 0 Normal and Symmetrical ☐ 9 Other

22. TONE OF NECK ☐ 0 Normal and Symmetrical ☐ 9 Other

23. MOLDING ☐ 0 Absent or Minimal ☐ 1 Moderate or Marked

24. FORCEPS MARKS ☐ 0 Absent ☐ 1 Present

25. UMBILICAL CORD ☐ 0 Unstained ☐ 1 Stained

26. LENGTH OF CORD (*Include all segments*)

On Body _____ Cm. Other _____ Cm.

On Placenta _____ Cm. Total _____ Cm.

27. SKIN (*Acute or transient findings*)

☐ 0 Normal (*Including peripheral cyanosis*)
☐ 1 Pallor ☐ 3 Petechiae
☐ 2 General Cyanosis ☐ 4 Stained
☐ 5 Other

28. CRY

☐ 0 Present
☐ 1 Present, Abnormal
☐ 2 Absent After Maximal Stimulation

29. MORO REFLEX

☐ 0 Flexor and Extensor Components Present and Symmetrical
☐ 8 Other Pattern
☐ 9 Not Evaluated

30. COMMENTS AND OTHER FINDINGS

(Continue on CP-5, Continuation Sheet)

31. RACE (*Copy from AR-1. Optional*) ☐ 1 W ☐ 2 N ☐ 3 Or ☐ 4 PR ☐ 8 Other

32. SEX ☐ 1 Male ☐ 2 Female ☐ 9 Undetermined

33. BIRTH WEIGHT

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(PED-1) (Rev. 1-61)

Form Item Numbers linked to Data Items on PED-1, Delivery Room Observations of Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	5999....VAR		1238	1238	Apgar total, 10 minute, classified
	6005....VAR		1244	1245	Apgar total, 15 minute
	6006....VAR		1245	1245	Apgar total, 15 minute, classified
	6013....VAR		1254	1254	Apgar total, 20 minute, classified
	5393....VAR		562	562	Apgar, total, 1 minute, classified
	5400....VAR		570	570	Apgar, total, 5 minute, classified
	3763..PED-1	1401	65	65	Bleeding
	3767..PED-1	1401	78	78	Card 14012, reason
	3762..PED-1	1401	64	64	Edema
	3760..PED-1	1401	62	62	Motor activity
	3761..PED-1	1401	63	63	Movements; body
	3765..PED-1	1401	68	68	Observation by study personnel
	5916....VAR		1092	1093	Outcome of study pregnancy; deaths; survivors
	5385....VAR		553	553	Records present; pediatric
	3764..PED-1	1401	66	67	Respiration, sustained; breath, 10th (min)
0	5920....VAR		1101	1102	Gestation at delivery (wks)
4	3819..PED-1	3401	17	18	Birth date (day)
4	3729..PED-1	1401	17	18	Birth date (day)
4	3772..PED-1	2401	17	18	Birth date (day)
4	3818..PED-1	3401	15	16	Birth date (mo)
4	3771..PED-1	2401	15	16	Birth date (mo)
4	3728..PED-1	1401	15	16	Birth date (mo)
4	6330...W-10		12	17	Birth date (mo/day/yr)
4	3730..PED-1	1401	19	20	Birth date (yr)
4	3820..PED-1	3401	19	20	Birth date (yr)
4	3773..PED-1	2401	19	20	Birth date (yr)
4	5921....VAR		1103	1108	Birth date; date of birth or delivery (mo/day/yr)
4-5	6162....VAR		1457	1460	Rupture of membranes, interval; INACCURATE DO NOT USE
5	3824..PED-1	3401	26	27	Birth time (hr)
5	3734..PED-1	1401	26	27	Birth time (hr)
5	3777..PED-1	2401	26	27	Birth time (hr)
5	5986....VAR		1218	1221	Birth time (hr/min)
5	6331...W-10		18	20	Birth time (hr/min)
5	5986....VAR		1218	1221	Birth time (hr/min)
5	3825..PED-1	3401	28	29	Birth time (min)
5	3735..PED-1	1401	28	29	Birth time (min)
5	3778..PED-1	2401	28	29	Birth time (min)
6	3736..PED-1	1401	30	30	Cord clamped, before or after delivery
6	5382....VAR		546	548	Cord clamped, interval time (sec)
6	3737..PED-1	1401	31	32	Cord clamped, time (min)
7	3739..PED-1	1401	34	35	Breath, first time (min)
7	3738..PED-1	1401	33	33	Breath, first, before or after delivery

Form Item Numbers linked to Data Items on PED-1, Delivery Room Observations of Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
7	5987....VAR		1222	1223	Breath, first, time before/after delivery (min)
8	3741..PED-1	1401	37	38	Cry, first time (min)
8	3740..PED-1	1401	36	36	Cry, first, before or after delivery
8	5935....VAR		1121	1122	Cry, first, before or after delivery
8	6035....VAR		1279	1280	Cry, first, before or after delivery, time (mins)
9	3827..PED-1	3401	31	31	Drugs; medication
9	5402....VAR		572	572	Drugs; medications administered
9	3743..PED-1	1401	40	40	Drugs; medications, DO NOT USE, see card 03401 column 31
9	3834..PED-1	3401	42	42	Intubation
9	5405....VAR		575	575	Intubation
9	3835..PED-1	3401	43	44	Intubation, age begun (min)
9	3836..PED-1	3401	45	46	Intubation, duration (min)
9	3744..PED-1	1401	41	41	Oxygen administered, DO NOT USE, see card 03401 column 32-41
9	3828..PED-1	3401	32	32	Oxygen administered, open
9	5403....VAR		573	573	Oxygen administered, open
9	3829..PED-1	3401	33	34	Oxygen administered, open, age begun (min)
9	3830..PED-1	3401	35	36	Oxygen administered, open, duration (min)
9	3831..PED-1	3401	37	37	Oxygen or air administered, positive pressure
9	5404....VAR		574	574	Oxygen or air administered, positive pressure
9	3832..PED-1	3401	38	39	Oxygen or air administered, positive pressure, age begun (min)
9	3833..PED-1	3401	40	41	Oxygen or air administered, positive pressure, duration (min)
9	3837..PED-1	3401	47	47	Procedures, other
9	5406....VAR		576	576	Procedures, other
9	3838..PED-1	3401	48	49	Procedures, other, age begun (min)
9	3839..PED-1	3401	50	51	Procedures, other, duration (min)
9	3745..PED-1	1401	42	42	Resuscitaton procedures, DO NOT USE, see card 03401 column 42-51
9	3826..PED-1	3401	30	30	Suction
9	5401....VAR		571	571	Suction
9	3742..PED-1	1401	39	39	Suction, DO NOT USE, see card 03401 column 30
10	5997....VAR		1235	1235	Apgar color, 10 minute
10	6004....VAR		1243	1243	Apgar color, 15 minute
10	6011....VAR		1251	1251	Apgar color, 20 minute
10	5993....VAR		1231	1231	Apgar heart rate, 10 minute
10	6000....VAR		1239	1239	Apgar heart rate, 15 minute
10	6007....VAR		1247	1247	Apgar heart rate, 20 minute
10	5995....VAR		1233	1233	Apgar muscle tone, 10 minute
10	6002....VAR		1241	1241	Apgar muscle tone, 15 minute
10	6009....VAR		1249	1249	Apgar muscle tone, 20 minute
10	5996....VAR		1234	1234	Apgar reflex irritability, 10 minute
10	6003....VAR		1242	1242	Apgar reflex irritability, 15 minute
10	6010....VAR		1250	1250	Apgar reflex irritability, 20 minute
10	5994....VAR		1232	1232	Apgar respiratory effort, 10 minute
10	6001....VAR		1240	1240	Apgar respiratory effort, 15 minute

Form Item Numbers linked to Data Items on PED-1, Delivery Room Observations of Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
10	6008....VAR		1248	1248	Apgar respiratory effort, 20 minute
10	5998....VAR		1236	1237	Apgar total, 10 minute
10	6012....VAR		1252	1253	Apgar total, 20 minute
10	3783..PED-1	2401	34	34	Apgar, color, 1 minute
10	5391....VAR		559	559	Apgar, color, 1 minute
10	3801..PED-1	2401	55	55	Apgar, color, 10 minute
10	3807..PED-1	2401	62	62	Apgar, color, 15 minute
10	3789..PED-1	2401	41	41	Apgar, color, 2 minute
10	3813..PED-1	2401	69	69	Apgar, color, 20 minute
10	3795..PED-1	2401	48	48	Apgar, color, 5 minute
10	5398....VAR		567	567	Apgar, color, 5 minute
10	5387....VAR		555	555	Apgar, heart rate, 1 minute
10	3779..PED-1	2401	30	30	Apgar, heart rate, 1 minute
10	3797..PED-1	2401	51	51	Apgar, heart rate, 10 minute
10	3803..PED-1	2401	58	58	Apgar, heart rate, 15 minute
10	3785..PED-1	2401	37	37	Apgar, heart rate, 2 minute
10	3809..PED-1	2401	65	65	Apgar, heart rate, 20 minute
10	3791..PED-1	2401	44	44	Apgar, heart rate, 5 minute
10	5394....VAR		563	563	Apgar, heart rate, 5 minute
10	5389....VAR		557	557	Apgar, muscle tone, 1 minute
10	3781..PED-1	2401	32	32	Apgar, muscle tone, 1 minute
10	3799..PED-1	2401	53	53	Apgar, muscle tone, 10 minute
10	3805..PED-1	2401	60	60	Apgar, muscle tone, 15 minute
10	3787..PED-1	2401	39	39	Apgar, muscle tone, 2 minute
10	3811..PED-1	2401	67	67	Apgar, muscle tone, 20 minute
10	3793..PED-1	2401	46	46	Apgar, muscle tone, 5 minute
10	5396....VAR		565	565	Apgar, muscle tone, 5 minute
10	5390....VAR		558	558	Apgar, reflex irritability, 1 minute
10	3787..PED-1	2401	33	33	Apgar, reflex irritability, 1 minute
10	3800..PED-1	2401	54	54	Apgar, reflex irritability, 10 minute
10	3788..PED-1	2401	40	40	Apgar, reflex irritability, 2 minute
10	3812..PED-1	2401	68	68	Apgar, reflex irritability, 20 minute
10	3794..PED-1	2401	47	47	Apgar, reflex irritability, 5 minute
10	5397....VAR		566	566	Apgar, reflex irritability, 5 minute
10	3806..PED-1	2401	61	61	Apgar, reflex irritability, 15 minute
10	3780..PED-1	2401	31	31	Apgar, respiratory effort, 1 minute
10	5388....VAR		556	556	Apgar, respiratory effort, 1 minute
10	3798..PED-1	2401	52	52	Apgar, respiratory effort, 10 minute
10	3804..PED-1	2401	59	59	Apgar, respiratory effort, 15 minute
10	3786..PED-1	2401	38	38	Apgar, respiratory effort, 2 minute
10	3810..PED-1	2401	66	66	Apgar, respiratory effort, 20 minute
10	3792..PED-1	2401	45	45	Apgar, respiratory effort, 5 minute
10	5395....VAR		564	564	Apgar, respiratory effort, 5 minute

Form Item Numbers linked to Data Items on PED-1, Delivery Room Observations of Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
10	3784..PED-1	2401	35	36	Apgar, total score, 1 minute
10	3802..PED-1	2401	56	57	Apgar, total score, 10 minute
10	3808..PED-1	2401	63	64	Apgar, total score, 15 minute
10	3790..PED-1	2401	42	43	Apgar, total score, 2 minute
10	3814..PED-1	2401	70	71	Apgar, total score, 20 minute
10	3796..PED-1	2401	49	50	Apgar, total score, 5 minute
10	5392....VAR		560	561	Apgar, total, 1 minute
10	5399....VAR		568	569	Apgar, total, 5 minute
17	3746..PED-1	1401	43	44	Physical examination, time since birth (min)
20	3747..PED-1	1401	45	45	Respiration
21	3748..PED-1	1401	46	46	Motor activity; tone
21	6014....VAR		1255	1255	Motor activity; tone (revision 3)
22	3749..PED-1	1401	47	47	Neck; tone
23	3750..PED-1	1401	48	48	Molding; birth
23	5988....VAR		1224	1224	Molding; birth
24	5989....VAR		1225	1225	Forceps marks
24	3751..PED-1	1401	49	49	Forceps marks
25	5990....VAR		1226	1226	Cord, stained / unstained
25	3752..PED-1	1401	50	50	Cord, stained/unstained
26	5383....VAR		549	550	Cord, length (cms)
26	3753..PED-1	1401	51	52	Cord, length on body (cm)
26	3754..PED-1	1401	53	54	Cord, length on placenta (cm)
26	3755..PED-1	1401	55	56	Cord, length other (cm)
26	3756..PED-1	1401	57	58	Cord, length total (cm)
26	5384....VAR		551	552	Cord, length, categorized
27	6017....VAR		1258	1258	Motor Activity, neonate
27	6015....VAR		1256	1256	Skin color
27	3757..PED-1	1401	59	59	Skin color
28	3758..PED-1	1401	60	60	Cry
28	6016....VAR		1257	1257	Cry, present / absent / abnormal / unknown
29	3759..PED-1	1401	61	61	Moro; reflex
32	3774..PED-1	2401	21	21	Sex
32	3821..PED-1	3401	21	21	Sex
32	3731..PED-1	1401	21	21	Sex
32	5386....VAR		554	554	Sex
33	5918....VAR		1095	1098	Birth; weight (gms)
33	3822..PED-1	3401	22	23	Birth; weight (lbs)
33	3732..PED-1	1401	22	23	Birth; weight (lbs)
33	3775..PED-1	2401	22	23	Birth; weight (lbs)
33	3733..PED-1	1401	24	25	Birth; weight (oz)
33	3823..PED-1	3401	24	25	Birth; weight (oz)
33	3776..PED-1	2401	24	25	Birth; weight (oz)

DEFINITION OF CODES
DELIVERY ROOM EXAMINATION OF THE NEONATE
FORM PED-1 CARD 1401

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 401	2-4
3.	Revision Number * Code: 0 - Form Dated: 1/59 1 - Form Dated: Rev. 11/59 2 - Form Dated: Test Rev. 11/59 or delivery elsewhere ** 3 - Form Dated: Rev. 1/61	5
4.	NINDB Number Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Birth Item 4 Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given Code for unknown date-delivery elsewhere only: 0231XX *** - Month and/or day unknown	15-20
6.	Sex Item 32 Code: 1 - Male 2 - Female 3 - Undetermined 9 - Not reported	21

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0", "1", "2", and "3". Item numbers refer to Form Dated Rev. 1/61.

** A card is punched for delivery elsewhere, with information in cols. 1-25, 70 only.

*** XX = year

FIELD		CARD COLUMN
7.	**Weight** Item 33 Code: As given in pounds and ounces 99 - Unknown pounds or ounces	22-25
8.	**Time of Birth** Item 5 Code: Blank - Delivered elsewhere As given based on 24 hour clock 9999 - Not reported	26-29
9.	**Cord Clamped** Item 6 Three-digit code for: **Before or After Delivery** (col. 30) Code: Blank - Delivered elsewhere 0 - Before 1 - After 9 - Not reported **Time** (cols. 31-32) Code: Blank - Delivered elsewhere 00 - Less than one minute 01-10 - As given in minutes 99 - Not reported Additional codes reviewed and approved (cols. 31-32): 11-15, 17-21, 24, 25, 30, 34, 35, 38, 46, 60, 92	30-32
10.	**First Breath** Item 7 Code: Same as in Field 9, except: Additional codes reviewed and approved (cols. 34-35): 11-20, 22, 23, 25, 26, 31, 33-35, 52	33-35
11.	**First Cry** Item 8 Three-digit code for: **Before or After Delivery** (col. 36) Code: Same as in Field 9 col. 30 **Time** (cols. 37-38) Code: Blank - Delivered elsewhere 00 - Less than one minute 01-15 - As given in minutes 99 - Not reported Additional codes reviewed and approved (cols. 37-38): 16-28, 30, 32-36, 41, 44, 45, 48, 49, 52, 54, 55, 60, 80, 97, 98	36-38

FIELD		CARD COLUMN
12.	**Procedures** Item 9 DO NOT USE IN ANY REQUEST Suction (col. 39) Code: Blank - Reported as "other on Rev. "0" and "1", now included as code 8 in col. 42 0 - None (includes reports of bulb on Rev. "0" and "1") 1 - Gastric 2 - Tracheal 9 - Not reported Drugs (Revisions "2" and "3" only) (col. 40) Code: Blank - Not included on Rev. "0" and "1" 0 - None 1 - Drugs 9 - Not reported Oxygen (column 41) Code: Blank - Reported as "other" on Rev. "0" and "1", now included as code 8 in column 42 0 - None 1 - Open Oxygen 2 - Positive pressure 3 - Mask - Revisions "0" and "1" only 9 - Not reported Resuscitation (column 42) Code: 0 - None 1 - Intubation 8 - Other 9 - Not reported NOTE: This field is not to be used in any tabulation. Refer to card 3 for procedures.	39-42
13.	**Time of Physical Examination** Item 17 Code: Blank - Delivered elsewhere 00 - Less than one minute 01-97 - As given in minutes 98 - 98 minutes and above 99 - Not reported	43-44
14.	**Respiration** Item 20 Code: Blank - Delivered elsewhere 0 - Normal 8 - Other 9 - Not reported	45

FIELD		CARD COLUMN
15.	**Motor Activity and Tone** (Rev. "3" only) Item 21 Code: Blank - Not on Rev. "0", "1" and "2", Del. elsewhere. 0 - Normal and symmetrical 8 - Other 9 - Not reported	46
16.	**Tone of Neck** (Rev. "2" and "3" only) Item 22 Code: Blank - Not on Rev. "0", "1", Del. elsewhere 0 - Normal and symmetrical 8 - Other 9 - Not reported	47
17.	**Molding** Item 23 Code: Blank - Delivered elsewhere 0 - Absent or minimal 1 - Marked 9 - Not reported	48
18.	**Forceps Marks** Item 24 Code: Blank - Delivered elsewhere 0 - Absent 1 - Present 9 - Not reported	49
19.	**Umbilical Cord** (Rev. "3" only) Item 25 Code: Blank - Not on Rev. "0", "1" and "2", Del. elsewhere 0 - Unstained 1 - Stained 9 - Not reported	50
20.	**Length of Cord on Body** Item 26 Code: Blank - Delivered elsewhere 00 - Less than one cm. 01-97 - As given in cms. 98 - 98 cms. or over 99 - Not reported	51-52
21.	**Length of Cord on Placenta** (Rev. "2" and "3" only) Item 26 Code: Same as in Field 20, except Blank - Not on Rev. "0" and "1", Delivered elsewhere	53-54

FIELD		CARD COLUMN
22.	Length of Cord (Other) (Rev. "2" and "3" only) Item 26 Code: Same as in Field 21	55-56
23.	Length of Cord (Total) (Rev. "2" and "3" only) Item 26 Code: Same as in Field 21	57-58
24.	Skin Item 27 Code: Blank - Peripheral Cyanosis on Rev. "2", Del. elsewhere 0 - Normal 1 - Pallor 2 - General Cyanosis (Rev. "2" and "3" only) 3 - Petechaie 4 - Stained 5 - Cyanosis (Rev. "0" and "1" only) 6 - Jaundice (Rev. "0" and "1" only) 7 - Combination of codes 8 - Other 9 - Not reported	59
25.	Cry Item 28 Code: Blank - Delivered elsewhere 0 - Present 1 - Abnormal 2 - Absent (Rev. "2" and "3" only) 9 - Not reported	60
26.	Moro Reflex Item 29 Code: Blank - Delivered elsewhere 0 - Flexor and extensor symmetrical 8 - Other pattern 9 - Not evaluated	61
27.	Motor Activity (Rev. "2" only) Code: Blank - Not on Rev. "0", "1" and "3", Del. elsewhere 0 - Normal and Symmetrical 8 - Other 9 - Not reported	62

DEFINITION OF CODES (Continued)

FORM PED-1
Card 1401

FIELD		CARD COLUMN
28.	Body Movements (Rev. "0" and "1" only) Code: Blank - Not on Rev. "2" and "3", Del. elsewhere 0 - Normal 1 - Abnormal 9 - Not reported	63
29.	Generalized Edema (Rev. "0", "1" and "2" only) Code: Blank - Not on Rev. "3", Delivered elsewhere 0 - Absent 1 - Present 9 - Not reported	64
30.	Bleeding (Rev. "0", "1" and "2" only) Code: Blank - Not on Rev. "3", Delivered elsewhere 0 - Absent 1 - Present 9 - Not reported	65
31.	Tenth Breath (Rev. "1") or Sustained Respiration (Rev. "0") Code: Blank - Not on Rev. "2" and "3", Delivered elsewhere 00 - Less than one minute 01-97 - As given in minutes 98 - 98 minutes and above 99 - Not reported	66-67
32.	Observations Made by Study Personnel Code: Blank - Yes, Delivered elsewhere 1 - No (Deliv. in hosp. & observed by non-study personnel)	68
33.	Reason for 14012 Card Code: Blank - Punched from Test Rev. 11/59 1 - Delivery elsewhere	78

DEFINITION OF CODES (Continued)

FORM PED-1
Card 2401

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-29 of Card 1	2-29
3.	One Minute Apgar Item 10 Heart Rate (column 30) Code: 0 - Absent 1 - Slow 2 - 100 or over 9 - Not reported Respiratory Effort (column 31) Code: 0 - Absent 1 - Weak cry 2 - Crying Lustily 9 - Not reported Muscle Tone (column 32) Code: 0 - Flaccid 1 - Some flexion 2 - Well flexed 9 - Not reported Reflex Irritability (column 33) Code: 0 - No response 1 - Some motion 2 - Cry 9 - Not reported Color (column 34) Code: 0 - Blue pale 1 - Blue hands and feet 2 - Entirely pink 9 - Not reported. Total Score (columns 35-36) Code: 00-10 - As given 20-29 - Total as given based on incomplete data 99 - No report	30-36

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0", "1", "2", and "3". Item numbers refer to Form Dated 1/61.

FIELD		CARD COLUMN
4.	Two Minute Apgar Item 10 Code: Same as in Field 3	37-43
5.	Five Minute Apgar Item 10 Code: Same as in Field 3	44-50
6.	Ten Minute Apgar Item 10 Code: Same as in Field 3	51-57
7.	Fifteen Minute Apgar Item 10 Code: Same as in Field 3	58-64
8.	Twenty Minute Apgar Item 10 Code: Same as in Field 3	65-71

DEFINITION OF CODES (Continued)

FORM PED-1
Card 3401

FIELD		CARD COLUMN
1.	**Card Number** Code: 3	1
2.	**Basic Data** * Code: Same as in columns 2-29 of Card 1	2-29
3.	**Suction** Item 9 Code: 0 - None 1 - Gastric Suction only 2 - Tracheal Suction 9 - Not reported	30
4.	**Drugs** (Revisions "2" and "3" only) Item 9 Code: Blank - Not on Rev. "0" and "1" 0 - None 1 - Drugs 9 - Not reported	31
5.	**Open Oxygen** Item 9 Code: 0 - Not used 1 - Used 9 - Not reported	32
6.	**Open Oxygen - Begun** Item 9 Code: 00 - Under 1 minute 01-97 - Age as given in minutes 98 - 98 minutes and above 99 - Unknown or not applicable	33-34
7.	**Open Oxygen - Duration** Code: Same as in Field 6	35-36
8.	**Positive Pressure** Item 9 Code: 0 - Not used 1 - Used 9 - Not reported	37

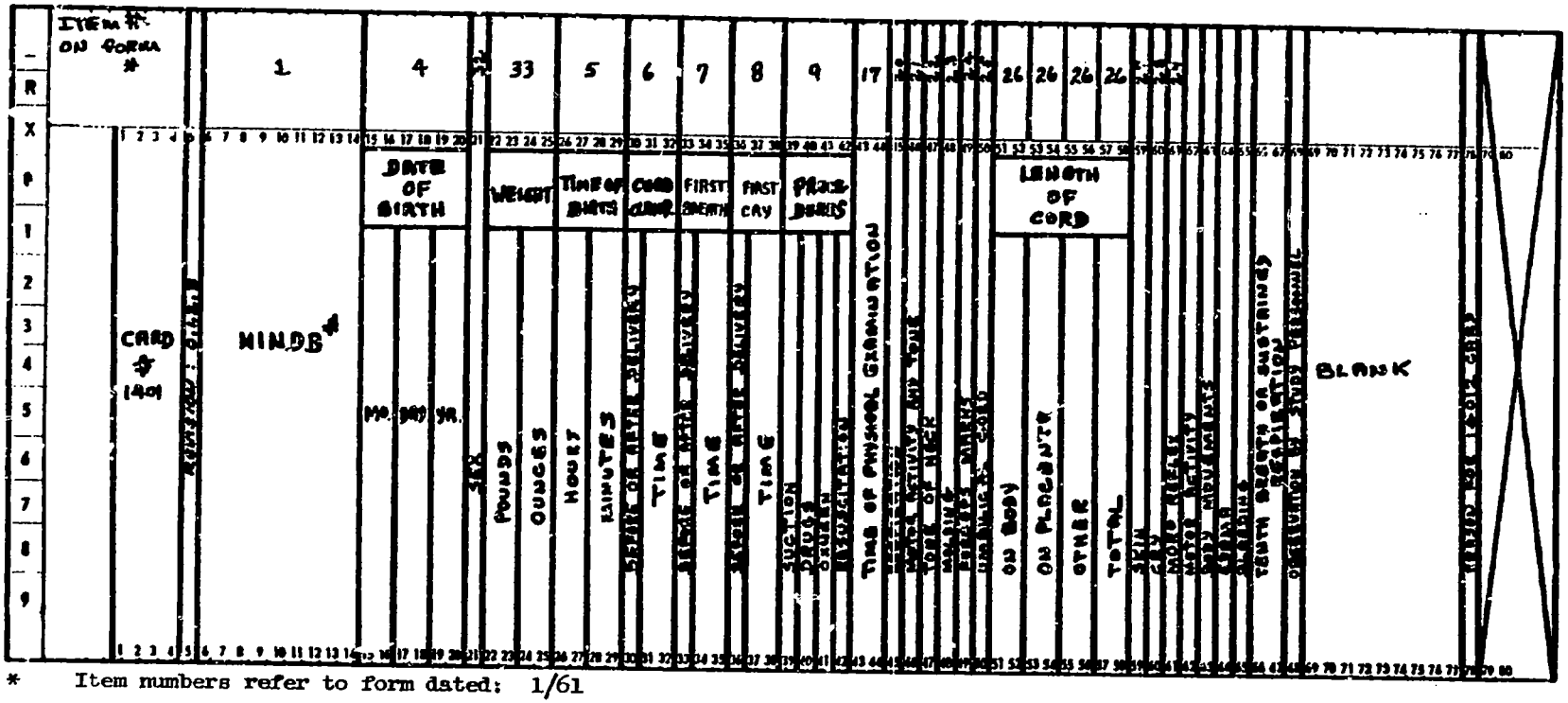
*. Unless specified, Fields, Codes and Card Columns refer to Revision Number "0", "1", "2" and "3". Item numbers refer to Form Dated: Rev. 1/61.

DEFINITION OF CODES (Continued)

FORM PED-1
Card 3401

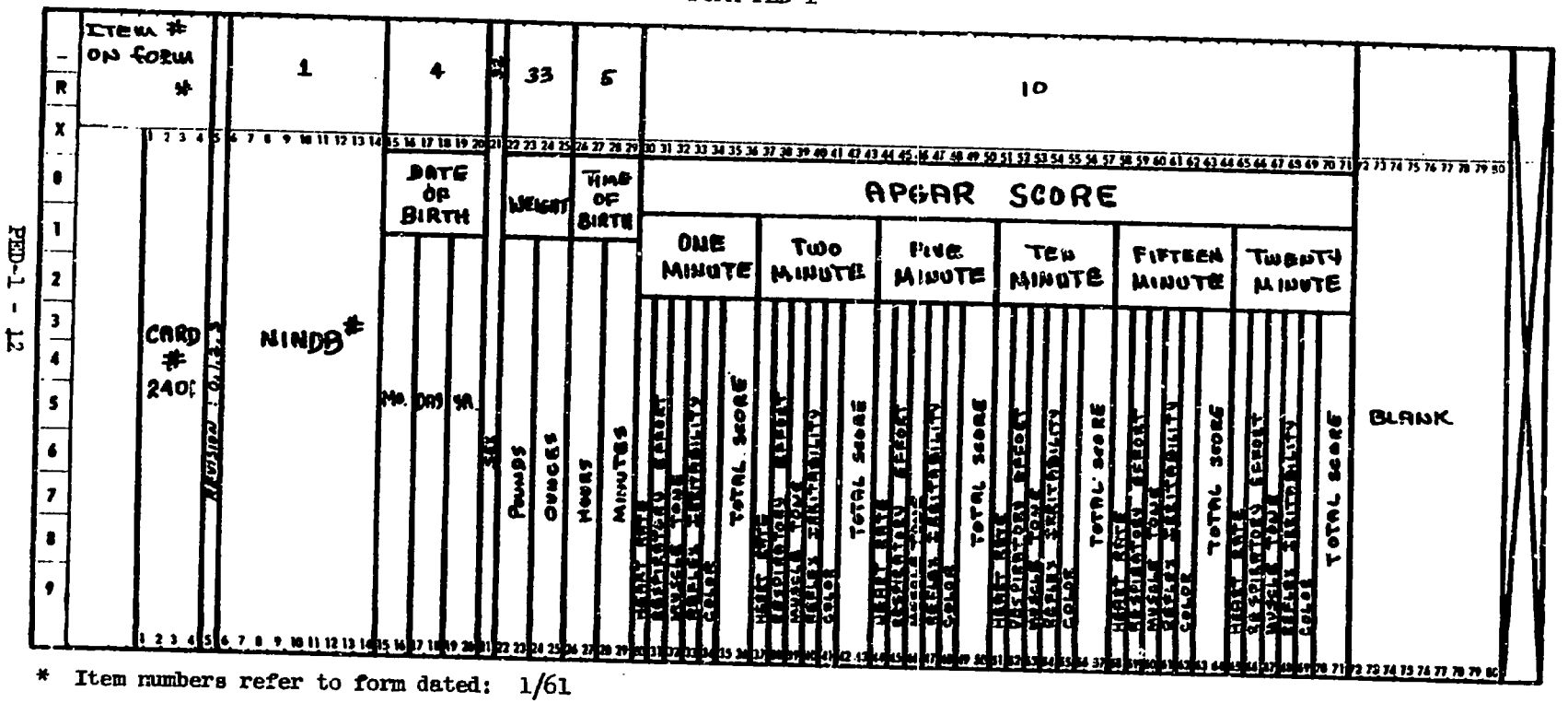
FIELD		CARD COLUMN
9.	**Positive Pressure - Begun** Item 9 Code: Same as in Field 6	38-39
10.	**Positive Pressure - Duration** Code: Same as in Field 6	40-41
11.	**Intubation** Item 9 Code: 0 - Not used 1 - Used 9 - Not reported	42
12.	**Intubation - Begun** Item 9 Code: Same as in Field 6	43-44
13.	**Intubation - Duration** Code: Same as in Field 6	45-46
14.	**Other** Item 9 Code: 0 - Not Used 1 - Used 9 - Not reported	47
15.	**Other - Begun** Item 9 Code: Same as in Field 6	48-49
16.	**Other - Duration** Code: Same as in Field 6	50-51

DELIVERY ROOM OBSERVATIONS OF THE NEONATE
FORM PED-1



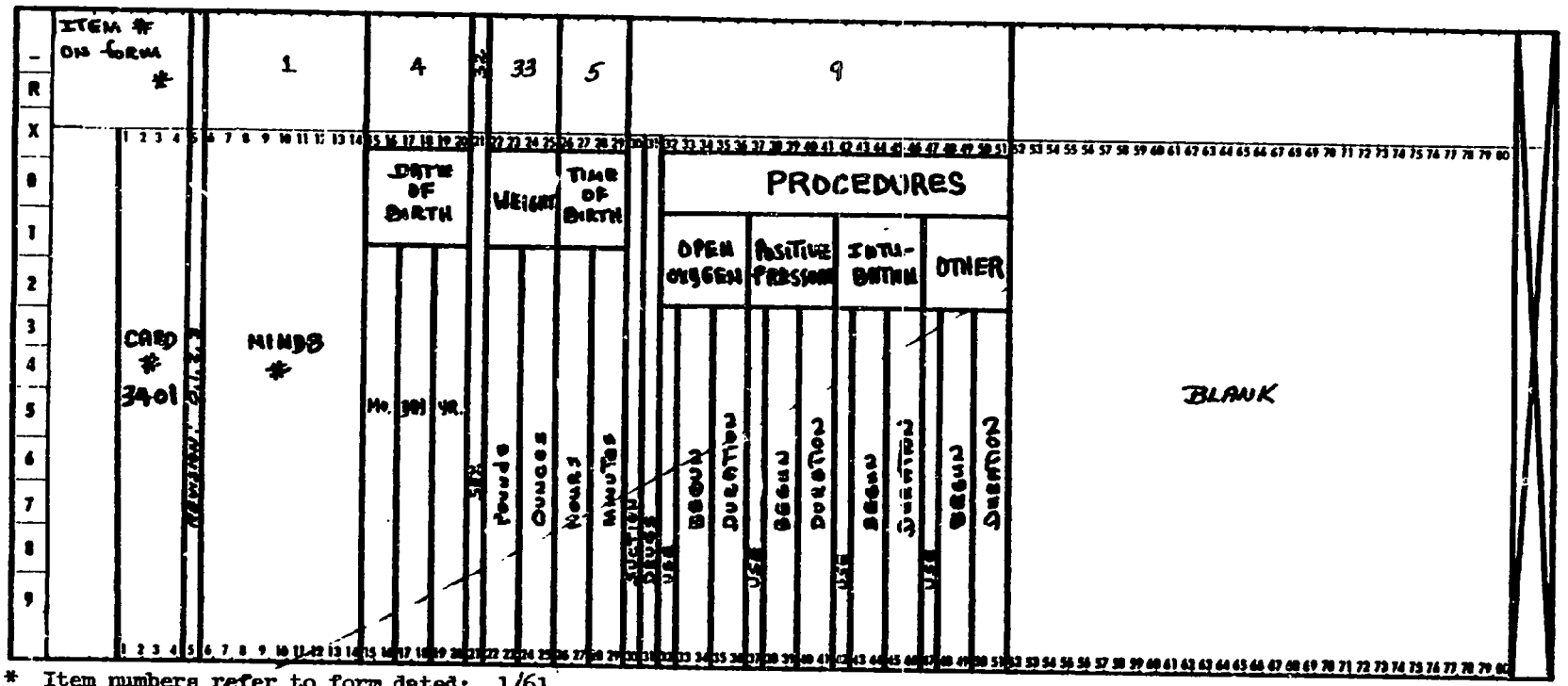
* Item numbers refer to form dated: 1/61

DELIVERY ROOM OBSERVATIONS OF THE NEONATE
FORM PED-1



* Item numbers refer to form dated: 1/61

DELIVERY ROOM OBSERVATIONS OF THE NEONATE
FORM PED-1



* Item numbers refer to form dated: 1/61

PEDIATRICS MANUAL
DELIVERY ROOM OBSERVATIONS OF THE NEONATE
(For Form PED-1, Rev. 1-61)

I. INTRODUCTION

The purposes of the Delivery Room Observations of the Neonate are:

A. To observe and record the time and sequence of events in the establishment of circulation and respiration in the extra-uterine environment.

B. To observe and record information reflecting the functional integrity of the infant immediately following the birth.

C. To observe and record possible signs of perinatal stress which cannot be observed elsewhere.

D. To observe and record potentially stressful influences operating immediately following birth.

E. To obtain and record certain measurements and facts about the child which are most conveniently obtained in the delivery room.

The PED-1 form has been provided to record the above types of information in a systematic fashion. This manual has been developed to assist in the uniform interpretation and recording of this information.

II. GENERAL INSTRUCTIONS

A. **The Examiner.** It is recommended that a nurse or a trained lay observer who does not have responsibility for other duties in the delivery room be present at the delivery and make the observations for this protocol. If no such person is available and it is necessary to employ a physician for this purpose it is essential that he be free of other responsibilities and be able to devote full attention to observing and timing the events of the first few minutes of life. The physical examination portion of this protocol should be performed by a physician or under the supervision of a physician. This is important in order that questionable findings be detected and properly classified and abnormal findings clearly described.

B. **Equipment.** The only equipment necessary for these observations are:

1. One, and preferably two, stop watches.
2. A stethescope.
3. A metric rule or tape.
4. Record form PED-1.
5. One or more sheets of record form CP-5 (Continuation Sheet).
6. Pencil or ball-point pen.

II. GENERAL INSTRUCTIONS (cont.)

C. **Timing of the Observation and Examination:** The emphasis of this examination is on accurate and objective observation and strict timing, with clinical or diagnostic interpretation being secondary. The observer should be in the delivery room at the time of the delivery, and should be equipped with at least one stop watch. The time of birth will be given as local twenty-four hour clock time. All other events shall be timed as the age before or after complete delivery of the child. Complete delivery shall be defined as that moment when all parts of the child's body became free of the maternal introitus. If any of the events in this protocol such as "first breath," "first cry," or "cord clamped" occur prior to complete delivery the time from occurrence of such an event to the moment of complete delivery should be measured with a stop watch. Then, at the moment of complete delivery the stop watch may be reset, or a second stop watch may be started to time the subsequent events.

The observations for the five parts of the Apgar score (Item 10, sub items 1-6) should be made on every child at age one minute, two minutes, and five minutes. Subsequent observations of this series are to be made if the score on the five minute series is seven or less.

The physical examination is to be performed between 10 and 20 minutes of age. If it is impossible to perform the physical examination during this time period, it should be performed as soon as possible and the child's age at the time it was begun recorded in Item 17.

D. **Bias.** Since it is necessary for the observer performing this examination to be present in the delivery room at the time of birth it is obvious that the observer will be aware of the events of labor and delivery. Every effort should be made to be as objective as possible in making and recording the observations and examination. Every reasonable effort has been made to phrase the items and instructions so as to encourage observations of fact rather than interpretation or judgment. However, this is manifestly impossible to accomplish when our "measuring sticks" are often not definable, and such terms as "weak" and "normal" are unavoidable.

The term "normal" as used in this examination form and manual should be interpreted

II. GENERAL INSTRUCTIONS (Cont.)

in the most limited sense as being nearly synonymous with "ideal." Thus, although it is statistically normal for respiration to be depressed by morphine, an infant exhibiting respiratory depression due to morphine would not be considered normal in this restricted sense of the term.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS

Item 1. Patient Identification: This item is to be completed using the child's name plate which should contain the following items in the order listed:

Name of Child (Surname, Given Name if known)
Child's NINDB number
Date of Birth - Hour of Birth (24 hr. clock)
Sex - Birth Weight (grams preferred) - Race

Item 2. Observed By: Here record the name of the person making the observations for items 6 through 16.

Item 3. Title or Position: Here record the professional status of the person whose name appears in Item 2 (nurse, pediatrician, obstetrician, intern, etc.).

Item 4. Date: Here record the date of the birth, using the sequence month, day, year.

Item 5. Time of Birth: Here record the time of the birth to the second, using local twenty-four clock time.

Items 6-8. The following three items represent the time of occurrence of certain crucial events in the establishment of extra-uterine life. The fact observed and reported is to be the age of the child at the moment the event occurred. This age is to be the age of the child recorded in minutes and seconds before or after the moment of complete delivery. (Complete delivery is, for this purpose, defined as that moment when all parts of the child's body become free of the maternal introitus.)

For each of these three items there are check boxes in which to indicate if the event occurred before or after complete delivery. If, by chance, the event should occur simultaneously with the moment of complete delivery, report it as 1 second after delivery.

Item 6. Cord Clamped: Record the age of the child in minutes and seconds at the time the cord was clamped. Check "before delivery" if the event occurred before complete delivery, or "after delivery" if the event occurred after complete delivery.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 7. First Breath: Record in minutes and seconds the age of the child at the time it took its first breath. Check "before delivery" if the event occurred before complete delivery, or "after delivery" if the event occurred after complete delivery.

Item 8. First Cry: Record the age of the child in minutes and seconds at the time the first cry was produced. Check "before delivery" if the event occurred before complete delivery, or "after delivery" if the event occurred after complete delivery.

Item 9. Procedures: The type of procedures which should be reported in this item are gastric suction, tracheal suction, the administration of drugs, the administration of oxygen either by open hose or mask or by positive pressure device, laryngeal intubation, and other resuscitative measures such as rocking bed, airlock, etc. Do not report routine oral-pharyngeal suction as a procedure.

If a catheter is passed into the stomach for the purpose of aspirating the stomach contents the first box "gastric suction" should be checked.

"Tracheal suction" is defined as passing a soft catheter into the larynx and trachea for the purpose of clearing those passages of foreign material (cf. definition of "intubation" below).

If drugs are given in the delivery room, check the box "drugs," and give the drug name (either trade name or generic name, whichever is in common use), the route of administration, and the dose. Do not include in this category silver nitrate prophylactic eye treatment, or medication applied topically to the umbilical cord in the delivery room. If there is insufficient room in this space continue under Item 30.

If extra oxygen is offered to the child by a means of open hose, oxygen tent, or loosely applied mask, check the box "open oxygen." Indicate in the adjacent blanks the ages of the child at which this procedure was begun and ended. If the procedure was intermittent the ages reported should be those at which the procedure was first started, and finally terminated. Report ages to the nearest minute.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 9. Procedures. (Cont.)

If oxygen was given to the child by means of a tight-fitting mask and rubber bag or other positive pressure device the box "positive pressure oxygen or air" should be checked. Mouth-to-mouth resuscitation, whether or not extra oxygen was added in the process, should also be reported here. Indicate the ages of the child at the time the procedure was begun and ended. If the procedure was intermittent, the ages reported should be those at which the procedure was first started, and finally terminated. Report ages to the nearest minute.

"Intubation" shall be defined as the insertion of a firm catheter into the larynx for the purpose of facilitating aspiration of foreign material and/or the establishment of respiration. (If positive pressure oxygen or air were administered through this tube by either a positive pressure device or by blowing or puffing with the mouth, the previous category "positive pressure oxygen or air" should be checked as well.) Indicate in adjacent blanks the ages of the child at which the procedure was begun and discontinued. If the procedure was repeated, report the ages of the child at which the procedure was first attempted, and finally discontinued. Report ages to the nearest minute.

"Other." Check this category if procedures other than those listed above are used for the purpose of inducing, assisting, or maintaining respiratory or cardiac function. Record the age of the child at the onset and termination of the procedure to the nearest minute. The procedure should be clearly identified.

Items 10-16. Apgar Score: This series of observations is designed to provide a uniform, systematic evaluation of certain physiological functions of every neonate at specified time intervals.

Timing:

(a) The first series of observations should be performed when the child is as close as possible to one minute of age.

(b) A second series of observations should be made when the child is as close as possible to two minutes of age.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Items 10-16. Apgar Score (Cont.)

(c) A third series of observations should be performed when the child is as close as possible to five minutes of age.

(d) If the total score on the five minute series is seven or below, the series of observations should be performed at 10, 15 and 20 minutes of age.

Reporting:

There are six columns provided on the form for scoring the one, two, five, ten, fifteen, and twenty minute observations. These columns should be used for reporting only those observations performed at approximately these times. Thus, if for some reason it is impossible to perform the observations at one minute, the observations performed at two minutes should be reported in the second column, not in the first column.

If the Apgar score at twenty minutes of age is still seven or below, the examiner should proceed with the physical examination and continue to keep careful notes on the child's progress, either in the form of the Apgar score categories or in narrative clinical progress notes in Item 30. In the event the space provided in Item 30 is too small, continue the comments on a properly labelled CP-5.

Instructions and Criteria for Scoring:

All scores should reflect the child's condition during the interval of the observations without regard to earlier condition or performance. It is very possible for the child to have a lower score at five minutes than at two minutes, or than the child might have had on a similar series of observations at three and a half minutes of age.

(1) Age at Time of Scoring
At the top of each column there is a box for reporting the age of the child at the time of the observations. The age of the child reported at the head of a column should be the start of the series of observations recorded in that column.

(2) Heart Rate

Score:	Observation:
0 —	No heart rate can be seen, felt or heard.
1 —	Heart rate below 100.
2 —	Heart rate 100 or over.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Items 10-16. Apgar Scores (Cont.)

Heart rate may be determined by auscultation of the precordium, observation of the epigastrium, or palpation of the umbilical cord near the umbilicus.

(3) Respiratory Effort

Score: Observation:
- 0 — Apnea, no respiratory effort.
- 1 — Weak respiratory effort, weak cry, hypoventilation.
- 2 — Breathing well, crying lustily.

Apnea shall be defined as the absence of breathing for a notable period — approximately 20 seconds or more.

(4) Muscle Tone

Score: Observation:
- 0 — Flaccid, very little or no muscle tone.
- 1 — Weak flexion tone, with persistent "floppiness."
- 2 — Spontaneous flexion of arms and legs.

(5) Reflex Irritability

Stimulus: Brisk tangential slap on the soles of the feet. (If child is spontaneously producing "active motion and crying," no stimulus is necessary, simply score 2.)

Score: Observation:
- 0 — No response.
- 1 — Some motion.
- 2 — Active motion and crying.

(6) Color

Score: Observation:
- 0 — Child entirely blue or cyanotic.
- 1 — Some areas persistently cyanotic.
- 2 — Child entirely pink.

(7) Total

Add the scores for each of the five categories in the column and record the sum in the "total" box. If it was impossible to score one or more of the categories, do not report a total for that column. Do not report fractions or more than one number per blank. Admittedly, these categories are coarse and for some the distinction between the score of 1 and the score of 2 is not sharp. However, the observer is in a better position than anyone will be subsequently to make the decision on the scoring. If there is doubt about the criteria for scoring, the physician in charge of this aspect of the study should be consulted and the matter discussed locally and perhaps with other institutions and pediatricians at NINDB in order to insure optimal uniformity in scoring.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Items 10-16. Apgar Scores (Cont.)

Physical Examination

The physical examination in the delivery room is a very brief series of observations of the neonate for the purpose of detecting and reporting signs of stress, and certain other items of information which cannot be obtained elsewhere. The examination should be performed by or under the supervision of a physician.

Timing of the Examination. The child should be examined between ten and twenty minutes of age. If it is impossible to examine the child during this interval it is desirable that the examination be performed as soon as possible after the child is twenty minutes of age and before it has left the delivery room.

Item 17. Here record the age of the child to the nearest minute at the start of the physical examination.

Item 18. Examined By: Here record the name of the person performing the physical examination.

Item 19. Title or Position: Here record the professional status of the person whose name is recorded in Item 18, i.e., nurse, pediatrician, obstetrician, intern, etc.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 20. Respiration: The examiner should observe the child's spontaneous respiration through the course of the examination. The box "normal" should be checked if, by the time of the examination, the child has established adequate air exchange and exhibits no potentially abnormal respiratory signs such as retractions, nasal flare, grunting or stridor, or unusual rhythm or rate. The box "other" should be checked if there are any indications of respiratory problems, including those listed in the previous sentence. All unusual or abnormal findings should be clearly described in Item 30.

Item 21. Motor Activity and Tone: The examiner should observe the child's spontaneous motor activity and tone throughout the course of the examination for signs of increase, decrease, or asymmetry of tone or movement. The box "normal and symmetrical" should be checked if there are no unusual features in the child's motor activity or tone. The box "other" should be checked if there are any unusual features and any such feature should be thoroughly described in Item 30.

Item 22. Tone of Neck: The examiner should evaluate specifically the tone of the child's neck muscles both by observing the spontaneous activity and by pulling the child by the arms to a sitting position. If no unusual findings are noted, the category "normal and symmetrical" should be checked. The box "other" should be checked if the neck is hypotonic or flaccid or if other unusual features of the neck muscle tone are noted. If this box is checked, a comment is required to differentiate the moderately limp neck from the neck which is so flaccid that the head falls back on the spine when the infant is pulled to the sitting position. Any other unusual features should also be described.

Item 23. Molding: The examiner should evaluate the child's head by inspection and palpation to determine the presence and degree of distortion of the child's head due to the birth process. Overriding of the bones at the suture lines as well as distortion of the shape of the bones themselves should be included in this item. The category "absent or minimal" should include the slight degree of molding seen in most children. The category "moderate or marked" should be checked if the degree of molding in this child is greater than that usually seen in normal children. The distinction between "absent or minimal" and "moderate or marked" is obviously only a vaguely quantitative one, but the examiner's judgment should remain as objective as possible and not be modified by his knowledge of the events of labor and delivery. If the molding is "moderate or marked," describe the locus and extent, including notation of the sutures which are overlapped.

Item 24. Forceps Marks: This item should be an objective observation not an interpretation of knowledge of prior events. If there is no evidence of tissue trauma from the use of forceps, the category "absent" should be checked. If there is evidence of tissue trauma about the head or face due to the use of forceps the box "present" should be checked and a clear and concise description of the location of the forceps marks should be recorded in Item 30. Clearly specify the location and the side (right or left). A sketch may make the description more simple and clear.

Item 25. Umbilical Cord: This item is intended for use only in reporting the presence or absence of meconium staining of the umbilical cord. Any fresh meconium should be wiped from the cord with a damp cloth before making the observation. If there is no evidence of staining of the cord, check the box "unstained." If the cord appears to be stained, check the appropriate box and describe the color and intensity.

Item 26. Length of Cord: It is desirable that the total length of the umbilical cord be determined and recorded in one spot, and this can only be done in the delivery room. Each segment of the cord should be measured with a metric ruler or tape and recorded in the appropriate blank. If there is no "other" segment of cord, enter "0" in the blank space labelled "other." It is not necessary to perform the addition and fill in the blank "total" as this can be done later or at NINDB.

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 27. Skin (Acute or transient findings). The examiner should observe the skin over the child's entire body for acute lesions and discoloration. It is not necessary to report and describe congenital malformations or nevi. Do not report Mongolian spots. Peripheral cyanosis should not be considered an abnormal finding in the delivery room examination. All acute or transient findings should be indicated by a check mark in the appropriate box, and described under Item 30.

"**Pallor**" should be checked if, in the examiner's judgment, the child is unusually pale.

"**Generalized cyanosis**" should be checked it the child is cyanotic over the entire body, or major portion of the body and should include such things as cyanosis of the head, one upper quadrant, one extremity, or one half of the body. Cyanosis of the hands, feet or perioral region alone should not be reported as generalized cyanosis.

"**Petechiae**" shall include any bleeding into the skin (including ecchymoses) but not bleeding from abrasions or forceps marks.

"**Stained**" means exogenous yellow, green or brown coloration of the skin, vernix or fingernails, which is not readily removable. Fresh meconium on the skin should not be reported as staining. Obviously, if there is fresh meconium on the skin, this should be removed with a damp cloth before the evaluation of the presence or absence of staining of the skin is made. If the skin is stained, check the appropriate box and describe the color and intensity.

"**Other**" should be checked if there are other acute lesions or conditions portrayed in or on the skin, such as abrasions, lacerations, and infection.

Item 28. Cry: If the child does not cry spontaneously, attempt to induce crying by such stimuli as slapping the soles of the feet or the buttocks or pinching the heel. These shall be considered maximal stimuli and more drastic methods are not recommended. If such stimulation does not make the child cry, check the box "absent after maximal stimulation." If the child cries spontaneously, consider such unusual qualities as high pitched, feeble, whining, hoarse, or stridulous, in evaluating whether the cry is normal or abnormal, and check the appropriate box. If the child does cry spontaneously and the cry has no unusual character, check the first box "present and normal quality." Describe all abnormal findings under Item 30.

Item 29. Moro Reflex: The same techniques as used in the other examinations of the neonate shall be employed here for eliciting the Moro reflex. That is, "support the child under the back and head, and let the head drop back about 30 degrees." Note that there is a definition of the reaction rather than the term "normal" following box 0. If the response fits this definition "flexor and extensor components, present and symmetrical" even if it is considered not to be normal, check box 0. Describe any reasons for considering it abnormal. If the response does not fit the definition following box 0, then box 8 "other pattern" should be checked. If box 8 is checked the pattern should be clearly described. The examiner is invited to register his opinion as to whether or not he thinks the response is normal, no matter which box is checked.

If the child is in an incubator or otherwise inaccessible, other stimuli such as slapping the incubator or producing a loud noise may be used to attempt to elicit a Moro reflex. If, by this method, the defined response (box 0) is elicited, check box 0 and describe the stimulus used. If this response is not elicited by the non-standard stimulus, check box 9 "not evaluated" and indicate the situation.

Item 30. Comments and Other Findings: This space is to be used for a narrative description of any abnormal findings or procedures reported above. Also, the examiner is invited to note any unusual features of the child not included in the above items such as a knot in the umbilical cord, congenital malformations, a single umbilical artery, etc., and to record his clinical impression of this child. The

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 30. Comments and Other Findings. (Cont.)

use of "normal" in this last situation will be interpreted in the usual clinical sense as a diagnostic statement. Therefore, although the examiner may have been forced by the strict definition of "normal" in the above items to report such things as grunting respiration, limp neck, or pallor, he may qualify these by writing "normal baby" under Item 30 if this indeed is his clinical evaluation or summary of the situation. No information concerning the mother's condition should be written in this comment space.

Since this record form is set up on one page for maximum convenience in use for the vast majority of cases that are normal or slightly unusual, one or more sheets of form CP-5 (Continuation Sheet) should be immediately available for extending comments and descriptions of unusual findings on abnormal cases. (If form CP-5 is used be certain to indicate "PED-1" in the space for form number to insure proper identification of the extended comments.)

Item 31. Race: The child's race is to be reported as the same as the mother's race (as it is recorded on form AR-1) in one of

III. SPECIFIC INSTRUCTIONS AND DEFINITIONS (Cont.)

Item 31. Race. (Cont.)

the categories: White, Negro, Oriental, Puerto Rican or Other. If this information appears in Item 1 on this form, it does not need to be repeated here.

Item 32. Sex: Record the infant's sex as male, female or undetermined.

Item 33. Birth Weight: Here record the child's official birth weight. It is desirable that a metric system scale be used and the weight be recorded in grams. However, if an English system scale is used, report the weight in pounds rather than converting to grams. Report ounces as fractions (--1/16) of a pound thus: seven pounds, six ounces is recorded as 7 and 6/16.

Distribution:

One copy of this form must become part of the local Study or hospital Pediatrics record, one copy should become part of either the Study or the hospital Obstetrics record, and one copy must be sent to NINDB with the Study Pediatrics nursery records.

July 1963

COLR-6004-1
REV. 1/61

DELIVERY ROOM OBSERVATION OF THE NEONATE

getting superseded by same but minor changes in items 6–8 incl.

1. PATIENT IDENTIFICATION

2. OBSERVED BY | 3. TITLE OR POSITION

4. DATE OF BIRTH Mo. | Day | Year | 5. TIME OF BIRTH (24-hr clock)

Time all events below as age before or after delivery

		Age Began	Age Ended
6. CORD CLAMPED (Age) Min. Sec. ☐ Before ☒ delivery	9. PROCEDURES (Omit uncomplicated oral-pharyngeal suction) ☐ 0X None ☐ 1 Gastric Suction ☐ 2 Tracheal Suction ☐ 3 Drugs (Give type & Dose) ☐ 4 Open Oxygen ☐ 5 Positive Pressure Oxygen or Air ☐ 6 Intubation ☐ 9 Other (Specify)	Min.	Min.
7. FIRST BREATH (Age) Min. Sec. ☐ Before ☒ delivery		Min.	Min.
8. FIRST CRY (Age) Min. Sec. ☐ Before ☒ delivery		Min.	Min.

10. APGAR SCORE (*Score infant at 1, 2 and 5 minutes of age. If score of 8 is not attained, score at 10, 15 and 20 minutes.*

				11.		12.		13.		14.		15.		16.	
1) AGE AT TIME OF SCORING				Min.	Sec.	Min.	Sec.	Min.	Sec.	Min.	Sec.	Min.	Sec.	Min.	Sec.
2) HEART RATE	0 – Absent	1 – Slow – Less Than 100	2 – 100 or over												
3) RESPIRATORY EFFORT	0 – Absent	1 – Weak Cry Hypoventilation	2 – Crying Lustily												
4) MUSCLE TONE	0 – Flaccid	1 – Some Flexion Extremities	2 – Well Flexed												
5) REFLEX IRRITABILITY	0 – No Response	1 – Some Motion	2 – Cry												
6) COLOR	0 – Blue Pale	1 – Blue Hands and Feet	2 – Entirely Pink												
			7) TOTAL												

PHYSICAL EXAMINATION | 17. Began at _____ min. of age | 18. EXAMINED BY | 19. TITLE OR POSITION

20. RESPIRATION ☐ 0 Normal ☐ 9 Other

21. MOTOR ACTIVITY AND TONE ☐ 0 Normal and Symmetrical ☐ 9 Other

22. TONE OF NECK ☐ 0 Normal and Symmetrical ☐ 9 Other

23. MOLDING ☐ 0 Absent or Minimal ☐ 1 Marked

24. FORCEPS MARKS ☐ 0 Absent ☐ 1 Present

25. UMBILICAL CORD ☐ 0 Unstained ☐ 1 Stained

26. LENGTH OF CORD (*Include all segments*)
On Body _____ Cm. Other _____ Cm.
On Placenta _____ Cm. Total _____ Cm.

27. SKIN (*Acute or transient findings*)
☐ 0 Normal (*Including peripheral cyanosis*)
☐ 1 Pallor ☐ 3 Petechiae
☐ 2 General Cyanosis ☐ 4 Stained
☐ 9 Other

28. CRY
☐ 0 Present
☐ 1 Present, Abnormal
☐ 2 Absent After Maximal Stimulation

29. MORO REFLEX
☐ 0 Flexor and Extensor Components Present and Symmetrical
☐ 8 Other Pattern
☐ 9 Not Evaluated

30. COMMENTS AND OTHER FINDINGS

(Continue on CP-5, Continuation Sheet)

31. RACE (*Copy from AR-7. Optional*) ☐ 1 W ☐ 2 N ☐ 3 Or ☐ 4 PR ☐ 9 Other

32. SEX (*Optional*) ☐ 1 Male ☐ 2 Female ☐ 3 Undetermined

33. BIRTH WEIGHT (*Optional*)

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(PED-1) (Rev. 1-61)

DELIVERY ROOM OBSERVATIONS OF THE NEONATE

1. PATIENT IDENTIFICATION — Test only

2. OBSERVED BY

3. STATUS

4. DATE — Mo. / Day / Year

5. TIME OF BIRTH (24-Hour Clock)

Time events as age before or after complete delivery.

6. CORD CLAMPED (Age) — Min. / Sec. — ☐ BEFORE (X) ☐ AFTER (0)

7. FIRST BREATH (Age) — Min. / Sec. — ☐ BEFORE (X) ☐ AFTER (0)

8. FIRST CRY (Age) — Min. / Sec. — ☐ BEFORE (X) ☐ AFTER (0)

9. PROCEDURES (Omit uncomplicated oral-pharyngeal suction)

☐ NONE (X)
☐ GASTRIC SUCTION (1)
☐ TRACHEAL SUCTION (2)
☐ DRUGS (Give type and dose) (3)

INDICATE AGE:	BEGUN	ENDED
☐ OPEN OXYGEN (4)		
☐ POSITIVE PRESSURE OXYGEN (5)		
☐ INTUBATION (6)		
☐ OTHER (8)		

10. COMMENTS ON EVENTS OR PROCEDURES
☐ NONE (0)

11. APGAR SCORE Note: *Score infant at 1, 3, and 5 minutes, and if score of 8 not attained, score at 10, 15, and 20 minutes.*

	12. 1st	13. 2nd	14. 3rd	15. 4th	16. 5th	17. 6th
1) AGE AT TIME OF SCORING						
2) HEART RATE (0-ABSENT; 1-SLOW, LESS THAN 100; 2-100 OR OVER)						
3) RESPIRATORY EFFORT (0-ABSENT; 1-WEAK CRY, HYPOVENT.; 2-CRYING LUSTILY)						
4) MUSCLE TONE (0-FLACCID; 1-SOME FLEX. EXTREM.; 2-WELL FLEXED)						
5) REFLEX IRRITABILITY (0-NO RESPONSE; 1-SOME MOTION; 2-CRY)						
6) COLOR (0-BLUE, PALE; 1-BLUE HANDS & FEET; 2-ENTIRELY PINK)						
7) TOTAL						

PHYSICAL EXAMINATION

18. AT _____ MIN. OF AGE

19. EXAMINED BY

20. STATUS

21. CRY
☐ PRESENT - NORMAL (0)
☐ PRESENT - ABNORMAL (Describe) (1)
☐ ABSENT AFTER MAXIMAL STIMULATION (2)

22. MORO
☐ FLEXOR AND EXTENSOR COMPONENTS PRESENT AND SYMMETRICAL (0)
☐ OTHER PATTERN (Describe) (1)
☐ NOT EVALUATED (9)

23. SKIN
☐ NORMAL (0)
☐ PALLOR (1)
☐ GENERALIZED CYANOSIS (2)
☐ PERIPHERAL CYANOSIS (3)
☐ PETECHIAE (4)
☐ STAINED (5)
☐ OTHER (8)

24. TONE OF NECK
☐ NORMAL (0)
☐ ABNORMAL (Describe) (2)

25. MOTOR ACTIVITY
☐ NORMAL AND SYMMETRICAL (0)
☐ OTHER (Describe) (9)

26. RESPIRATIONS
☐ NORMAL (0)
☐ ABNORMAL (Describe) (1)

27. GENERALIZED EDEMA
☐ ABSENT (0)
☐ PRESENT (Describe) (2)

28. LENGTH OF CORD IN CM. (Measured last sequence)
ON BODY _____ OTHER _____
ON PLACENTA _____ TOTAL _____

29. BLEEDING
☐ ABSENT (0)
☐ PRESENT (Describe) (1)

30. FORCEPS MARKS
☐ ABSENT (0)
☐ PRESENT (Describe) (2)

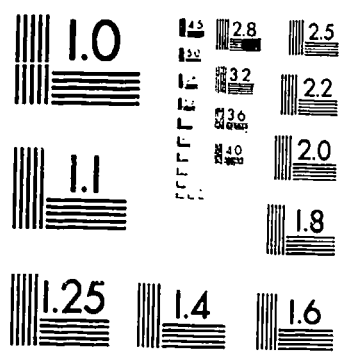
31. MOLDING
☐ ABSENT OR MINIMAL (0)
☐ MODERATE OR MARKED (Describe)

32. COMMENTS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

TEST

(REV. 11-58) PED-1



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No 2)

CONTINUED ON NEXT FICHE


THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
SCRIPTA
MANET
★ 1934 ★

PED-4 (ADM-44) Report of Fetal or Infant Death

Form PED-4 was used to report fetal death or the death of a study infant and certain additional information regarding the death. Its use was expanded to report the death of a study child at any age. First implemented in February 1959, the form underwent revision in July 1959, in February 1961, and again in October 1961. The first revision resulted in a layout change and in a renumbering of items; the 1961 revision resulted in minor changes only. The October 1961 revision resulted in an additional measurement of crown rump length (item 15) and in another reitemization of the form. Data from PED-4 were abstracted on to ADM-44 "Report of Non-Liveborn Termination of Pregnancy or Death of Study Child" by study personnel at NINDB for punching. Records of fetal, infant and child death are available on card 0844 of the master file, where information from ADM-44 was recorded (Table PED-4.1).

TABLE PED-4.1 Cards and Data Records by Revision for Form PED-4

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-4: Report of Infant Death	0844	1	4,001
			4,001
	total for form		4,001

Data Items Referencing Form ADM-44, Report of Fetal or Infant Death

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4931.....		OR44	1	5	Card number (sequence, form type, form number, revision number)
4932.....		OR44	6	14	NINDB case number
4933.ADM-44		OR44	15	16	Form ADM-44 date (mo)
4934.ADM-44		OR44	17	18	Form ADM-44 date (day)
4935.ADM-44		OR44	19	20	Form ADM-44 date (yr)
4936.ADM-44		OR44	21	22	Date of; fetal or; infant; death (mo)
4937.ADM-44		OR44	23	24	Date of; fetal or; infant; death (day)
4938.ADM-44		OR44	25	26	Date of; fetal or; infant; death (yr)
4939.ADM-44		OR44	27	28	Birth date (mo)
4940.ADM-44		OR44	29	30	Birth date (day)
4941.ADM-44		OR44	31	32	Birth date (yr)
4942.ADM-44		OR44	33	33	Fetal or; infant; death; autopsy performed
4943.ADM-44		OR44	34	35	Death, type
4944.ADM-44		OR44	36	36	Death, place
4945.ADM-44		OR44	37	40	Fetal death; weight (gms)
4946.ADM-44		OR44	41	43	Fetal death; length, crown rump (cm)
4947.ADM-44		OR44	44	45	Fetal death; gestation (wks)
4948.ADM-44		OR44	46	59	Name, last
4949.ADM-44		OR44	60	60	Name, last, child or mother
4950.ADM-44		OR44	61	61	Sex
4951.....		OR44	62	76	Blank
4952.ADM-44		OR44	77	78	Death, type, revised definition
4953.ADM-44		OR44	79	80	Quarterly addition to file
5385....VAR			553	553	Records present; pediatric
5386....VAR	9		554	554	Sex
5915....VAR			1091	1091	Infant death 0 to 12 months
5916....VAR	6		1092	1093	Outcome of study pregnancy; deaths; survivors
5917....VAR			1094	1094	Outcome of study pregnancy; deaths; survivors (grouped)
5918....VAR	14		1095	1098	Birth; weight (gms)
5919....VAR			1099	1100	Birth; weight (coded)
5921....VAR	11		1103	1108	Birth date; date of birth or delivery (mo/day/yr)

[redacted]

REV. 10-61

REPORT OF FETAL OR INFANT DEATH

2. NAME OF RECORDER | 3. TITLE OR POSITION

4. DATE OF RECORD (Mo. / Day / Year) | 5. DO NOT WRITE IN THIS SPACE | 6. TYPE OF RECORD ☐ FETAL DEATH 1 ☐ INFANT DEATH 2 | 7. AUTOPSY NUMBER | 8. OTHER RECORD NUMBER

9. SEX ☐ MALE 1 ☐ FEMALE 2 ☐ UNDETERMINED 9

10. AUTOPSY ☐ NONE 0 YES ☐ IN REPORTING HOSPITAL 1 ☐ OTHER (Specify) 8

COMPLETE THESE ITEMS FOR FETAL DEATH ONLY

11. DATE OF DELIVERY OF FETUS (Mo. / Day / Year) | 12. DO NOT WRITE IN THIS SPACE

13. PLACE OF DELIVERY ☐ REPORTING HOSPITAL 1 ☐ HOME 2 ☐ OTHER 8 (Specify) _____

14. WEIGHT OF FETUS _____ Grams | 15. CROWN RUMP LENGTH _____ Cms.

16. FETUS DIED ☐ BEFORE LABOR 1 ☐ DURING LABOR OR DELIVERY 2 ☐ UNKNOWN 9

COMPLETE THESE ITEMS FOR INFANT DEATH ONLY

17. DATE OF DEATH (Mo. / Day / Year) | 18. TIME OF DEATH (Use 24-hr. clock)

19. PLACE OF DEATH ☐ REPORTING HOSPITAL 1 ☐ HOME 2 ☐ OTHER 8 (Specify) _____

20. BIRTH INJURIES PRESENT ☐ NO 0 ☐ YES 1 ☐ UNKNOWN 9

21. IF "YES", DESCRIBE _____

22. DO NOT WRITE IN THIS SPACE

COMPLETE THESE ITEMS FOR EACH DEATH

23. CAUSE OF DEATH (Include associated illnesses and conditions. CIRCLE the number of the underlying cause of death.)

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

24. DO NOT WRITE IN THIS SPACE

25. MALFORMATIONS PRESENT: ☐ NO 0 ☐ YES 1 ☐ UNDETERMINED 9

26. IF "YES", DESCRIBE

(1) _____

(2) _____

(3) _____

27. DO NOT WRITE IN THIS SPACE

28. REMARKS

IF MORE SPACE IS NEEDED, INDICATE ITEM NUMBER AND ATTACH CONTINUATION SHEET (FORM CP-5)

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

PED-4 (REV. 10-61)

[redacted]

Form Item Numbers linked to Data Items on ADM-44, Report of Fetal or Infant Death

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4940.ADM-44	0R44	29	30	Birth date (day)
	4939.ADM-44	0R44	27	28	Birth date (mo)
	4941.ADM-44	0R44	31	32	Birth date (yr)
	5919....VAR		1099	1100	Birth; weight (coded)
	4937.ADM-44	0R44	23	24	Date of; fetal or; infant; death (day)
	4936.ADM-44	0R44	21	22	Date of; fetal or; infant; death (mo)
	4938.ADM-44	0R44	25	26	Date of; fetal or; infant; death (yr)
	4944.ADM-44	0R44	36	36	Death, place
	4943.ADM-44	0R44	34	35	Death, type
	4952.ADM-44	0R44	77	78	Death, type, revised definition
	4947.ADM-44	0R44	44	45	Fetal death; gestation (wks)
	4946.ADM-44	0R44	41	43	Fetal death; length, crown rump (cm)
	4945.ADM-44	0R44	37	40	Fetal death; weight (gms)
	4942.ADM-44	0R44	33	33	Fetal or; infant; death; autopsy performed
	4934.ADM-44	0R44	17	18	Form ADM-44 date (day)
	4933.ADM-44	0R44	15	16	Form ADM-44 date (mo)
	4935.ADM-44	0R44	19	20	Form ADM-44 date (yr)
	4948.ADM-44	0R44	46	59	Name, last
	4949.ADM-44	0R44	60	60	Name, last, child or mother
	5917....VAR		1094	1094	Outcome of study pregnancy; deaths; survivors (grouped)
	4953.ADM-44	0R44	79	80	Quarterly addition to file
	5385....VAR		553	553	Records present; pediatric
	4950.ADM-44	0R44	61	61	Sex
6	5916....VAR		1092	1093	Outcome of study pregnancy; deaths; survivors
9	5386....VAR		554	554	Sex
11	5921....VAR		1103	1108	Birth date; date of birth or delivery (mo/day/yr)
14	5918....VAR		1095	1098	Birth; weight (gms)
17	5921....VAR		1103	1108	Birth date; date of birth or delivery (mo/day/yr)

Definition of Codes
Cause of Fetal Death
Form PED-4 Card G404

[redacted]

FIELD		CARD COLUMN
1.	Card Number* Code: G	1
2.	Form Number Code: 404	2-4
3.	Revision Number** Code: 0 - Form dated: 2/59 1 - Forms dated: Rev. 7/59 or Rev. 2/61 2 - Forms dated: Rev. 10/61	5
4.	NINDB # Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Delivery Item 11 Six-digit code for: Month (cols. 15-16) Day (cols. 17-18) Year (cols. 19-20) Code: As given 99 - month, day or year unknown F and five blank - Fetal death	15-20
6.	Type of Fetal Death Code: 01 - Abortion 02 - Ectopic Pregnancy 11 - Stillbirth, other 12 - Stillbirth, macerated 19 - Stillbirth, type unknown 29 - Fetal death, type unknown	21-22
7.	Place of Death Code: 0 - Study Institution 1 - Home 2 - Other hospital 3 - Other place 8 - Elsewhere 9 - Unknown	23

* As many cards are required as causes of death reported.

** Item numbers refer to Form dated: Rev. 10/61.

Definition of Codes (Continued)

FORM PED-4
Card G-404

FIELD		CARD COLUMN
8.	Weight of Fetus Item 14 Code: 0001-5999 - As given in grams 9999 - Unknown	24-27
9.	Fetus Died Item 16 Code: 1 - Before labor 2 - During labor and delivery 9 - Unknown	28
10.	Cause of Death Item 23 Code: Alpha code as given Unk - Unknown	29-80

DEFINITION OF CODES
REPORT OF NON-LIVEBORN TERMINATION OF
PREGNANCY OR DEATH OF STUDY CHILD
FORM ADM-44 CARD 0844

FIELD		CARD COLUMN
1.	Card Number Code: 0	1
2.	Form Number Code: 844	2-4
3.	Revision Number Code: 1 Form Dated: Rev. 12/63	5
4.	NINDB Number Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Report Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20). Code: As given 079961 - Prior to July 1961	15-20
6.	Date of Event Six-digit code for month (cols. 21-22), day (cols. 23-24), and year (cols. 25-26) Code: As given 99 - Month, day and/or year unknown	21-26
7.	Date of Birth Code: Same as in Field 6, except F and five blanks - Fetal death	27-32
8.	Autopsy Code: 1 - Yes 2 - No 9 - Unknown	33
9.	Type of Death Code: 01 - Abortion 02 - Ectopic Pregnancy 11 - Stillbirth, Other 12 - Stillbirth, Macerated 19 - Stillbirth, Type Unknown 29 - Fetal Death, Type Unknown	34-35

FIELD		CARD COLUMN
9.	Type of Death (continued) Code: 30 - Under 24 hours of age 31 - One day 32 - Two days 33 - Three days 34 - Four days 35 - Five days 36 - Six days 37 - Seven days 38 - 8 -- 27 days 39 - Neonatal Death, Time Unknown 40 - 28 days through one year 51 - Over one year -- two years 52 - Over two years -- three years 53 - Over three years -- four years 54 - Over four years -- five years 55 - Over five years years -- six years 56 - Over six years -- seven years 57 - Over seven years -- eight years 58 - Over 8 years 59 - Child death, time unknown 60 - Mole 99 - Unknown	34-35
10.	Place of Death Code: 0 - Study Institution 1 - Home 2 - Other Hospital 3 - Other Place 8 - Elsewhere, Unknown 9 - Unknown	36
11.	Weight at Death (Fetal Death Only) Code: X and three blanks - no fetal death - (-) dash & 3 blanks 0000 - Unknown 0001-5999 - As given in grams 9999 - Not reported	37-40

DEFINITION OF CODES (Continued)

FORM ADM-44
Card 0844

FIELD		CARD COLUMN
12.	Crown-Rump Length (Fetal Death only) Code: Blank - No fetal death 001-550 - As given in cms. to tenths 999 - Not reported 000 - Unknown	41-43
13.	Gestation (Fetal Death only) Code: Blank - No fetal death 01-50 - Weeks as given 99 - Not reported 00 - Unknown	44-45
14.	Last Name Fourteen-digit code for name Code: As given	46-59
15.	Mother or Child Code: 0 - Mother's last name 1 - Child's last name 9 - Unknown	60
16.	Sex Code: 1 - Male 2 - Female 3 - Undetermined 9 - Unknown	61
17.	Blank	62-76
18.	Type of Death: Revised Definition Code: 01 - Abortion - weeks gestation $\leq$ 19 02 - Abortion - PRB review 03 - Mole 11 - Stillbirth - weeks gestation $\geq$ 20 12 - Stillbirth - PRB review 29 - Fetal Death - Type Unknown 30 - Under 24 hours of age 31 - One day 32 - Two days 33 - Three days 34 - Four days 35 - Five days 36 - Six days 37 - Seven days 38 - 8-27 days 39 - Neonatal Death, Time Unknown 40 - 28 days thru 1 year	77-78

FIELD

CARD COLUMN

51 - Over 1 year - 2 years
52 - Over 2 years - 3 years
53 - Over 3 years - 4 years
54 - Over 4 years - 5 years
55 - Over 5 years - 6 years
56 - Over 6 years - 7 years
57 - Over 7 years - 8 years
58 - Over 8 years
59 - Child Death, Time Unknown
99 - Unknown

19. Quarterly Addition to File — 79-80

Two-digit code for:

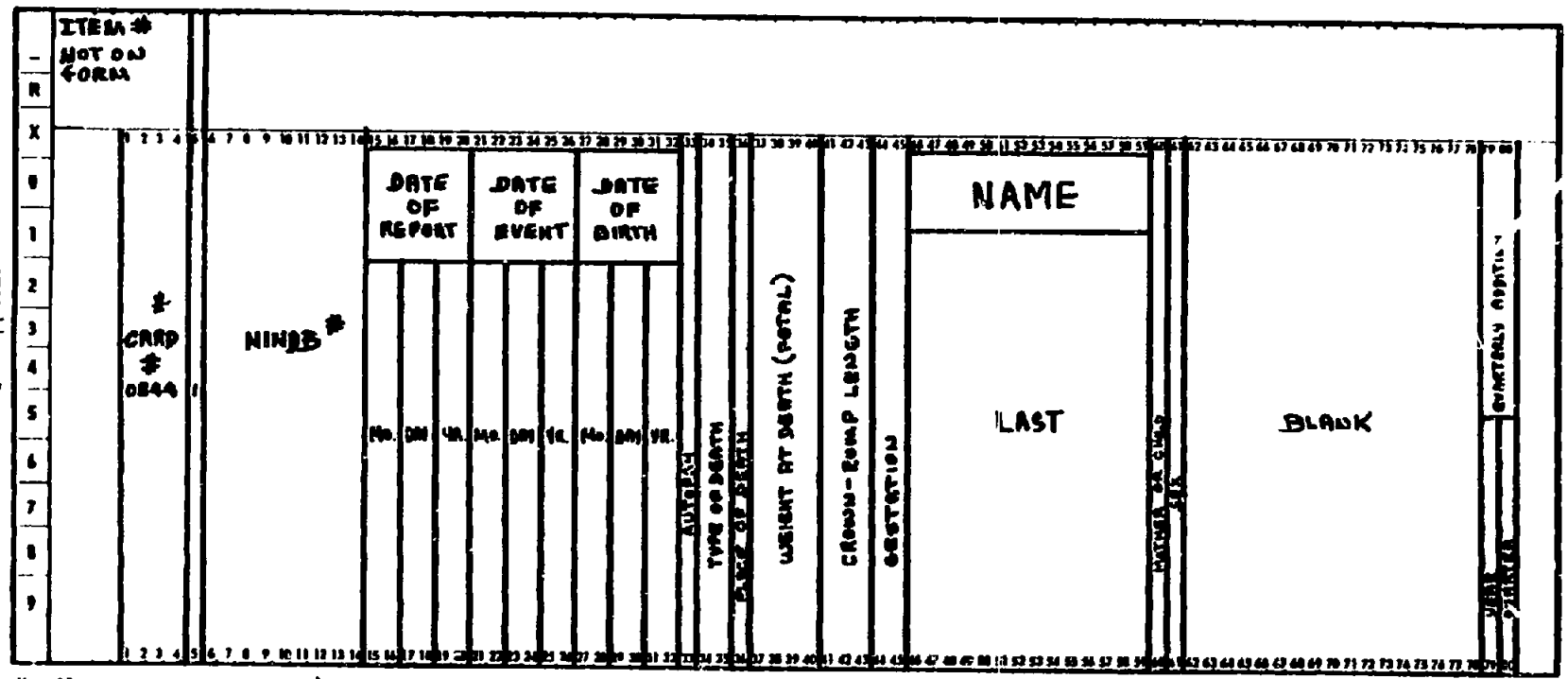
Year (col. 79)

Code: Blank - Prior to July 1963
3-9 - 1963-1969 as given
0-2 - 1970-1972 as given

Quarter Case First Reported (col. 80)

Code: Blank - Prior to July 1963
1 - January - March
2 - April - June
3 - July - September
4 - October - December

REPORT OF NON-LIVEBORN TERMINATION OF PREGNANCY OR DEATH OF STUDY CHILD
FORM AIM-44



* Abstracted from PED-4 and PATH-3 Forms.

REPORT OF FETAL OR INFANT DEATH
(For Form PED-4, Revised 10-61)

I. INTRODUCTION

The PED-4 Form is to be used to report the fact of death of a Study product of conception and to report certain additional information regarding the death.

The fact of death need not be reported on a Form CP-1.

II. GENERAL INSTRUCTIONS

A PED-4 report is to be submitted on every Study product of conception that dies. This includes abortions and stillbirths (fetal deaths), deaths that occur in the nursery period, and deaths that occur after discharge from the nursery.

A. SCHEDULE OF REPORTING

1. **Fetal Deaths.** The PED-4 report is to be submitted within ten (10) days of the date of fetal death or the date the Study hospital becomes informed of the death. The report should not be delayed in anticipation of more detailed or complete information regarding the death.

2. **Deaths in the Nursery Period.** The PED-4 report is to be submitted together with other Nursery Study Records within three weeks after the infant's discharge from the hospital, as provided for in the PED-7 Manual. The report should not be delayed in anticipation of more detailed or complete information regarding the death.

3. **Deaths After Discharge from the Nursery.** The PED-4 report is to be submitted within ten (10) days after the Study hospital becomes informed of the death. The report should not be delayed in anticipation of more detailed or complete information regarding the death.

B. CONTENT OF REPORT

The report is to contain the required patient identification data and other requested data which are available. Be sure to indicate whether an autopsy has been done and include the provisional diagnoses from gross autopsy findings when available.

C. SUPPLEMENTARY INFORMATION

Detailed autopsy findings and any additional data regarding the death are to be reported on a CP-5 or other applicable Study forms, with patient identification of the PED record which is being supplemented. The supplementary report is to be submitted only after complete information has been obtained regarding the death.

D. TRANSMITTAL

The original and first carbon copy of completed Form PED-4 are to be sent to PRB.

III. SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. For fetal deaths this item is to be completed by using the gravida's name and the NINDB number which would have been assigned to the live-born child. The suffix "FD" should be added to the NINDB number. For all other deaths this item is to be completed by using the infant's identification stamp which is to contain the following information: name, NINDB number, date of birth, time of birth, birth weight, sex, and race.

Item 2, Name of Recorder. Record the name of the person completing this record.

Item 3, Title or Position. Record the professional title or position of the person completing this record (i.e., pediatrician, obstetrician, pathologist, nurse, secretary, etc.).

Item 4, Date of Record. Record the month, day, and year on which this record was completed.

Item 5, Do Not Write in This Space. This space and spaces numbered 12, 22, 24, and 27 are reserved for coding purposes and require no entry by the recorder.

Item 6, Type of Record. Check the appropriate box to indicate whether this is a report of a fetal death (death of a product of conception prior to complete separation from the mother) or a report of an infant death (death of a live-born child occurring at any age, even beyond the period of infancy).

Item 7, Autopsy Number. If an autopsy has been done, record the identifying number here. Otherwise write "none" in this space.

Item 8, Other Record Number. Record here identification numbers, not included in Items 1 or 7, by which this case is known to other departments or other institutions.

Item 9, Sex. If this information is included in Item 1, it is not necessary to repeat it here. Otherwise check the appropriate box for sex.

Item 10, Autopsy. Record whether an autopsy was performed and, if so, where. If the autopsy was performed in another hospital (including morgue or coroner's laboratory), give the name and address of the other hospital and any other information in addition to Items 7 and 8 which may be necessary to identify the case in that hospital.

Items 11 to 16. Complete These Items For Fetal Death Only. These items are to be completed only in the case of a fetal death. Disregard these items in the case of an infant or child death.

Item 11, Date of Delivery Of Fetus. Record the month, day, and year of the delivery of the fetus.

Item 12, Do Not Write In This Space. Same as Item 5.

Item 13, Place of Delivery. Record whether the delivery occurred in the reporting hospital, home, or other place. If "other" place, specify where. If in another hospital, give the name and address of the institution and other identification data necessary to trace the case.

Item 14, Weight of Fetus. Record in grams the weight of the fetus at birth. If this weight is unknown, write "unknown" in this space.

Item 15, Crown Rump Length. To obtain this measurement, extend the measuring instrument on a flat table. Over the instrument place the fetus flat on its back with the head extended in the midline. Flex the thighs to a right angle with the body. Measure the distance from the outer-most extension of the crown to the outermost extension of the rump. Record this distance in centimeters.

Item 16, Fetus Died. Record whether the fetus died before onset of labor or during labor and delivery. If this information is not known, check the box "Unknown."

Item 17 to 21, Complete These Items For Infant Death Only. These items are to be completed only in the case of an infant death. Disregard these items in the case of a fetal death.

Item 17, Date of Death. Record month, day, and year on which death occurred.

Item 18, Time of Death. Record the time of death in 24-hour-clock time for all infant deaths under 7 days of age. Disregard this item for infant deaths occurring at age 7 days and over.

Item 19, Place of Death. Record whether the death occurred in the reporting hospital, home, or other places. If "other" place, specify where. If in another hospital, give the name and address of the institution and other identification data necessary to trace the case.

Items 20 and 21, Birth Injuries Present. Record the absence or presence of birth injury in infant deaths under 28 days of age. If present, specify the type and location of the injuries. Disregard this item for infant deaths at age 28 days and over.

Item 22, Do Not Write In This Space. Same as Item 5.

Items 23 to 28, Complete These Items For Each Death. These items are to be completed for each fetal or infant death.

Item 23, Cause of Death. List in standard medical terms your clinical impressions of the medical condition initiating the sequence of events terminating in death and of any other medical conditions associated with the death. Circle the number of the underlying cause of death. Maternal factors which may have initiated or contributed to the death should be clearly identified as maternal factors. Gross autopsy findings are to be listed under Item 28, Remarks.

Item 24, Do Not Write In This Space. Same as Item 5.

Items 25 and 26, Malformations Present. Record the absence or presence of congenital malformations. If present, specify the type and location of each malformation.

Item 27, Do Not Write In This Space. Same as Item 5.

Item 28, Remarks. Use this space to record gross autopsy findings and to provide further information on any of the preceding items. Identify the remarks with the number of the item to which they refer. If more space is needed, continue on Form CP-5, Continuation Sheet.

REV 3-61

REPORT OF FETAL OR INFANT DEATH

Superseded by CDLR-3004-4 Rev. 10-61

2. NAME OF EXAMINER | 3. TITLE OR POSITION

4. DATE OF RECORD (Mo. / Day / Year) | 5. DO NOT WRITE IN THIS SPACE | 6. TYPE OF RECORD ☐ 1 FETAL DEATH ☐ 2 INFANT DEATH | 7. AUTOPSY NUMBER | 8. OTHER RECORD NUMBER

9. SEX ☐ 1 MALE ☐ 2 FEMALE ☐ 9 UNDETERMINED

10. AUTOPSY ☐ 0 NONE ☐ YES ☐ 1 IN REPORTING HOSPITAL ☐ 9 OTHER (Specify)

COMPLETE THESE ITEMS FOR FETAL DEATH ONLY

11. DATE OF DELIVERY OF FETUS (Mo. / Day / Year) | 12. DO NOT WRITE IN THIS SPACE

13. PLACE OF DELIVERY ☐ 1 REPORTING HOSPITAL ☐ 2 HOME ☐ 9 OTHER (Specify) _____

14. WEIGHT OF FETUS _____ GRAMS CHECK HERE IF WEIGHT UNKNOWN ☐ 9

15. FETUS DIED ☐ 1 BEFORE LABOR ☐ 2 DURING LABOR OR DELIVERY ☐ 9 UNKNOWN

COMPLETE THESE ITEMS FOR INFANT DEATH ONLY

16. DATE OF DEATH (Mo. / Day / Year) | 17. TIME OF DEATH (Use 24-hr clock)

18. PLACE OF DEATH ☐ 1 REPORTING HOSPITAL ☐ 2 HOME ☐ 9 OTHER (Specify) _____

19. BIRTH INJURIES PRESENT ☐ 0 NO ☐ 1 YES ☐ 2 UNKNOWN

20. IF "YES", DESCRIBE _____

21. DO NOT WRITE IN THIS SPACE

22. CAUSE OF DEATH (Include associated illnesses and conditions. CIRCLE the number of the underlying cause of death.)

(1.) _____
(2.) _____
(3.) _____
(4.) _____
(5.) _____
(6.) _____
(7.) _____
(8.) _____
(9.) _____
(10.) _____

23. DO NOT WRITE IN THIS SPACE

24. REMARKS (Also use this space to describe circumstances associated with death)

IF MORE SPACE IS NEEDED INDICATE ITEM NUMBER AND ATTACH CONTINUATION SHEET (FORM CP-S)

25. MALFORMATIONS PRESENT: ☐ 0 NO ☐ 1 YES ☐ 9 NOT DETERMINED

26. IF "YES", LIST AND DESCRIBE MALFORMATIONS HERE

(1.) _____
(2.) _____
(3.) _____
(4.) _____
(5.) _____
(6.) _____
(7.) _____
(8.) _____
(9.) _____

27. DO NOT WRITE IN THIS SPACE

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

PED-4 (REV. 2-61)

PHS-3004-4
REV. 7-59

white

REPORT OF FETAL OR INFANT DEATH

1. PATIENT IDENTIFICATION

Superseded by COL R-3004-4 Rev. 3-61

2. NAME OF EXAMINER | 3. TITLE OR POSITION

4. DATE (MO. / DAY / YEAR) | 5. TIME RECORDED (Use 24-hr clock) | 6. TYPE OF RECORD: ☐ FETAL DEATH ☐ INFANT DEATH | RECORD NUMBERS: 7. HOSPITAL | 8. OTHER

9. SEX: ☐ MALE ☐ FEMALE ☐ UNDETERMINED

10. AUTOPSY: ☐ NONE ☐ YES ☐ IN REPORTING HOSPITAL ☐ OTHER (Specify)

COMPLETE THESE ITEMS FOR FETAL DEATH ONLY

11. DATE OF DELIVERY OF FETUS (MO. / DAY / YEAR) | 12. TIME OF DELIVERY (Use 24-hr clock)

13. PLACE OF DELIVERY: ☐ REPORTING HOSPITAL ☐ HOME ☐ OTHER (Specify) _____

14. WEIGHT OF FETUS: _____ GRAMS; CHECK HERE IF WEIGHT UNKNOWN ☐

15. FETUS DIED: ☐ BEFORE LABOR ☐ DURING LABOR OR DELIVERY ☐ UNKNOWN

COMPLETE THESE ITEMS FOR INFANT DEATH ONLY

16. DATE OF DEATH (MO. / DAY / YEAR) | 17. TIME OF DEATH (Use 24-hr clock)

18. PLACE OF DEATH: ☐ REPORTING HOSPITAL ☐ HOME ☐ OTHER (Specify) _____

19. BIRTH INJURIES PRESENT: ☐ NO ☐ YES ☐ UNKNOWN

20. IF "YES", DESCRIBE _____

21. DO NOT USE

22. CAUSE OF DEATH (Include antecedent illness and conditions. CIRCLE the number of the underlying cause of death.)

(1.)
(2.)
(3.)
(4.)
(5.)
(6.)
(7.)
(8.)
(9.)
(10.)

23. DO NOT WRITE IN THIS SPACE

24. REMARKS (Use this space to describe circumstances associated with death.)

IF MORE SPACE IS NEEDED INDICATE ITEM NUMBER AND ATTACH CONTINUATION SHEET (FORM ADM-5)

25. MALFORMATIONS PRESENT: ☐ NO ☐ YES ☐ NOT DETERMINED

26. IF "YES", LIST AND DESCRIBE MALFORMATIONS HERE

(1.)
(2.)
(3.)
(4.)
(5.)
(6.)
(7.)
(8.)
(9.)

27. DO NOT USE

Department of Health, Education, and Welfare
Public Health Service

REV 7-59 (PED-4)

white

PHS-5054-4
3-59

REPORT OF FETAL OR INFANT DEATH

Prepared by
Nov. 1959

1. NAME OF EXAMINER | 2. TITLE OR POSITION

3. DATE (Mo-Day-Yr) | 4. TIME RECEIVED (Use 24-hr clock) | 5. TYPE OF RECORD: ☐ FETAL DEATH 1 ☐ INFANT DEATH 2 | RECORD NUMBERS: 6. HOSPITAL | 7. OTHER

8. SEX: ☐ MALE ☐ FEMALE ☐ UNDETERMINED 3 | 9. AUTOPSY: ☐ NONE 0 YES ☐ IN REPORTING HOSPITAL 1 ☐ OTHER (Specify) 2

COMPLETE THESE ITEMS FOR FETAL DEATH ONLY

10. DATE OF DELIVERY OF FETUS (Mo-Day-Yr) | 11. TIME OF DELIVERY (Use 24-hr clock)

12. PLACE OF DELIVERY: ☐ REPORTING HOSPITAL 1 ☐ HOME 2 ☐ OTHER (Specify) 3 _____

13. WEIGHT OF FETUS: _____ GRAMS; CHECK HERE IF WEIGHT UNKNOWN ☐ 9

14. FETUS DIED: ☐ BEFORE LABOR 1 ☐ DURING LABOR OR DELIVERY 2 ☐ UNKNOWN 9

COMPLETE THESE ITEMS FOR INFANT DEATH ONLY

15. DATE OF DEATH (Mo-Day-Yr) | 16. TIME OF DEATH (Use 24-hr clock)

17. PLACE OF DEATH: ☐ REPORTING HOSPITAL 1 ☐ HOME 2 ☐ OTHER (Specify) 3 _____

18. BIRTH MARRIED PRESENT: ☐ NO 0 ☐ YES 1 ☐ UNKNOWN 9

IF "YES", DESCRIBE _____

19. CAUSE OF DEATH (Include associated illnesses and conditions. CIRCLE the number of the underlying cause of death.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DO NOT WRITE IN THIS SPACE

REMARKS (Also use this space to describe circumstances associated with death.)

IF MORE SPACE IS NEEDED USE REVERSE OF FORM

20. MALFORMATIONS PRESENT: ☐ NO 0 ☐ YES 1 ☐ NOT DETERMINED 2

IF "YES", LIST AND DESCRIBE MALFORMATIONS HERE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Department of Health, Education, and Welfare
Public Health Service

GPO 872228

(PED-4)

PED-5 Results of Tests and Procedures Done on the Neonate

Form PED-5 was used to provide a record of the results of all tests and procedures performed on the neonate. Implemented in May 1960, the form was not revised. Data from PED-5 were punched onto card 0405 Revision 0 of the master file (Table PED-5.1). Prior to May 1960, results from tests and procedures were included on the January 1959 version of PED-7 "Summary of the Hospital Course of the Neonate, Record of Examination." These data are also included in the master data file on card 0405 Revision No. 1 (see Table PED-5.1).

TABLE PED-5.1 Cards and Data Records by Revision for Form PED-5

Card Name	Card Number	Rev. No.	Number Records
PED-5: Serum Bilirubin, Hemoglobin and Hematocrit, etc.	0405	0	47,094
PED-7: Serum Bilirubin, Hemoglobin and Hematocrit	0405	1	6,109
	total for form		53,203

Data Items Referencing Form PED-5, Result of Test and Procedures done on the Neonate

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4106.....		0405	1	5	Card number (sequence, form type, form number, revision number)
4107.....		0405	6	14	NINDB case number
4108..PED-5	1	0405	15	16	Birth date (mo)
4109..PED-5	1	0405	17	18	Birth day (day)
4110..PED-5	1	0405	19	20	Birth day (yr)
4111..PED-5	3	0405	21	21	Blood type
4112..PED-5	4	0405	22	22	Rh type
4113..PED-5	4	0405	23	23	Rh type, additional information
4114..PED-5	5	0405	24	24	Coombs' test, direct
4115..PED-5	6	0405	25	25	Cord; blood
4116..PED-5	12	0405	26	26	Blood for neonate characterization, source
4117..PED-5	14	0405	27	29	Bilirubin, serum, first, age (hrs)
4118..PED-5	16	0405	30	31	Bilirubin, serum, first, direct (mg %)
4119..PED-5	17	0405	32	33	Bilirubin, serum, first, total (mg %)
4120..PED-5	14	0405	34	36	Bilirubin, serum, 48 hr, age (hrs)
4121..PED-5	16	0405	37	38	Bilirubin, serum, 48 hr, direct (mg %)
4122..PED-5	17	0405	39	40	Bilirubin, serum, 48 hr, total (mg %)
4123..PED-5	14	0405	41	43	Bilirubin, serum, highest, age (hrs)
4124..PED-5	16	0405	44	45	Bilirubin, serum, highest, direct (hrs)
4125..PED-5	17	0405	46	47	Bilirubin, serum, highest, total (hrs)
4126..PED-5	15	0405	48	48	Bilirubin, serum, number
4127..PED-5	18	0405	49	51	Hemoglobin, 48 hr, age (hrs)
4128..PED-5	18	0405	52	53	Hemoglobin, 48 hr, (gm %)
4129..PED-5	18	0405	54	56	Hemoglobin, lowest, age (hrs)
4130..PED-5	18	0405	57	58	Hemoglobin, lowest (gm %)
4131..PED-5	19	0405	59	61	Hematocrit, 48 hr, age (hrs)
4132..PED-5	19	0405	62	63	Hematocrit, 48 hr (percent)
4133..PED-5	19	0405	64	66	Hematocrit, lowest, age (hrs)
4134..PED-5	19	0405	67	68	Hematocrit, lowest (percent)
4135..PED-5	20,21	0405	69	69	Protein; albumin; serum, performed
4136..PED-5	22	0405	70	70	Laboratory tests, other
4137.....		0405	71	80	Blank
5416....VAR	5		586	586	Coombs' test, direct
5417....VAR	17		587	588	Bilirubin, serum, first, total (mg%)
5418....VAR	19		589	590	Hematocrit, lowest (mg%)
5419....VAR	18		591	592	Hemoglobin, lowest (mg%)
5420....VAR			593	594	Bilirubin, serum, maximum (mg%)
5421....VAR			595	595	Bilirubin, serum, maximum (coded)
5941....VAR	3		1129	1129	Blood type
5942....VAR	4		1130	1130	Rh type
5943....VAR	18		1131	1133	Hemoglobin, lowest, age (hrs)
5944....VAR	19		1134	1136	Hematocrit, lowest, age (hrs)

Data Items Referencing Form PED-5, Result of Test and Procedures done on the Neonate

DATA ITEM ID		ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5991....	VAR	18		1227	1228	Hemoglobin 48 hrs (gm%)
5992....	VAR	19		1229	1230	Hematocrit 48 hrs (gm%)

COLR.-508646
REV. 8-68

1. PATIENT'S IDENTIFICATION

RESULTS OF TESTS AND PROCEDURES DONE ON THE NEONATE

2. CORD BLOOD – REQUIRED

3. ABO BLOOD TYPE ☐ O (1) ☐ A (2) ☐ B (3) ☐ AB (4) ☐ Not Done (Explain) (9)

4. Rh BLOOD TYPE ☐ Pos. (1) ☐ Neg. (2) ☐ Not Done (Explain) (9)

5. DIRECT COOMBS' TEST ☐ Pos. (1) ☐ Neg. (2) ☐ Not Done (Explain) (9)

6. CORD BLOOD – OPTIONAL

7. BILIRUBIN

8. DIRECT Mg. %

9. TOTAL Mg. %

10. HEMOGLOBIN Gm. %

11. HEMATOCRIT %

12. BLOOD (Check one) ☐ Capillary (1) or ☐ Venous (2)

	(1)	(2)	(3)	(4)	(5)	(6)
13. DATE DRAWN (Month, day, year)						
14. TIME DRAWN (24 hour clock)						
15. SERUM BILIRUBIN – 16. DIRECT (Mg. %)						
15. SERUM BILIRUBIN – 17. TOTAL (Mg. %)						
18. HEMOGLOBIN (Gm. %)						
19. HEMATOCRIT (%)						
20. TOTAL SERUM PROTEIN (Gm. %)						
21. SERUM ALBUMIN (Gm. %)						

22. OTHER TESTS AND PROCEDURES (Bacterial and Viral Cultures, Blood and CSF Chemistries, X-rays, etc.)

	(1) DATE	(2) TIME	(3) TEST OR PROCEDURE	(4) RESULTS
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				

35. COMMENTS

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(PED-5)

Form Item Numbers linked to Data Items on PED-5, Result of Test and Procedures done on the Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	5421....VAR		595	595	Bilirubin, serum, maximum (coded)
	5420....VAR		593	594	Bilirubin, serum, maximum (mg%)
1	4108..PED-5	0405	15	16	Birth date (mo)
1	4109..PED-5	0405	17	18	Birth day (day)
1	4110..PED-5	0405	19	20	Birth day (yr)
3	4111..PED-5	0405	21	21	Blood type
3	5941....VAR		1129	1129	Blood type
4	5942....VAR		1130	1130	Rh type
4	4112..PED-5	0405	22	22	Rh type
4	4113..PED-5	0405	23	23	Rh type, additional information
5	4114..PED-5	0405	24	24	Coombs' test, direct
5	5416....VAR		586	586	Coombs' test, direct
6	4115..PED-5	0405	25	25	Cord; blood
12	4116..PED-5	0405	26	26	Blood for neonate characterization, source
14	4120..PED-5	0405	34	36	Bilirubin, serum, 48 hr, age (hrs)
14	4117..PED-5	0405	27	29	Bilirubin, serum, first, age (hrs)
14	4123..PED-5	0405	41	43	Bilirubin, serum, highest, age (hrs)
15	4126..PED-5	0405	48	48	Bilirubin, serum, number
16	4121..PED-5	0405	37	38	Bilirubin, serum, 48 hr, direct (mg %)
16	4118..PED-5	0405	30	31	Bilirubin, serum, first, direct (mg %)
16	4124..PED-5	0405	44	45	Bilirubin, serum, highest, direct (hrs)
17	4122..PED-5	0405	39	40	Bilirubin, serum, 48 hr, total (mg %)
17	4119..PED-5	0405	32	33	Bilirubin, serum, first, total (mg %)
17	5417....VAR		587	588	Bilirubin, serum, first, total (mg%)
17	4125..PED-5	0405	46	47	Bilirubin, serum, highest, total (hrs)
18	5991....VAR		1227	1228	Hemoglobin 48 hrs (gm%)
18	4128..PED-5	0405	52	53	Hemoglobin, 48 hr, (gm %)
18	4127..PED-5	0405	49	51	Hemoglobin, 48 hr, age (hrs)
18	4130..PED-5	0405	57	58	Hemoglobin, lowest (gm %)
18	5419....VAR		591	592	Hemoglobin, lowest (mg%)
18	4129..PED-5	0405	54	56	Hemoglobin, lowest, age (hrs)
18	5943....VAR		1131	1133	Hemoglobin, lowest, age (hrs)
19	5992....VAR		1229	1230	Hematocrit 48 hrs (gm%)
19	4132..PED-5	0405	62	63	Hematocrit, 48 hr (percent)
19	4131..PED-5	0405	59	61	Hematocrit, 48 hr, age (hrs)
19	5418....VAR		589	590	Hematocrit, lowest (mg%)
19	4134..PED-5	0405	67	68	Hematocrit, lowest (percent)
19	4133..PED-5	0405	64	66	Hematocrit, lowest, age (hrs)
19	5944....VAR		1134	1136	Hematocrit, lowest, age (hrs)
20,21	4135..PED-5	0405	69	69	Protein; albumin; serum, performed
22	4136..PED-5	0405	70	70	Laboratory tests, other

DEFINITION OF CODES
RESULTS OF TESTS AND PROCEDURES
DONE ON THE NEONATE
FORM PED-5 CARD 0405

FIELD		CARD COLUMN
1.	**Card Number** Code: 0	1
2.	**Form Number** Code: 405	2-4
3.	**Revision Number** * Code: 0 - PED-5- Form Dated: 5/60 1 - PED-7- Form Dated: 1/59	5
4.	**NIMDB Number** ~~Nine-digit number for Patient Identification~~ Code: As given	6-14
5.	**Date of Birth** Six-digit code for month (cols. 15-16), day (cols. 17-18), and year 19-20). Code: As given	15-20
6.	**Blood Type** Item 3 Code: 1 - O 2 - A 3 - B 4 - AB 9 - Unknown	21
7.	**RH Blood Type** Item 4 **Type** (column 22) Code: 1 - Positive 2 - Negative 9 - Unknown **Additional Information** (column 23) Code: 1 - Type and Additional Information 2 - Type and No Additional Information 3 - No Type but Additional Information 9 - Type and additional information unknown	22-23

* Unless specified, Fields, Codes and Card Columns refer to Revision Numbers "0" and "1". Item Numbers refer to Form Dated: 5/60

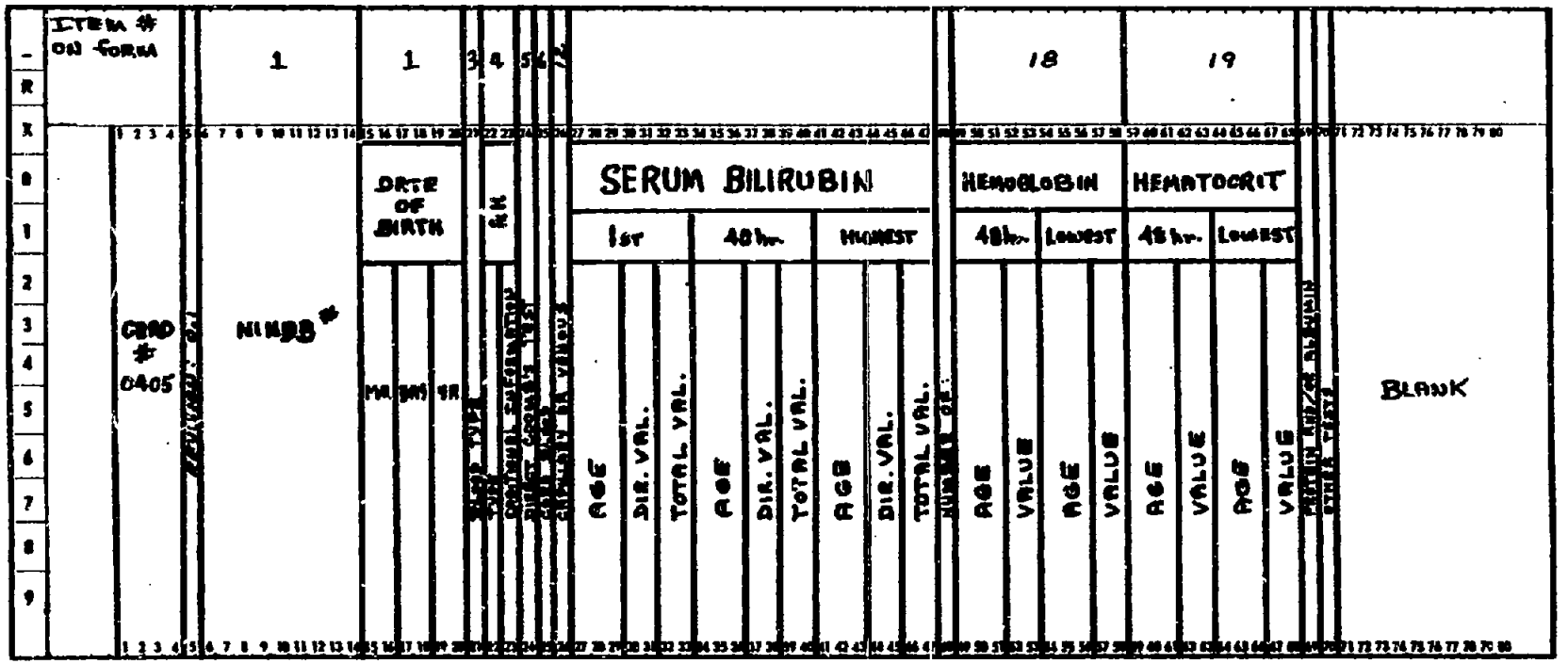
Revised September 1965

FIELD		CARD COLUMN
8.	**Direct Coomb's Test** Item 5 Code: 1 - Positive 2 - Negative 9 - Unknown	24
9.	**Cord Blood** Item 6 Code: 0 - Bilirubin only 1 - Hemaglobin only 2 - Hematocrit only 3 - Combination of codes 0 and 1 4 - Combination of codes 0 and 2 5 - Combination of codes 0, 1 and 2 6 - Combination of codes 1 and 2 9 - Unknown	25
10.	**Capillary or Venous** (Rev. "0" only) Item 12 Code: Blank - Not on Rev. "1" 1 - Capillary 2 - Venous 3 - Capillary and Venous 9 - Unknown	26
11.	**First Serum Bilirubin** Seven-digit code for: Age (cols. 27-29) Code: 000 - Less than one hour 001-997 - As given in hours 998 - 998 hours or more 999 - Unknown Direct Value (cols. 30-31) Code: 00 - Less than 1 01-08 - As given in mgms. % 99 - Unknown Total Value (cols. 32-33) Code: 00 - Less than 1 01-25 - As given in mgms. % 99 - Unknown Additional codes reviewed and approved (cols. 32-33): 26, 29, 35	27-33

FIELD		CARD COLUMN
12.	**48 Hour Serum Bilirubin** Seven-digit code for: Age (cols. 34-36) Code: Same as in Field 11, cols. 27-29 Direct Value (cols. 37-38) Code: Same as in Field 11, cols. 30-31 except additional codes reviewed and approved: 10, 16, 22 Total Value (cols. 39-40) Code: Same as in Field 11, cols. 32-33 except additional codes reviewed and approved: 26-29, 35, 43	34-40
13.	**Highest Serum Bilirubin** Seven-digit code for: Age (cols. 41-43) Code: Same as in Field 11, cols. 27-29 Direct Value (cols. 44-45) Code: Same as in Field 11, cols. 30-31 except additional codes reviewed and approved: 09,10,16,21,35 Total Value (cols. 46-47) Code: Same as in Field 11, cols. 32-33 except additional codes reviewed and approved: 26-38, 53	41-47
14.	**Number of Bilirubins** Code: 0 - 1 bilirubin 1 - 2 bilirubins 2 - 3 bilirubins 3 - 4 or more bilirubins 9 - Not reported	43
15.	**48 Hour Hemoglobin** Item 18 Five-digit code for: Age (cols. 49-51) Code: Same as in Field 11, cols. 27-29 Value (cols. 52-53) Code: 01-30 - As given in gms. % 99 - Unknown Additional codes reviewed and approved: 50, 52, 55, 57, 59, 60,62	49-53

FIELD		CARD COLUMN
16.	**Lowest Hemoglobin** Item 18 Five-digit code for: Age (cols. 54-56) Code: Same as in Field 11, cols. 27-29 Value (cols. 57-58) Code: Same as in Field 15, cols. 52-53 except additional codes reviewed and approved: 02-04, 50, 55, 57, 59, 60, 62.	54-58
17.	**48 Hour Hematocrit** Item 19 Five-digit code for: Age (cols. 59-61) Code: Same as in Field 11, cols. 27-29 Value (cols. 62-63) Code: 25-85 - As given in % 99 - Unknown Additional codes reviewed and approved: 19, 22-24, 86-90	59-63
18.	**Lowest Hematocrit** Item 19 Five-digit code for: Age in Hours (cols. 64-66) Code: Same as in Field 11, cols. 27-29 Value (cols. 67-68) Code: 10-85 - As given 99 - Unknown Additional codes reviewed and approved: 86-90	64-68
19.	**Protein and/or Albumin** Code: 0 - Serum protein and/or albumin reported 9 - Not reported	69
20.	**Other Tests** Code: 0 - Other tests and/or procedures reported 9 - Not reported	70

RESULTS OF TESTS AND PROCEDURES DONE ON THE NEONATE
FORM PED-5, PED-7*



* Item numbers refer to form dated: 5/60

PEDIATRICS MANUAL
RESULTS OF TESTS AND PROCEDURES DONE ON THE NEONATE
(For Form PED-5, 5-60)

A. INTRODUCTION. The purpose of Form PED-5 is to provide a record of the results of all tests and procedures performed on the neonate. This manual has been prepared for use as a guide in reporting this information. Specific instructions for performing the laboratory tests and procedures are not included in this manual.

B. GENERAL INSTRUCTIONS. The form is arranged for convenience in reporting the required laboratory tests. Space is also provided for easy reporting of other frequently performed tests. A large portion of the form is left for detailed reporting of other laboratory tests and special procedures performed as part of another research study or for the care of the infant.

Local policy shall determine when and by whom the results of laboratory tests and procedures are transferred from the hospital record to the study record PED-5. It is desirable that this be done and forwarded to NIH as soon as possible after the child is discharged from the hospital. If certain studies, such as viral cultures which may take several weeks or months to complete, are in progress, PED-5, containing the routine data should be sent in promptly with an indication that the results of other tests (specify) will be sent later.

C. INSTRUCTIONS AND DEFINITIONS FOR COMPLETING ITEMS ON FORM PED-5.

Item 1, Patient Identification. This item is to be completed using the patient's name plate.

Cord Blood-Required. The following three items are the tests on cord blood the Study requires for every infant. If the cord blood is lost and venous blood is used for the tests, record the results in these spaces, but indicate the source of the blood.

Item 3, ABO Blood Type. Report as "A", "B", "O", or "AB" as minimum data. Subtypes may also be reported but should not confuse the report of the major type.

Item 4, Rh Blood Type. Report as "Rh positive," or "Rh negative" as minimum data. If further typing is done, this data should also be reported, but should not confuse the report of the major (big D) type.

Item 5, Direct Coombs' Test. Report as "negative" or "positive."

Cord Blood-Optional. The following three items are tests which are not required, but are frequently done on cord blood. Space is provided for recording these separate from the tests done on capillary or venous blood, both to simplify editing and coding of the required tests, and because they may be of special interest.

Items 7-9, Bilirubin—Direct, Total. Record the values in mg.% in the appropriate spaces.

Item 10, Hemoglobin. Report as grams percent.

Item 11, Hematocrit. Report as percent.

Item 12, Blood (check one) Capillary ☐ or Venous ☐. Check one of the two boxes to indicate the type of blood used for the tests reported in Items 13-21. It is assumed that the single check-mark will apply to all determinations reported in this section. Please clearly indicate if there are exceptions to this in "comments," Item 35.

Item 13, Date Drawn. This information should appear at the head of each column in which determinations are reported. Do not record the results of tests done on blood drawn at different times in the same column.

Item 14, Time Drawn. Indicate in each column the approximate (nearest hour) time that the blood was drawn for the determinations reported in that column.

Items 15-17, Serum Bilirubin—Direct, Total. Record the values in mg. percent in the appropriate spaces.

The Study requires that a serum bilirubin determination be done on every infant between 36 and 60 hours of age, centering about 48 hours of age. If the total bilirubin on the first determination is 10 mg.% or over, the test should be repeated in 24 hours, and if still over 10 mg.%, a third determination should be done at 4-5 days of age.

In the case of infants weighing 2250 grams (5 pounds) or less at birth, the minimum requirement will be three bilirubin determinations: one at 36 to 60 hours of age centering about 48 hours of age, a second 24 hours after the first, and a third at 4-5 days of age. If on the third determination the value is 10 mg.% or higher, the test should be repeated at intervals until the value falls below 10 mg.%.

If bilirubin determinations are done in excess of those required by the Study, or in laboratories different from that in which the routine Study bilirubins are done, these should be reported under Item 22.

Item 18, Hemoglobin. Report as grams percent.

The Study requires that a hemoglobin determination be done on every infant between 36 and 60 hours of age, centering about 48 hours of age.

Item 19, Hematocrit. Record as percent.

This is not required, but since it is frequently done, a space is provided for reporting the value here rather than under Item 22.

Item 20, Total Serum Protein. This is not required, but since it is frequently done, a space is provided for reporting the value here rather than under Item 22.

Item 21, Serum Albumin. This is not required, but since it is frequently done, a space is provided for reporting the value here rather than under Item 22.

Items 22-34, Other Tests and Procedures. Report here the results of all special tests and procedures such as bacterial and viral cultures, blood and CSF chemistries, X-rays, surgical procedures and biopsies, urinalysis, EEG, sub-dural tap, etc.

Indicate the date and approximate time the specimen was obtained or the procedure performed, clearly identify the test or procedure, and record the results with the units or other qualifications clearly stated.

Item 35, Comments. Use this space for any appropriate notes or comments.

PED-6 Neonatal Neurological Examination

Form PED-6 was used to evaluate by physical examination techniques, the function of the child's central nervous system in the first few days of life. Introduced into the study in January 1959, the form was revised in November 1959 and again in June 1961. Both revisions resulted in a reitemization of the form and some changes in wording. New items were added on the last revision (1961). This examination could be administered on a repetitive basis, however only the first two examinations were coded. Data from form PED-6 were recorded on four cards in the master file (Table PED-6.1).

TABLE PED-6.1 Cards and Data Records by Revision for Form PED-6

Card Name	Card Number	Rev. No.	Number Records
PED-6: Motor Activity, Moro, Labyrinthine (1st exam)	1406	0	11,134
		1	2,033
		3	39,012
			52,179
PED:6: Tone and Eye Observation (1st exam)	2406	0	11,133
		1	2,033
		3	39,007
			52,173
PED-6: Motor Activity, Moro, Labyrinthine (2nd exam)	3406	0	1,093
		1	531
		3	5,417
			7,041
PED-6: Tone and Eye Observation (2nd exam)	4406	0	1,093
		1	530
		3	5,416
			7,039
	total for form		118,432

Data Items Referencing Form PED-6, Neonatal Neurological Exam

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4138.....		1406	1	5	Card number, (sequence, form type, form number, revision number)
4139.....		1406	6	14	NINDB case number
4140..PED-6	1	1406	15	16	Birth date (mo)
4141..PED-6	1	1406	17	18	Birth date (day)
4142..PED-6	7	1406	19	20	Birth date (yr)
4143..PED-6	7	1406	21	23	Age at examination (hrs)
4144..PED-6	8	1406	24	25	Feeding, time since last (hrs)
4145..PED-6		1406	26	26	Neurological exams, number
4146..PED-6	9	1406	27	28	Eyes, position at rest
4147..PED-6	12	1406	29	29	Reflex; blink
4148..PED-6	13	1406	30	30	Movements; face
4149..PED-6	14	1406	31	31	Motor activity; tremulous; jittery
4150..PED-6	14	1406	32	32	Motor activity; jerky; myclonic
4151..PED-6	14	1406	33	33	Motor activity; writhing
4152..PED-6	14	1406	34	34	Motor activity; asymmetrical
4153..PED-6	14	1406	35	35	Motor activity; convulsions, local
4154..PED-6	14	1406	36	36	Motor activity; convulsions, generalized
4155..PED-6	14	1406	37	37	Motor activity, other
4156..PED-6	15	1406	38	38	Movements; extremity
4157..PED-6	16	1406	39	39	Cry
4158..PED-6	19	1406	40	40	Grasp; palmar
4159..PED-6	20	1406	41	41	Grasp; plantar
4160..PED-6	21	1406	42	42	Reflex; patellar/knee jerk
4161..PED-6	23	1406	43	43	Clonus; ankle, right
4162..PED-6	24	1406	44	44	Clonus; ankle, left
4163..PED-6	25	1406	45	45	Suck
4164..PED-6	26	1406	46	46	Rooting response
4165..PED-6	27	1406	47	47	Prone position
4166..PED-6	28	1406	48	48	Traction response
4167..PED-6	31	1406	49	49	Reflex; withdrawal
4168..PED-6	32	1406	50	50	Trunk; incurvation response
4169..PED-6	33	1406	51	51	Stepping response
4170..PED-6	34	1406	52	52	Placing response
4171..PED-6	36	1406	53	53	Moro response, general
4172..PED-6	37	1406	54	54	Moro response, arms
4173..PED-6	38	1406	55	55	Moro response, legs
4174..PED-6		1406	56	56	Traction response
4175..PED-6		1406	57	57	Palpebral tissue
4176..PED-6		1406	58	58	Auditory response
4177..PED-6		1406	59	59	Reflex; labyrinthine, deviation during right rotation
4178..PED-6		1406	60	60	Reflex; labyrinthine, nystagmus during right rotation
4179..PED-6		1406	61	61	Reflex; labyrinthine, deviation after right rotation

Data Items Referencing Form PED-6, Neonatal Neurological Exam

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4180..PED-6		1406	62	62	Reflex; labyrinthine, nystagmus after right rotation
4181..PED-6		1406	63	63	Reflex; labyrinthine, deviation during left rotation
4182..PED-6		1406	64	64	Reflex; labyrinthine, nystagmus during left rotation
4183..PED-6		1406	65	65	Reflex; labyrinthine, deviation after left rotation
4184..PED-6		1406	66	66	Reflex; labyrinthine, nystagmus after left rotation
4185..PED-6		1406	67	67	Reflex; labyrinthine, deviation during right rotation
4186..PED-6		1406	68	68	Reflex; labyrinthine, deviation after right rotation
4187..PED-6		1406	69	69	Reflex; labyrinthine, deviation during left rotation
4188..PED-6		1406	70	70	Reflex; labyrinthine, deviation after left rotation
4189.....		1406	71	80	Blank
4190.....		2406	1	5	Card number (sequence, form type, form number, revision number)
4191.....		2406	6	14	NINDB case number
4192..PED-6	1	2406	15	16	Birth date (mo)
4193..PED-6	1	2406	17	18	Birth date (day)
4194..PED-6	1	2406	19	20	Birth date (yr)
4195..PED-6	7	2406	21	23	Age at examination
4196..PED-6	8	2406	24	25	Feeding, time since last feeding
4197..PED-6	41	2406	26	26	Eyes; movements
4198..PED-6	42	2406	27	27	Eyes; pupils, direct reaction
4199..PED-6	43	2406	28	28	Eyes; pupils, size
4200..PED-6	44	2406	29	29	Eyes; external exam
4201..PED-6	49	2406	30	30	Eyes; ophthalmoscopic exam
4202..PED-6	51	2406	31	32	Tone; extremity, upper
4203..PED-6	52	2406	33	34	Tone; extremity, lower
4204..PED-6	53	2406	35	36	Tone; neck flexor
4205..PED-6	54	2406	37	38	Tone; neck extensor
4206..PED-6	55	2406	39	40	Tone; trunk
4207..PED-6	58	2406	41	41	Transillumination
4208..PED-6	59	2406	42	43	Reflex; tonic neck
4209..PED-6	64	2406	44	44	Reflex; tonic neck, right jaw arm
4210..PED-6	65	2406	45	45	Reflex; tonic neck, right jaw leg
4211..PED-6	66	2406	46	46	Reflex; tonic neck, right occiput arm
4212..PED-6	67	2406	47	47	Reflex; tonic neck, right occiput leg
4213..PED-6	68	2406	48	48	Reflex; tonic neck, left jaw arm
4214..PED-6	70	2406	49	49	Reflex; tonic neck, left jaw leg
4215..PED-6	71	2406	50	50	Reflex; tonic neck, left occiput arm
4216..PED-6	72	2406	51	51	Reflex; tonic neck, left occiput leg
4217..PED-6	73	2406	52	52	Neurological; signs, other
4218..PED-6	73	2406	53	53	Neurological; abnormalities
4219..PED-6	75	2406	54	54	Non neurological; abnormalities
4220..PED-6	76	2406	55	55	Examination conditions
4221..PED-6		2406	56	56	Neurological; diagnosis (rev 0 only)
4222..PED-6		2406	57	57	Tone; neck

Data Items Referencing Form PED-6, Neonatal Neurological Exam

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4223..PED-6		2406	58	58	Tone; trunk
4224..PED-6		2406	59	59	Tone; extremity, upper
4225..PED-6		2406	60	60	Tone; extremity, lower
4226..PED-6		2406	61	62	Eyes; cornea
4227..PED-6		2406	63	64	Eyes; anterior chamber
4228..PED-6		2406	65	66	Eyes; iris
4229..PED-6		2406	67	68	Eyes; lens
4230..PED-6		2406	69	70	Eyes; vitreous
4231..PED-6		2406	71	72	Eyes; disc
4232..PED-6		2406	73	74	Eyes; fundus
4233..PED-6		2406	75	76	Eyes; pupil and other
4234.....		2406	77	80	Blank
4235..PED-6	1-38	3406	1	80	Neurological re-examination (if given), repeat of card 1406
4236..PED-6	41-76	4406	1	80	Neurological re-examination (if given), repeat of card 2406
5936....VAR	74		1123	1123	Neurological abnormalities, neonatal

COLR-3004-6
(REV. 6-61)

NEONATAL NEUROLOGICAL EXAMINATION

1. PATIENT IDENTIFICATION

2. NAME OF EXAMINER

3. TITLE OR POSITION

4. DATE OF EXAM. Mo. | Day | Year

5. TIME EXAMINATION STARTED (24 hour clock)

6. TIME LAST FEEDING STARTED (24 hour clock)

7. AGE OF CHILD (Hours completed if less than 72 hours, days completed, if 72 hours [3 days] or more

8. TIME SINCE LAST FEEDING (Item 5 minus Item 6 to nearest 15 minutes.)

17. COMMENTS

9. EYES—POSITION AT REST (Draw Position of Pupils)

10. RIGHT 11. LEFT

9 ☐ Unable to evaluate (give reason)

12. BLINK REFLEX (Light stimulus)

0 ☐ Present and symmetrical
1 ☐ Questionable response symmetrical (describe)
2 ☐ Absent bilaterally
3 ☐ Asymmetrical response (describe)
8 ☐ Other (describe)

13. MOVEMENTS OF FACE

0 ☐ Normal, symmetrical
1 ☐ Absent or diminished, symmetrical
2 ☐ Asymmetrical (describe)
8 ☐ Other (describe)

14. MOTOR ACTIVITY

0 ☐ Normal

	Slight	Moderate	Marked
1 ☐ Tremulous or Jittery	1	2	3
2 ☐ Jerky or Myoclonic Movements	1	2	3
3 ☐ Writhing Movements	1	2	3
4 ☐ Asymmetrical Movements	1	2	3

5 ☐ Local Convulsions
6 ☐ Generalized Convulsions
8 ☐ Other (describe)

15. EXTREMITY MOVEMENTS (Intensity and range)

0 ☐ Normal
1 ☐ Questionable abnormality (describe)
2 ☐ Abnormal (describe)

16. CRY (quality)

0 ☐ Normal
1 ☐ Questionable abnormality (describe)
2 ☐ Abnormal (describe)
3 ☐ Not heard

COLR-5004-6
(REV. 6-67)

NEONATAL NEUROLOGICAL EXAMINATION

18. PATIENT IDENTIFICATION

19. PALMAR GRASP *(With head in midline. Stimulus — Finger applied to ulnar side of palm.)*

- ☐ 0 Response present, symmetrical and consistent *(3 out of 3)*
- ☐ 1 Response present, symmetrical, but not consistent
- ☐ 2 Absent bilaterally
- ☐ 3 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

20. PLANTAR GRASP *(With head in midline. Stimulus — Finger applied to medial side of sole.)*

- ☐ 0 Symmetrical response present
- ☐ 1 Absent bilaterally
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

21. PATELLAR JERK *(With head in midline)*

- ☐ 0 Symmetrical response present
- ☐ 1 Absent bilaterally
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 3 Other *(describe)*

22. ANKLE CLONUS *(With knees flexed at 45°, count number of clonic movements.)*

23. RIGHT	24. LEFT
☐ 0 None	☐ 0 None
☐ 1 Under 8	☐ 1 Under 8
☐ 2 8 or more	☐ 2 8 or more

25. SUCK *(Evaluate with sterile nipple)*

- ☐ 0 Strong
- ☐ 1 Weak
- ☐ 2 Absent

26. ROOTING RESPONSE *(Stimulus — Touch a corner of lips. Record movement toward stimulus)*

- ☐ 0 Movement toward stimulus, symmetrical
- ☐ 1 No movement
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

27. PRONE POSITION

- ☐ 0 Normal *(Child lifts chin up or turns head to side or makes crawling movements)*
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal *(No chin up, no head to side, no crawl)*
- ☐ 8 Other *(describe)*

28. TRACTION RESPONSE *(Elicit by lifting child from supine position by pulling arms)*

- ☐ 0 Normal *(Weak flexion, head controlled and shoulder muscles assist movement)*
- ☐ 1 Questionable *(describe)*
- ☐ 2 Abnormal *(Check all that apply below)*
  - ☐ 8 No head control
  - ☐ 4 No neck flexion
  - ☐ 9 No shoulder muscle assistance

29. COMMENTS

NEONATAL NEUROLOGICAL EXAMINATION

30. PATIENT IDENTIFICATION

31. WITHDRAWAL REFLEX *(Stimulus – Pinprick to both soles.)*

- 0 ☐ Withdrawal of stimulated extremity elicited bilaterally
- 1 ☐ Response other than withdrawal of stimulated extremity elicited bilaterally
- 2 ☐ No response bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

32. INCURVATION OF TRUNK *(Child prone, stroke or tap paravertebral area)*

- 0 ☐ Normal, symmetrical
- 1 ☐ Questionable response *(describe)*
- 2 ☐ Absent bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

33. STEPPING *(Child erect, sole of foot on surface, and trunk and head inclined forward)*

- 0 ☐ Present bilaterally and symmetrically
- 1 ☐ Questionable response *(describe)*
- 2 ☐ Absent bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

34. PLACING *(Child held erect and dorsum of foot drawn under lower edge of surface)*

- 0 ☐ Present bilaterally and symmetrically
- 1 ☐ Questionable response *(describe)*
- 2 ☐ Absent bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

35. MORO *(Support child under back and head – let child's head drop back about 30° and note pattern of response on three successive attempts. If no constant pattern or no response, repeat series of three attempts once again later in the examination before completing the item.*

36. RESPONSE – GENERAL

- 1 ☐ Obtained with ease
- 2 ☐ Obtained with difficulty
- 3X ☐ No constant pattern *(skip to item 41)*
- 4X ☐ No response *(skip to item 41)*

37. RESPONSE OF ARMS

- 0 ☐ Normal *(Extensor and flexor components symmetrically present)*
- 1 ☐ Flexor component absent with anterior extension
- 2 ☐ Flexor component absent with lateral extension
- 3 ☐ Asymmetrical
- 4 ☐ Other *(Specify)*

38. RESPONSE OF LEGS

- 0 ☐ Movement
- 1 ☐ No movement

39. COMMENTS

NEONATAL NEUROLOGICAL EXAMINATION

40. PATIENT IDENTIFICATION

41. EYE MOVEMENTS *(Stimulus: lateral translocation of child in frontal plane, both left and right.)*

- ☐ 0 Normal *(horizontal)*
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal *(describe)*

42. PUPILS—DIRECT REACTION TO LIGHT

- ☐ 0 Present and rapid bilaterally
- ☐ 1 Present but sluggish bilaterally
- ☐ 2 Absent bilaterally
- ☐ 3 Asymmetrical response *(describe)*
- ☐ 8 Unable to evaluate *(give reason)*

43. PUPIL—SIZE

- ☐ 0 Normal and equal bilaterally
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal bilaterally *(describe in detail with drawing)*
- ☐ 3 Asymmetrical *(describe)*
- ☐ 8 Unable to evaluate *(give reason)*

44. EYES—STRUCTURE—EXTERNAL EXAMINATION

- ☐ 0 Normal
- ☐ 1 Hemorrhage—scleral or conjunctival
- ☐ 2 Other *(describe)*

56. COMMENTS

NOTE: If ophthalmoscopic exam is done separately, complete items 45-48, otherwise skip them.

45. NAME OF EXAMINER	46. DATE OF EXAM. Mo. | Day | Year
47. TITLE OR POSITION	48. TIME EXAM. STARTED (24 hour clock)

49. EYES—STRUCTURE—OPHTHALMOSCOPIC EXAMINATION

- ☐ 0 Normal
- ☐ 1 Hemorrhage—retinal
- ☐ 2 Other *(describe)*
- ☐ 8 Unable to evaluate *(give reason)*
- ☐ 9 Not done

50. TONE—Use the following code which will indicate a gradation from flaccid to rigid. Describe any asymmetry in right hand column.

1. Hypotonic
2. Questionable Hypotonicity
3. Normal
4. Questionable Hypertonicity
5. Hypertonic
6. Unable to evaluate *(give reason)*

	Bilateral	Right	Left
51. Upper Extremity			
52. Lower Extremity			
53. Neck Flexor			
54. Neck Extensor			
55. Trunk			

COLR-8004-6
(REV. 6-61)

NEONATAL NEUROLOGICAL EXAMINATION

57. PATIENT IDENTIFICATION

58. TRANSILLUMINATION

- ☐ 0 Absent (normal)
- ☐ 1 Doubtful or questionable (describe)
- ☐ 2 Present (describe in detail)
- ☐ 8 Unable to evaluate (give reason)

59. TONIC NECK REFLEX (Optional)

	60. BILATERAL	61. RIGHT	62. LEFT
Obtained with ease	☐ 1	☐ 1	☐ 1
Obtained with difficulty	☐ 2	☐ 2	☐ 2
No concrete pattern	☐ 3X	☐ 3X	☐ 3X
No response	☐ 4X	☐ 4X	☐ 4X

63. HEAD ROTATED TO RIGHT

	Fl.	Ext.	O.
64. Jaw Arm	☐ 1	☐ 2	☐ 0
65. Jaw Leg	☐ 1	☐ 2	☐ 0
66. Occiput Arm	☐ 1	☐ 2	☐ 0
67. Occiput Leg	☐ 1	☐ 2	☐ 0

68. HEAD ROTATED TO LEFT

	Fl.	Ext.	O.
69. Jaw Arm	☐ 1	☐ 2	☐ 0
70. Jaw Leg	☐ 1	☐ 2	☐ 0
71. Occiput Arm	☐ 1	☐ 2	☐ 0
72. Occiput Leg	☐ 1	☐ 2	☐ 0

79. COMMENTS

73. OTHER SIGNS, REFLEXES, TESTS, ETC.

- ☐ 0 No
- ☐ 1 Yes (Specify)

IMPRESSION

74. NEUROLOGICAL ABNORMALITIES

- ☐ 0 None
- ☐ 1 Neurologically suspicious but no definite abnormalities (describe reason for this statement in detail)
- ☐ 2 Neurologically abnormal child (describe fully and give reasons)

75. NON-NEUROLOGICAL ABNORMALITIES (Check all that apply.)

- ☐ 0 None
- ☐ 1 Minor abnormalities or deviations (describe)
- ☐ 2 Questionable abnormalities (describe)
- ☐ 3 Definite abnormalities (describe)

76. UNSATISFACTORY CONDITIONS FOR EXAMINATION

- ☐ 0 Absent
- ☐ 1 Present (specify)

77. REPEAT EXAMINATION SCHEDULED FOR VERIFICATION OF ABNORMALITY

- ☐ 0 No
- ☐ 1 Yes

Form Item Numbers linked to Data Items on PED-6, Neonatal Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4176..PED-6	1406	58	58	Auditory response
	4227..PED-6	2406	63	64	Eyes; anterior chamber
	4226..PED-6	2406	61	62	Eyes; cornea
	4231..PED-6	2406	71	72	Eyes; disc
	4232..PED-6	2406	73	74	Eyes; fundus
	4228..PED-6	2406	65	66	Eyes; iris
	4229..PED-6	2406	67	68	Eyes; lens
	4233..PED-6	2406	75	76	Eyes; pupil and other
	4230..PED-6	2406	69	70	Eyes; vitreous
	4145..PED-6	1406	26	26	Neurological exams, number
	4221..PED-6	2406	56	56	Neurological; diagnosis (rev 0 only)
	4175..PED-6	1406	57	57	Palpebral tissue
	4188..PED-6	1406	70	70	Reflex; labyrinthine, deviation after left rotation
	4183..PED-6	1406	65	65	Reflex; labyrinthine, deviation after left rotation
	4179..PED-6	1406	61	61	Reflex; labyrinthine, deviation after right rotation
	4186..PED-6	1406	68	68	Reflex; labyrinthine, deviation after right rotation
	4181..PED-6	1406	63	63	Reflex; labyrinthine, deviation during left rotation
	4187..PED-6	1406	69	69	Reflex; labyrinthine, deviation during left rotation
	4177..PED-6	1406	59	59	Reflex; labyrinthine, deviation during right rotation
	4185..PED-6	1406	67	67	Reflex; labyrinthine, deviation during right rotation
	4184..PED-6	1406	66	66	Reflex; labyrinthine, nystagmus after left rotation
	4180..PED-6	1406	62	62	Reflex; labyrinthine, nystagmus after right rotation
	4182..PED-6	1406	64	64	Reflex; labyrinthine, nystagmus during left rotation
	4178..PED-6	1406	60	60	Reflex; labyrinthine, nystagmus during right rotation
	4225..PED-6	2406	60	60	Tone; extremity, lower
	4224..PED-6	2406	59	59	Tone; extremity, upper
	4222..PED-6	2406	57	57	Tone; neck
	4223..PED-6	2406	58	58	Tone; trunk
	4174..PED-6	1406	56	56	Traction response
1	4141..PED-6	1406	17	18	Birth date (day)
1	4193..PED-6	2406	17	18	Birth date (day)
1	4140..PED-6	1406	15	16	Birth date (mo)
1	4192..PED-6	2406	15	16	Birth date (mo)
1	4194..PED-6	2406	19	20	Birth date (yr)
1-38	4235..PED-6	3406	1	90	Neurological re-examination (if given), repeat of card 1406
7	4195..PED-6	2406	21	23	Age at examination
7	4143..PED-6	1406	21	23	Age at examination (hrs)
7	4142..PED-6	1406	19	20	Birth date (yr)
8	4144..PED-6	1406	24	25	Feeding, time since last (hrs)
8	4196..PED-6	2406	24	25	Feeding, time since last feeding
9	4146..PED-6	1406	27	28	Eyes, position at rest
12	4147..PED-6	1406	29	29	Reflex; blink

Form Item Numbers linked to Data Items on PED-6, Neonatal Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
13	4148..PED-6	1406	30	30	Movements; face
14	4155..PED-6	1406	37	37	Motor activity, other
14	4152..PED-6	1406	34	34	Motor activity; asymmetrical
14	4154..PED-6	1406	36	36	Motor activity; convulsions, generalized
14	4153..PED-6	1406	35	35	Motor activity; convulsions, local
14	4150..PED-6	1406	32	32	Motor activity; jerky; myclonic
14	4149..PED-6	1406	31	31	Motor activity; tremulous; jittery
14	4151..PED-6	1406	33	33	Motor activity; writhing
15	4156..PED-6	1406	38	38	Movements; extremity
16	4157..PED-6	1406	39	39	Cry
19	4158..PED-6	1406	40	40	Grasp; palmar
20	4159..PED-6	1406	41	41	Grasp; plantar
21	4160..PED-6	1406	42	42	Reflex; patellar/knee jerk
23	4161..PED-6	1406	43	43	Clonus; ankle, right
24	4162..PED-6	1406	44	44	Clonus; ankle, left
25	4163..PED-6	1406	45	45	Suck
26	4164..PED-6	1406	46	46	Rooting response
27	4165..PED-6	1406	47	47	Prone position
28	4166..PED-6	1406	48	48	Traction response
31	4167..PED-6	1406	49	49	Reflex; withdrawal
32	4168..PED-6	1406	50	50	Trunk; incurvation response
33	4169..PED-6	1406	51	51	Stepping response
34	4170..PED-6	1406	52	52	Placing response
36	4171..PED-6	1406	53	53	Moro response, general
37	4172..PED-6	1406	54	54	Moro response, arms
38	4173..PED-6	1406	55	55	Moro response, legs
41	4197..PED-6	2406	26	26	Eyes; movements
41-76	4236..PED-6	4406	1	80	Neurological re-examination (if given), repeat of card 2406
42	4198..PED-6	2406	27	27	Eyes; pupils, direct reaction
43	4199..PED-6	2406	28	28	Eyes; pupils, size
44	4200..PED-6	2406	29	29	Eyes; external exam
49	4201..PED-6	2406	30	30	Eyes; ophthalmoscopic exam
51	4202..PED-6	2406	31	32	Tone; extremity, upper
52	4203..PED-6	2406	33	34	Tone; extremity, lower
53	4204..PED-6	2406	35	36	Tone; neck flexor
54	4205..PED-6	2406	37	38	Tone; neck extensor
55	4206..PED-6	2406	39	40	Tone; trunk
58	4207..PED-6	2406	41	41	Transillumination
59	4208..PED-6	2406	42	43	Reflex; tonic neck
64	4209..PED-6	2406	44	44	Reflex; tonic neck, right jaw arm
65	4210..PED-6	2406	45	45	Reflex; tonic neck, right jaw leg
66	4211..PED-6	2406	46	46	Reflex; tonic neck, right occiput arm
67	4212..PED-6	2406	47	47	Reflex; tonic neck, right occiput leg

Form Item Numbers linked to Data Items on PED-6, Neonatal Neurological Exam

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
68	4213..PED-6	2406	48	48	Reflex; tonic neck, left jaw arm
70	4214..PED-6	2406	49	49	Reflex; tonic neck, left jaw leg
71	4215..PED-6	2406	50	50	Reflex; tonic neck, left occiput arm
72	4216..PED-6	2406	51	51	Reflex; tonic neck, left occiput leg
73	4218..PED-6	2406	53	53	Neurological; abnormalities
73	4217..PED-6	2406	52	52	Neurological; signs, other
74	5936....VAR		1123	1123	Neurological abnormalities, neonatal
75	4219..PED-6	2406	54	54	Non neurological; abnormalities
76	4220..PED-6	2406	55	55	Examination conditions

DEFINITION OF CODES
NEONATAL NEUROLOGICAL EXAMINATION
FORM PED-6 CARD-1406 and 3406

FIELD		CARD COLUMN
1.	**Card Number** Code: 1 - First card for infant's initial examination 3 - First card for infant's second examination, if any	1
2.	**Form Number** Code: 406	2-4
3.	**Revision Number** * Code: 0 - Form Dated: 1/59 1 - Form Dated: 11/59 3 - Form Dated: 6/61	5
4.	**NIMDS Number** Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	**Date of Birth** Item 1 Six-digit code for month (cols. 15-16), day (cols. 17-18), and year (cols. 19-20) Code: As given	15-20
6.	**Age** (Computed from time of birth to time of exam) Item 7 Code: 000 - Less than one hour 001-997 - As given in hours 998 - 998 hours or more 999 - Unknown	21-23
7.	**Time Since Last Feeding** Item 8 Code: 00 - Less than one hour 01-72 - As given in hours 99 - Not reported, not on Rev. "0"	24-25

* Unless specified, Fields, Codes and Cards Columns refer to Revision Number "0", "1" and "3". Item numbers refer to Form Dated 6/61.

DEFINITION OF CODES (Continued)

FORM PED-6
Card 1406 a 3406

FIELD

CARD COLUMN

8. **Number of Examinations** — 26
Code: 1-7 - As given
8 - 8 or more exams

9. **Eyes - Position at Rest** — 27-28
Item 9
Two-digit code for:
Pupil Position of Right Eye (col. 27)
Pupil Position of Left Eye (col. 28)
Code for each column:
0 - Central position
1 - Position 1
2 - Position 2
3 - Position 3
4 - Position 4
5 - Combination of codes 1 and 2
6 - Combination of codes 1 and 4
7 - Combination of codes 2 and 3
8 - Combination of codes 3 and 4
9 - Not evaluated or not reported

10. **Blink Reflex** — 29
Item 12
Code: 0 - Present and symmetrical
1 - Questionable response symmetrical
2 - Absent bilaterally
3 - Asymmetrical response
7 - Other on Rev. "0"
Includes questionable response which is not reported separately on this revision
8 - Other on Revisions "1" and "3"
9 - No report

11. **Movements of Face** — 30
Item 13
Code: 0 - Normal, symmetrical
1 - Absent or diminished, symmetrical
2 - Asymmetrical
3 - Absent on Revisions "0" and "1", does not include diminished
7 - Other on Revisions "0" and "1", includes diminished
8 - Other on Revision "3"
9 - No report

FIELD		CARD COLUMN
12.	Motor Activity - Tremulous or Jittery Item 14 Code: 0 - Normal 1 - Slight 2 - Moderate 3 - Marked 4 - Tremulous on Revision "0" 5 - Rapid, jittery movements on Revision "1" 9 - No report	31
13.	Motor Activity - Jerky or Myoclonic (Rev. "0" and "3" only) Item 14 Code: 0 - Normal 1 - Slight 2 - Moderate 3 - Marked 4 - Rapid, jerky movements on Rev. "0" 9 - No report, not on Rev. "1"	32
14.	Motor Activity - Writhing Item 14 Code: 0 - Normal 1 - Slight 2 - Moderate 3 - Marked 4 - Writhing on Rev. "0", "1" 9 - No report	33
15.	Motor Activity - Asymmetrical (Rev. "3" only) Item 14 Code: 0 - Normal 1 - Slight 2 - Moderate 3 - Marked 9 - No report, Not on Rev. "0" or "1"	34
16.	Motor Activity - Local Convulsions Item 14 Code: 0 - No local convulsions 1 - Local convulsions 9 - No report	35

FIELD		CARD COLUMN
17.	Motor Activity - Generalized Convulsions Item 14 Code: 0 - No generalized convulsions 1 - Generalized convulsions 9 - No report	36
18.	Motor Activity - Other Item 14 Code: 0 - None 1 - "Other" on Rev. "3" 2 - "Other" on Rev. "0" 3 - "Other" on Rev. "1" includes questionable abnormalities 9 - No report	37
19.	Extremity Movements Item 15 Code: 0 - Normal 1 - Questionable abnormality 2 - Abnormal on Revisions "1" and "3" 3 - Abnormal on Revision "0", includes questionable abnormality 9 - No report	38
20.	Cry (Rev. "1" and "3" only) Item 16 Code: 0 - Normal 1 - Questionable abnormality 2 - Abnormal 3 - Not heard 9 - Not reported, not on Rev. "0"	39
21.	Palmar Grasp Item 19 Code: 0 - Response present, symmetrical and consistent (or strong symmetrical response) 1 - Response present, symmetrical but not consistent (or weak symmetrical response) on Rev. "1" and "3" only 2 - Absent bilaterally 3 - Asymmetrical response	40

FIELD		CARD COLUMN
21.	Palmar Grasp (continued) Code: 7 - "Other" on Rev. "0" 8 - "Other" on Rev. "1" and "3" only 9 - No report	40
22.	Plantar Grasp Item 20 Code: 0 - Symmetrical response present 1 - Absent bilaterally 2 - Asymmetrical response 7 - "Other" on Rev. "0" 8 - "Other" on Rev. "1" and "3" 9 - No report	41
23.	Patellar Jerk Item 21 Code: 0 - Symmetrical response present 1 - Absent bilaterally 2 - Asymmetrical response 7 - "Other" on Rev. "0" 8 - "Other" on Rev. "1" and "3" 9 - No report	42
24.	Ankle Clonus - Right Item 23 Code: 0 - None 1 - Under 8 2 - 8 or more 9 - No report	43
25.	Ankle Clonus - Left Item 24 Code: Same as in Field 24	44
26.	Suck Item 25 Code: 0 - Strong 1 - Weak 2 - Absent 9 - No report	45

FIELD		CARD COLUMN
27.	**Rooting Response** Item 26 Code: 0 - Movement towards stimulus, symmetrical 1 - No movement 2 - Asymmetrical response 7 - "Other" on Rev. "0", includes asymmetrical 8 - "Other" on Rev. "1" and "3" 9 - No report	46
28.	**Prone Position** Item 27 Code: 0 - Normal 1 - Questionable abnormality 2 - Abnormal 3 - Abnormal on Rev. "0", includes questionable and "other" 8 - Other 9 - No report	47
29.	**Traction Response** (Rev. "1" and "3" only Item 28 Code: 0 - Normal 1 - Questionable 2 - No head control 3 - No neck flexion 4 - No shoulder muscle assistance 5 - Combination of codes 2 and 3 6 - Combination of codes 2 and 4 7 - Combination of codes 3 and 4 8 - Combination of codes 2, 3, and 4 9 - No report, not on Rev. "0"	48
30.	**Withdrawal Reflex** Item 31 Code: 0 - Withdrawal of stimulated extremity elicited bilaterally 1 - Response other than withdrawal of stimulated extremity elicited bilaterally 2 - No response bilaterally	49

DEFINITION OF CODES (Continued)

FORM PED-6
Card 1406 and 3406

FIELD		CARD COLUMN
30.	Withdrawal Reflex (continued) Code: 3 - Asymmetrical 7 - "Other" on Rev. "0" (includes codes 1 and 3 8 - "Other" on Rev. "1" and "3" 9 - No report	49
31.	Incurvation of Trunk Item 32 Code: 0 - Normal, symmetrical 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 6 - "Other" on Rev. "1" (includes code 3) 7 - "Other" on Rev. "0" (includes codes 1 and 3) 8 -"Other"on Revision "3" 9 - No report	50
32.	Stepping Item 33 Code: 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 7 - "Other" on Rev. "0" (includes codes 1 and 3) 8 - "Other" on Rev. "1" and "3" 9 - No report	51
33.	Placing Item 34 Code: 0 - Present bilaterally and symmetrically 1 - Questionable response 2 - Absent bilaterally 3 - Asymmetrical 7 - "Other" on Rev. "0" (includes codes 1 and 3) 8 - "Other" on Rev. "1" and "3" 9 - No report	52

FIELD		CARD COLUMN
34.	Moro - General Response Item 36 Code: 1 - Obtained with ease 2 - Obtained with difficulty 3 - No constant pattern 4 - No response (Rev. "1" and "3" only) 9 - No report	53
35.	Moro - Response of Arms Item 37 Code: 0 - Normal 1 - Flexor component absent with anterior extension 2 - Flexor component absent with lateral extension 3 - Asymmetrical 4 - Combination of codes 1 or 2 and "other" 5 - Flexor component absent (Rev. "0" and "1" only) 6 - Combination of codes "3" and "other" 7 - Combination of codes "5" and "other" 8 - Other 9 - No report	54
36.	Moro - Response of Legs Item 38 Code: 0 - Movement 1 - No movement 9 - No report	55
37.	Traction Response (Rev. "0" only) Code: Blank - not on Rev. "3" 0 - Normal 1 - No assistance from shoulder muscles 2 - No flexor action of neck muscles 9 - No report, not on Rev. "1"	56

FIELD		CARD COLUMN
38.	Palpebral Tissue (Rev. "0" only) Code: Blank - Not on Rev. "3" 0 - Equal 1 - Unequal 9 - No report, not on Rev. "1"	57
39.	Auditory Response (Rev. "0" only) Code: Blank - Not on Rev. "3" 0 - Present 1 - Absent bilaterally 2 - Asymmetrical 8 - Other 9 - No report, not on Rev. "1"	58
40.	Labyrinthine (Rev. "1" only) Eight-digit code for: Right Rotation - During rotation Deviation (col. 59) Nystagmus (col. 60) - After rotation Deviation (col. 61) Nystagmus (col. 62) Left Rotation - During rotation Deviation (col. 63) Nystagmus (col. 64) - After rotation Deviation (col. 65) Nystagmus (col. 66) Code for each column: Blank - Not on Rev. "3" 0 - None 1 - Right 2 - Left 3 - Asymmetrical 9 - No report, not on Rev. "0"	59-66

DEFINITION OF CODES (Continued)

FORM PED-6
Card 1406 and 3406

FIELD		CARD COLUMN
41.	Labyrinthine Reflex(Rev. "0" only) Four-digit code for: Rotation to Child's Right Deviation of eyes during rotation (col. 67) Deviation of eyes after stopping (col. 68) Rotation to Child's Left Deviation of eyes during rotation (col. 69) Deviation of eyes after stopping (col. 70) Code for each column: Blank - Not on Rev. "3" 0 - No movement 1 - To right 2 - To left 8 - Other 9 - No report, not on Rev. "1"	67-70

FIELD		CARD COLUMN
1.	**Card Number** Code: 2 - Second card for infant's initial examination 4 - Second card for infant's second examination	1
2.	**Basic Data*** Code: Same as in columns 2-25 of Card 1	2-25
3.	**Eye Movements** Item 41 Code: 0 - Normal 1 - Questionable 2 - Abnormal 3 - Abnormal on Rev. "0", includes questionable 9 - No report	26
4.	**Pupils - Direct Reaction** Item 42 Code: 0 - Present and rapid bilaterally 1 - Present but sluggish bilaterally 2 - Absent bilaterally 3 - Asymmetrical response 8 - Unable to evaluate (Rev. "3" only) 9 - No report	27
5.	**Pupil - Size** (Rev. "1" and "3" only) Item 43 Code: 0 - Normal and equal bilaterally 1 - Questionable abnormality 3 - Asymmetrical 8 - Unable to evaluate (Rev. "3" only) 9 - No report, not on Rev. "0"	28

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0", "1" and "3". Item numbers refer to Form Dated: 6/61.

FIELD		CARD COLUMN
6.	Eyes - External Exam (Rev. "3" only) Item 44 Code: 0 - Normal 1 - Hemorrhage - scleral 2 - Other 3 - Combination of codes 1 and 2 9 - No report, not on Rev. "0" and "1"	29
7.	Eyes - Ophthalmoscopic Exam (Rev. "3" only) Item 49 Code: 0 - Normal 1 - Hemorrhage - retinal 2 - Other 3 - Combination of codes 1 and 2 8 - Unable to evaluate 9 - Not done, not on Rev. "0" and "1"	30
8.	Tone - Upper Extremity (Rev. "3" only) Item 51 Two-digit code for: Right (col. 31) Code: 0 - Bilateral 1 - Hypotonic 2 - Questionable hypotonicity 3 - Normal 4 - Questionable hypertonicity 5 - Hypertonic 6 - Unable to evaluate 9 - No report, not on Rev. "0" and "1" Left or Bilateral (col. 32) Code: Same as in col. 31 except code "0" does not apply	31-32
9.	Tone - Lower Extremity Item 52 Code: Same as in Field 8	33-34
10.	Tone - Neck Flexor Item 53 Code: Same as in Field 8	35-36

FIELD		CARD COLUMN
11.	Tone - Neck Extensor Item 54 Code: Same as in Field 8	37-38
12.	Tone - Trunk Item 55 Code: Same as in Field 8	39-40
13.	Transillumination Item 58 Code: 0 - Absent 1 - Doubtful or questionable (Rev. "1" and "3") 2 - Present (Rev. "1" and "3") 3 - Supratentorial (Rev. "0" only) 4 - Infratentorial (Rev. "0" only) 5 - Comb. of codes 3 & 4 (Rev. "0" only) 8 - Unable to evaluate (Rev. "3") 9 - No report	41
14.	Tonic Neck Reflex Item 59 Two-digit code for: Right (col. 42) Code: 0 - Bilateral 1 - Obtained with ease 2 - Obtained with difficulty 3 - No constant pattern 4 - No response (Rev. "1" and "3") 8 - No distinction as to right, left or bilateral on Rev. "0" and "1" 9 - No report Left or Bilateral (col. 43) Code: Same as in col. 42 except codes "0" and "8" do not apply	42-43
15.	Jaw Arm - Right Item 64 Code: 0 - Other movement or no movement (Rev. "3") 1 - Flexion 2 - Extension 3 - "Absent" on Rev. "1" and "0" 9 - No constant pattern, no response or no report	44

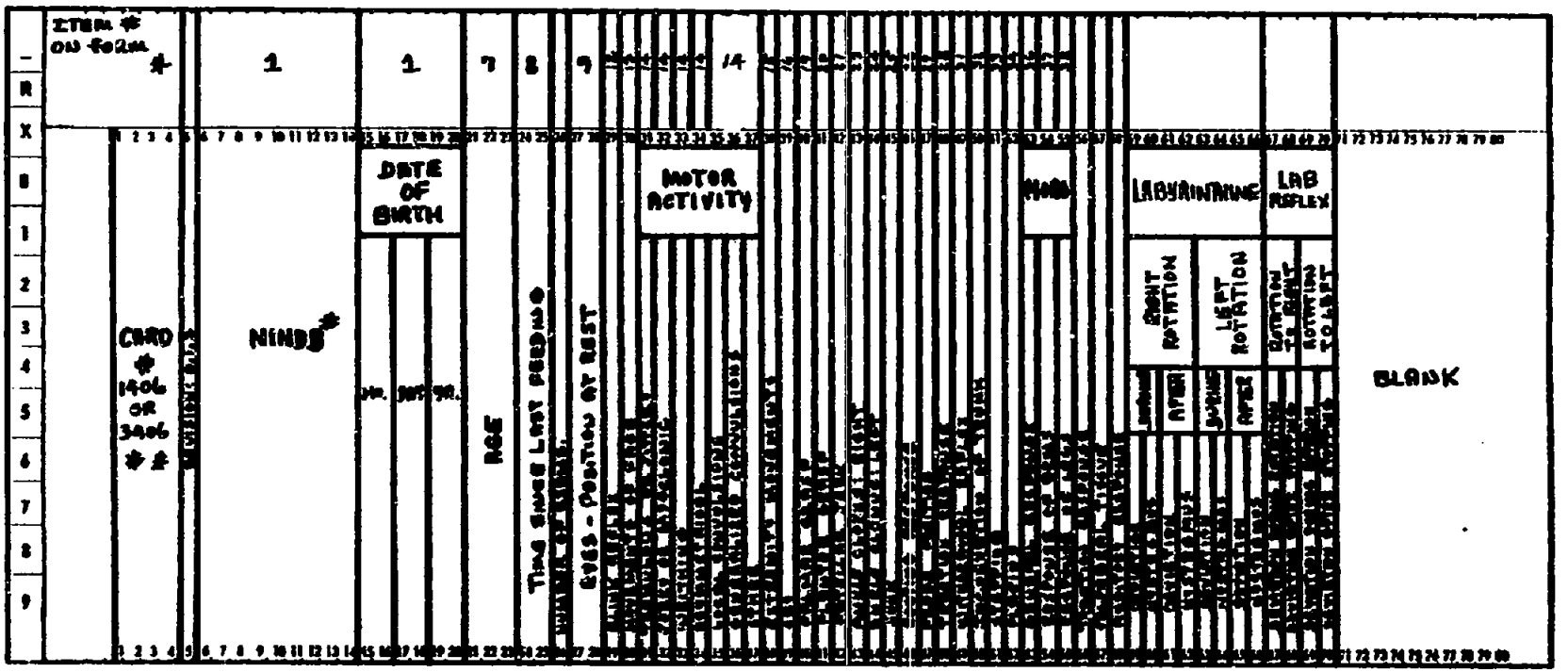
FIELD		CARD COLUMN
16.	Jaw Leg - Right Item 65 Code: Same as in Field 15	45
17.	Occiput Arm - Right Item 66 Code: Same as in Field 15	46
18.	Occiput Leg - Right Item 67 Code: Same as in Field 15	47
19.	Jaw Arm - Left Item 68 Code: Same as in Field 15	48
20.	Jaw Leg - Left Item 70 Code: Same as in Field 15	49
21.	Occiput Arm - Left Item 71 Code: Same as in Field 15	50
22.	Occiput Leg - Left Item 72 Code: Same as in Field 15	51
23.	Other Signs (Rev. "3" only) Item 73 Code: 0 - No 1 - Yes 9 - No report, not on Rev. "0" and "1"	52
24.	Neurological Abnormalities (Rev. "1" and "3" only) Item 74 Code: 0 - None 1 - Neurologically suspicious 2 - Neurologically abnormal 9 - No report, not on Rev. "0"	53

FIELD		CARD COLUMN
25.	**Non-Neurological Abnormalities** (Rev. "1" and "3" only) Item 75 Code: 0 - None 1 - Minor abnormalities 2 - Questionable abnormalities (Rev. "3") 3 - Definite major abnormalities (Rev. "3") 4 - Abnormalities (Rev. "1") 9 - No report, not on Rev. "0"	54
26.	**Examination Conditions** Item 76 Code: 0 - Unsatisfactory conditions absent 1 - Unsatisfactory conditions present 9 - No report	55
27.	**Diagnosis** (Rev. "0" only) Code: Blank - Not on Rev. "3" 0 - Normal 1 - Other 9 - No report, not on Rev. "1"	56
28.	**Tone - Neck** (Rev. "0" and "1" only) Code: Blank - Not on Rev. "3" 0 - Flaccid on Rev. "0" } classify as Hypotonic 1 - Flaccid on Rev. "1" } 2 - Questionable flaccidity on Rev. "1" 3 - Normal 4 - Questionable hypertonicity on Rev. "1" 5 - Hypertonic on Rev. "1" 6 - Hypertonic on Rev. "0" 9 - No report	57

FIELD		CARD COLUMN
29.	Tone - Trunk (Rev. "0" and "1" only) Code: Same as in Field 28	58
30.	Tone - Upper Extremity (Rev. "0" and "1" only) Code: Same as in Field 28	59
31.	Tone - Lower Extremity (Rev. "0" and "1" only) Code: Same as in Field 28	60
32.	Eyes - Cornea (Rev. "0" and "1" only) Two-digit code for: Right (col. 61) Left (col. 62) Code for each: Blank - Not on Rev. "3" 0 - Normal 1 - Suspicious (Rev. "1" only) 2 - Abnormal (Rev. "1" only) 3 - Abnormal on Rev. "0"; includes suspicious 9 - Not observed, not reported	61-62
33.	Eyes - Anterior Chamber (Rev. "1" only) Code: Same as in Field 32 except 9 - No report, not on Rev. "0"	63-64
34.	Eyes - Iris (Rev. "1" only) Code: Same as in Field 33	65-66
35.	Eyes - Lens (Rev. "0" and "1" only) Code: Same as in Field 32	67-68
36.	Eyes - Vitreous (Rev. "0" and "1" only) Code: Same as in Field 32	69-70
37.	Eyes - Optic Disc (Rev. "0" and "1" only) Code: Same as in Field 32	71-72
38.	Eyes - Fundus (Rev. "0" and "1" only) Code: Same as in Field 32	73-74

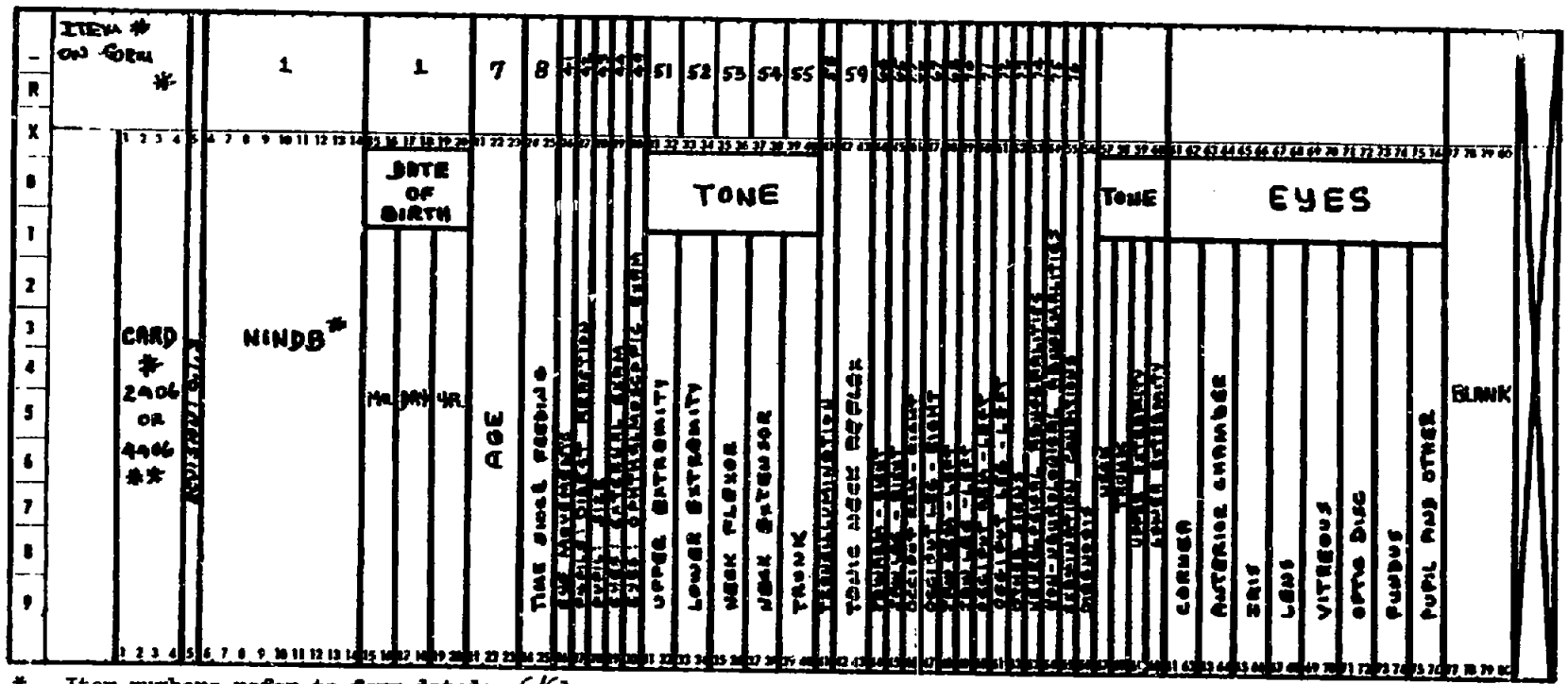
FIELD		CARD COLUMN
39.	Eyes - Pupil and Other (Rev. "0" only) Two-digit code for: Right (col. 75) Left (col. 76) Code for each: Blank - Not on Rev. "3" 0 - Normal 1 - Abnormal pupil 2 - Other abnormality 3 - Abnormal pupil plus other abnormality 9 - No report, not on Rev. "1"	75-76

NEONATAL NEUROLOGICAL EXAMINATION
FORM PED-6



* Item numbers refer to form dated: 6/61
** 3406 is first card for second exam, if given.

NEONATAL NEUROLOGICAL EXAMINATION
FORM PED-6



* Item numbers refer to form dated: 6/61
** 4406 is second card for second exam, if given.

NEONATAL NEUROLOGICAL EXAMINATION

(PED-6, rev. June 1961)

I Introduction

The purpose of the Neonatal Neurological Examination is to evaluate by physical examination techniques, the function of the child's central nervous system in the first few days of life. Information obtained from the examination is to be recorded for the following purposes:

A. To characterize the child as neurologically normal or other-than normal at a specified age.
B. To identify manifestations of suspected or definite neurological abnormality.
C. To provide a base line for subsequent neurological examinations.
D. To study the relevance or predictive value of certain traditional neurological examination items.

The reporting form PED-6 is provided to facilitate recording and coding of the information obtained from the Neonatal Neurological Examination. This manual has been prepared for use as a guide in performing the examination and in the proper recording of the information obtained.

A movie, *The Neurological Examination of the Newborn,* is highly recommended for use in orientation and training for the performance of the Neonatal Neurological Examination. This film, produced by Dr. Richmond Paine, is in 16 mm color sound. Viewing time is approximately 30 minutes. It may be purchased from Churchill-Wexler Film Productions, 801 N. Seward Street, Los Angeles 38, California, or may be obtained on loan from NIH by request to Information Specialist, Perinatal Research Branch, NINDB.

II General Instructions for Performing and Recording the Examination

A. **The Examiner.** The person performing the Neonatal Neurological Examination should be a pediatrician with special interest and training in neurology or a neurologist with special interest and training in pediatrics. An ophthalmologist may be asked to do the funduscopic examination.

B. **Time of Examination.** The Neonatal Neurological Examination should be performed when the child is between 36 and 60 hours of age. If the child's condition is such as to make it unwise to perform the complete examination during this time, as much of the examination as can reasonably be done should be done and recorded, and an explanation for the incompleteness given. As soon as the child's condition permits, a complete examination should be performed and recorded. The examination should be repeated weekly as long as the child is in the nursery (routine or special care). Additional examinations may be done at any time, and it is recommended that an extra examination be done early if the child is critically ill.

It is not necessary that the ophthalmoscopic examination be performed during the 36 to 60 hour age interval. It may be performed at any time during the child's stay in the nursery. Provision is made for recording it on the initial examination report, even though it is performed at a different time.

C. **Elimination of Bias.** Ideally the examiner performing the Neonatal Neurological Examination should be unaware of the child's history, including the events of pregnancy and previous physical findings, so that the possibility of such knowledge introducing spurious correlation between prior events and the presence of abnormal findings can be avoided. It is obviously impossible to avoid all such information, but every effort should be made to prevent the examiner's access to or consideration of information which could be a source of such bias.

D. **Construction of the Reporting Form.** The items on the reporting form are arranged, in general, in order of increasing intensity of stimulation or handling of the child. This arrangement of items is for convenience in recording and is *not* to be construed as a required order of examination.

The form is set up so that the results of the normal child may be recorded quickly. In most items other-than-normal responses or signs require description. The abnormal responses are to be indexed by a check mark in the appropriate box, and described in narrative or outline fashion in the blank space on the right-hand side of the page.

The itemized instructions to follow will specify those items that need no further comment even for an abnormal response.

E. **Completeness of Examination and Recording.** The examiner is requested to perform at least all of the tests and observations indicated on the form. Beyond this he may perform other tests and observations that are his custom or special interest. The "Impression" (Items 75 and 75) need not be based only on the items routinely recorded on the form. However, if the "Impression" is based on the results of tests and observations other than those listed on the form, a description or comment on these should be included in the diagnostic statements.

F. **Confirmation of Abnormal Findings.** It is strongly recommended that every child judged to be neurologically other-than-normal on the basis of the Neonatal Neurological Examination be subjected to a repeat examination by a second examiner who is unaware of the findings on the initial examination. Confirmatory re-examination for isolated unusual or abnormal findings would be interesting but is not requested.

G. **Preparation for the Eye Examination.** The eyes should be properly prepared for an adequate examination. This includes dilating the pupils. The recommended drug for pupil dilatation is cyclogel 1/2%, plain or with 1/4% Neosynephrine. It is important that the dilating drug not be instilled prior to the evaluation of the pupillary reflexes. At the discretion of the examiner, it is permissible for the nurse to record pupil reflexes and size (Items 42 and 43) prior to instillation of the dilating fluid. However, if the nurse suspects abnormality of either the reflexes or the size of pupils, these signs should be further evaluated by the physician prior to pupillary dilatation.

III Specific Instructions for Performing and Recording the Examination.

Item 1. Patient Identification. This item is to be completed using the child's name plate containing at least the following information: child's name, NINDB number, date of birth, time of birth, sex, birth weight, and race.

Item 2. Name of Examiner. Record the surname and initials of the examiner.

Item 3. Title or Position. Record the professional training status of the examiner as neurologist, pediatrician, pediatric neurologist, etc.

Item 4. Date of Examination. Record the date of examination using the sequence month, day, year.

Item 5. Time Examination Started. Record in 24-hour-clock-time the time that the examination was begun.

Item 6. Time Last Feeding Started. Record in 24-hour-clock-time the time that the last feeding was started. This information may be taken from the nursery nurses' records. The time should be recorded as an approximation to the nearest 15 minutes, even though it is recognized that from some nurseries the basic information does not provide this order of precision.

Item 7. Age of Child. It is not necessary to complete this item. This space is provided for convenience in the subsequent computation and coding of this information in relation to analysis of the examination data. However, it is recommended that it be completed and used for local quality control purposes. If this item is completed locally, it should be computed as follows:
a. Subtract date and time of birth from date and time of examination to the nearest minute.
b. If the age is less than 72 hours, strike off the minutes and report as hours completed.
c. If the age is 72 hours or over, strike off minutes, divide by 24, strike off the fraction and report as whole days completed.

Item 8. Time Since Last Feeding. It is not necessary to complete this item. This space is provided for convenience in the subsequent computation and coding of this information in relation to analysis of the examination data. If this item is completed locally, it should be computed as follows:
a. Subtract Item 6 from Item 5 to the nearest minute. b. Decrease to the nearest 15 minute interval (00', 15', 30', 45'). c. Report as hours and minutes (e.g., 47 hrs. 15 min.).

Items 9-11. Eyes – Position at Rest. Observe the position of the child's pupils when the child is awake and not attempting lateral or near point fixation. Record by considering

the recording chart (Items 10 and 11) expanded and superimposed on the child's eyes with the intersections of the two crosses on the P-A axes of the globes. (Be wary of either over- or under-diagnosing strabismus by relating position of pupils to palpebral fissures.) Indicate position of pupils at rest by two small (approximately 2 mm.) circles on the chart. This chart is designed to indicate direction but not magnitude of deviation from the central position. Only definite or obligatory imbalance or deviation should be recorded as non-central. Any circle enclosing the intersection of the vertical and horizontal lines will be coded as central. Do not equivocate.

Spontaneous nystagmus or aimless wandering eye movements should be reported by checking the box "Unable to evaluate" and describing the situation under the comments section.

Item 12. Blink Reflex (Light Stimulus). The blink reflex is tested in each eye separately by shining a strong light directly into the eye. The test may be performed even when the lids are closed and the child is asleep, but should not be attempted while the child is crying. Whether the lids are open or closed at the time of stimulation, the normal response is reflex tightening of the orbicularis oculi.

This is a test for the integrity of the visual system, not for strength and symmetry of lid movement. Weakness or inequality of the movements of the lids should be reported in Item 13.

If a satisfactory response is not obtained in the lighted room, the test should be repeated in a darkened room or with a stronger light before a recording of other-than-normal is made.

Item 13. Movements of Face. Evaluate the child's facial movements under both resting and active states if possible. This is an evaluation of the integrity of the innervation of the facial musculature, not of the static anatomy. If there is asymmetry of the facial structure, special attention is needed to ensure accurate evaluation of movements.

Item 14. Motor Activity (check all that apply). This is an evaluation of the integrity of the child's general somatic motor system as manifested by the intensity and character of movement. The examiner should observe the child's spontaneous movements as well as the activity evoked by non-specific stimuli such as handling. For the purpose of this examination the following definitions are to be used:

0. Normal. As employed in those few items (except the IMPRESSION categories) where its use is unavoidable, the term "Normal" is to be considered in the restricted sense of "ideal" or "none of the following apply". This interpretation is particularly important here since the examiner is asked to record the presence of certain physical signs of questionable significance in order that their significance or predictive value may be studied. Therefore, in this item the category "Normal" is applicable only by exclusion of all of the subsequent categories.

1. Tremulous or jittery (movements). Record here the presence of tremulousness, i.e., the presence of rapid, repetitive oscillations of the extremities occurring only in response to specific stimuli such as used to elicit the Moro reflex or withdrawal reaction should not be reported. The check boxes "Slight", "Moderate", and "Marked" are provided for convenience in recording the intensity or definiteness of the movements. No further comment or description is necessary.

2. Jerky or myoclonic movements. Record under this category the presence of abnormal movements of several types variously described as sudden twitches, massive spasms, "extensor thrust", myoclonic jerks, etc. The check boxes "Slight", "Moderate" and "Marked" are provided for convenience in recording the intensity or definiteness of the abnormal movements.

3. Writhing movements. Record here the presence of spontaneous, sinuous, stretching movements. Although such movements are commonly seen in small premature infants, the examiner is asked first to record the presence of such movements, and then to indicate by checking one of the boxes "Slight", "Moderate" or "Marked" the intensity or definiteness of the movements. No further comment or description is necessary.

4. Asymmetrical movements. If any of the general body movements, exclusive of localized seizures, differ in quality or

intensity between the two sides, record the fact of the asymmetry by checking this category. Further, check one of the boxes "Slight", "Moderate" or "Marked" to indicate the degree of asymmetry and note under the "Comments" section the direction of the asymmetry. A description of localized weakness or paralysis, if unilateral, should be included under this category.

5 and 6. Local Convulsions, Generalized Convulsions. These are usually clonic or tonic movements which are spontaneous in nature, but this term also includes unconscious or atonic spells. Generalized clonic or tonic movements or unconscious or atonic spells are to be reported as generalized convulsions. If the convulsive movement is localized to a definable area, it is to be reported as a localized convulsion.

8. Other. Report here the presence of any manifestations of general somatic motor function which the examiner considers to be pathologic and which are not recorded under one of the preceding categories. Generalized paucity of movement and symmetric paralysis would be included under this category. Describe the abnormality in detail.

Item 15. Extremity Movements. This is an evaluation of the functional range of motion in the joints of the extremities and spine as determined by observation of both active and passive movements. Abnormalities of motor activity or tone *per se* are to be reported under Item 14 or Item 50 and are not to be included in this item. Abnormal spontaneous posturing and excessive or limited movement in any joint should be reported here.

Item 16. Cry (Quality). Evaluate the quality of the child's cry (high-pitched, stridulous, incessant, etc.). If the child does not cry spontaneously, attempt to elicit a cry by slapping the bottom of his feet or pinching his heel.

Item 17. Comments. Use this space for recording comments or descriptions concerning the numbered items. Be careful to identify the comment with the number of the item to which it relates.

Item 17. Patient Identification. Same as Item 1.

Item 18. Palmar Grasp. The palmar grasp reflex is elicited by touching or stroking the ulnar side of the palm of the child's hand. The child must be awake and quiet. The head should be in the midline. It is desirable that the wrist be in the neutral position and the arm partially flexed. The examiner should avoid extending the child's arm, or stimulating the dorsum of the hand, as a traction reflex or an extensor reflex respectively may confuse the sought-after grasp reflex.

The principal part of the normal grasp reflex is flexion of the fingers. Three trials on either side in alternation should be performed to assess the presence, symmetry and reproducibility of the reflex.

If a normal reflex response is not obtained, the test should be repeated once again later in the examination before making a final judgment.

Item 20. Plantar Grasp. The plantar grasp, reflex is elicited by touching or stroking the sole of the child's foot. The child should be awake and quiet. The child's head must be in the midline (see Pollack, Seymour L., *Archives of Neurology*, 3, 574, 581, 1960). The legs should be in the semi-flexed position. It is important to avoid using a noxious stimulus as this would evoke a withdrawal response.

The principal part of the normal plantar grasp reflex is flexion of the toes. Three trials on either side in alternation or on the two sides simultaneously should be performed to assess the presence and symmetry of the reflex.

If a normal reflex response is not obtained, the test should be repeated once again later in the examination before making a final judgment.

Item 21. Patellar Jerk. The patellar jerk reflex is elicited by tapping the patellar tendon with a standard reflex hammer. The legs should be in the midline during this test.

Three trials on either side in alternation should be performed to assess the presence and symmetry of the reflex. No attempt should be made to quantitate the response.

If a symmetrical reflex response is not obtained, the test should be repeated once again later in the examination before making a final judgment.

Items 22-24. Ankle Clonus. Ankle clonus is elicited by sudden dorsal flexion at the ankle forced by pressure of the examiner's finger on the plantar surface of the forefoot. The legs should be semi-flexed and the head should be in the midline during the test.

Three trials on either side in alternation should be performed to assess the presence and symmetry of ankle clonus. Count the number of clonic cycles, if any, and record as "None", "Under 8", or "8 or more"

Item 25. Suck. The sucking reflex is elicited by placing a sterile nipple or similar shaped object in the child's mouth. If the child does not begin sucking spontaneously, gently increase the stimulation by moving or attempting to withdraw the nipple. If the sucking reflex is weak or absent repeat the test once again later in the examination before making a final judgment.

Item 26. Rooting Response. The rooting reflex is elicited by touching the angle of the lips or adjacent region of the cheek with a nipple or finger. Movement of the child's head or mouth toward the stimulus will be considered a normal response. This stimulation should be repeated three times on each side before interpreting the response. If the response is absent or asymmetrical the test should be repeated once again later in the examination before making a final judgment.

Item 27. Prone Position. Place the child prone on a flat surface and observe the resulting activity. The normal response in this situation is considered to be one or a combination of the following three actions: 1. The child lifts his chin up; 2. The child turns his head to the side; 3. The child makes crawling movements. If none of these three actions result, the test should be scored "Abnormal." If none of the three actions are performed well but there is feeble performance of one or more, "Questionable Abnormality" should be checked and the performance described. If it is impossible to evaluate the response to this stimulus, check the category "Other" and describe the situation.

Item 28. Traction Response. This reflex is elicited with the child in supine position. The examiner grasps the child's hands and forearms and pulls the child gently forward to a sitting position. The response of the child's neck and shoulder muscles and control of the head during the action are observed. If neck flexion, head control, and shoulder muscle assistance are well performed the response should be considered normal. The test should be repeated three times before interpreting the response. If any of the three parts of the normal response was absent, check the box "Abnormal", and check which of the three times was absent. If all three parts of the response were present but any were poorly performed, check the box "Questionable" and describe the response.

Item 29. Comments. Same as Item 17.

Item 30. Patient Identification. Same as Item 1.

Item 31. Withdrawal Reflex. This is a crude test for the integrity of cutaneous sensation to pain. The stimulus for this test is a painful pin prick on the sole of the foot.

If, with each stimulus, the stimulated extremity withdraws, regardless of what other response is also elicited, the first category "Withdrawal of stimulated extremity elicited bilaterally" should be checked.

If, with each stimulus, the stimulated extremity does not withdraw but some other response indicating the perception of pain is elicited, the second category is to be checked. If there is no response on stimulation of either side, the third category "No response bilaterally" should be checked. If the response to stimulation of the two sides is different, the fourth category "Asymmetrical" should be checked and the responses described.

An absent response is difficult to interpret in the presence of abnormal function of the muscles of the lower extremity. If you are unable to evaluate the response, or a result that doesn't fit one of the above categories is obtained, check "Other" and describe the situation.

Item 32. Incurvation of the Trunk. The incurvation reflex (Galant's reflex) is elicited with the child in the prone position, either lying on a flat surface or being held in the examiner's hand. The stimulus for this test is tactile stimulation of the thoracolumbar paravertebral area by light tapping or stroking with the finger. The examiner should avoid using a noxious or muscle-stretching stimulus.

The test should be repeated three times on either side in alternation before assessing the presence and symmetry of the response.

The expected normal response is contraction of the long muscles of the back on the side of the stimulus so that the child's head and legs curl around the stimulated area while the trunk moves away from the stimulus. If the response is absent or asymmetrical, the test should be repeated once again later in the examination before a final judgment is made.

Item 33. Stepping. This response is elicited by holding the child erect and placing the soles of both feet on a flat surface. If necessary incline the child's head, shoulders and trunk slightly forward and by rotating the child's trunk alternately simulate a walking motion. The child is expected to alternately place one foot ahead of another in a *very slow* pseudo-walking motion.

There is a different response in a premature baby from the full term baby. The premature walks on tiptoe whereas the full term baby walks on the flat feet, often beginning on the heel. This might indicate the essential stimulus for this response comes from proprioceptive impulses in the ankle joint as well as from sense receptors in the plantar skin. It is probable that both sources are involved. The premature baby does not go on to walk on the heel or flat feet when he reaches his full term age, as the position of the foot is determined by factors relating to the intrauterine position. Breech babies with extended legs often will not walk at all. This is presumably due to the previous intrauterine position though the exact mechanism of their failure to respond is unknown.[1]

Three trials should be attempted before assessing the presence and symmetry of the response. If stepping is not present and symmetrical, the test should be performed once again later in the examination before a final judgment is made.

Item 34. Placing. The placing reflex is elicited with the child held in the erect position (not inclined forward). The stimulus is provided by drawing the dorsum of the child's foot across the lower edge of a moderately sharp surface such as the edge of the examining table. As it is often difficult to stimulate both feet simultaneously, the test is usually performed first with one foot and then with the other. If stimulated at the same time, the two feet need not move synchronously.

The response consists of flexion at the knee and hip followed by extension at the hip. If the plantar surface of the foot comes in contact with the flat surface a third phase ensues, namely, further extension of the knee and hip (the Positive Supporting Reaction in the Legs). The placing reflex is often present in the first few days of life, but is usually stronger when the infant is two or three weeks old. Perhaps the main value of the test is the demonstration of symmetry or asymmetry of the response.[1]

This test is included for two reasons. The first is to test for asymmetry of the lower extremity reflexes. The other is to study the significance or predictive value of either the presence or the absence of a symmetrical placing reflex. Flexion at the knee and hip sufficient to withdraw the toes from under the stimulus surface and raise the foot above the level of the surface, followed by extension at the hip sufficient to return the foot to the level of the surface, will be considered a placing reflex.

The examiner should avoid the temptation to perform the movements for the child. After the stimulus has been applied, the examiner should not elevate the child further, but rather hold it steady in order to determine the presence of flexion and extension in relation to the stimulus surface.

Three trials should be attempted before assessing the presence and symmetry of the response. If a placing reflex is not present and symmetrical, the test should be performed once again later in the examination before a final judgment is made.

Items 35-38. Moro. Of the many ways of eliciting the Moro reflex, the one to be used for the purposes of the Study begins with the child held face up in the examiner's hands (semi-sitting position) with head supported by one

[1]Rephrased from the *Minutes of the Gröningen Meeting of the Little Club, July 3-9, 1960.* (unpublished)

[1]Rephrased from the *Minutes of the Gröningen Meeting of the Little Club, July 3-9, 1960.* (unpublished)

of the examiner's hands. The stimulus is a sudden extension of the neck: the head is allowed suddenly to drop back through an angle of approximately 30 degrees. The speed, character, extent of response of the arms, and the presence of movement in the legs are to be noted. The stimulus-response sequence should be repeated three times before evaluating the response. If the expected response is not obtained, the test should be repeated once again later in the examination before a final judgment is made.

The results of this test are to be recorded in three categories:

Item 35. Response—General. Record here the ease and consistency with which a response was obtained. If there was no reflex movement of the arms or legs during any of the three trials, check the box labeled "No response" and leave Items 37 and 38 blank. If a response was obtained but not reproduced on at least two out of the three attempts, the box "No constant pattern" should be checked and Items 37 and 38 left blank. If the same response was obtained two out of three times, the box "Obtained with difficulty" should be checked. If the same response was obtained on three out of three attempts, the box, "Obtained with ease" should be checked.

Since the intensity of the stimulus should be the same on all trials in all cases, the distinction between "Obtained with ease" and "Obtained with difficulty" represents a difference in the consistency of the response not in the intensity of stimulus necessary to elicit a response.

If a response was "Obtained with ease" or "Obtained with difficulty," Items 37 and 38 should be completed.

Item 37. Response of Arms. If a response was obtained (Item 36, categories 1 or 2), the character of the reflex activity in the arms should be recorded under this item. The first 4 categories refer specifically to the extent of involvement of the arms in the response. The quality of the response is another parameter which is much more difficult to define and record. If the extent of involvement corresponds to one of the first 4 categories but is considered to be abnormal in quality, two check marks can be used to record the responses; the first in the appropriate box to indicate the extent of involvement, and the second in the box "Other". A description of the abnormal quality of the response should be recorded in the "Comments" section. The category "Other" may also be used for recording a response which does not fit into one of the previous four categories.

Item 38. Response of Legs. If a response was obtained (Item 36, categories 1 or 2), record simply whether or not there was reflex movement of the legs in response to the stimulus. The quality, extent, and character of the response need not be described unless the examiner feels it is frankly abnormal.

Item 39. Comments. Same as Item 17.

Item 40. Patient Identification. Same as Item 1.

Item 41. Eye Movements. This is a test for the presence of weakness or paralysis of extraocular movements in the horizontal plane. The stimulus for this test is lateral translocation in the frontal plane. The examiner holds the child upright facing him and moves the child from side to side, observing for symmetry of eye movements in the horizontal plane. The normal response is conjugate deviation of the eyes in the direction of movement (toward the advancing side).

Evaluation of eye movements in other planes may be performed and recorded in the "Comments" section, but for consistency Item 41 shall be limited to horizontal movements.

Item 42. Pupils—Direct Reaction to Light. The stimulus for the direct reaction to light will be a standard flashlight directed alternately into each eye. Observe the presence and rate of the reaction in the stimulated eye. The magnitude of the response and consensual reaction may be recorded separately in the "Comments" section but should not enter into the recording of this item. Unequal size either before or after constriction should be reported under Item 43.

Item 43. Pupils—Size. Observe for symmetry and absolute size of the pupils before and after the reaction to direct illumination. The emphasis in this observation is on definite abnormalities, either bilateral or unilateral. Such abnormalities should be clearly described. The significance of minor variations from normal size or of minor inequality is not

known, and such findings should be recorded as "Questionable abnormality" and described with a very brief comment.

Item 44. Eyes – Structure – External Examination. The structure of the eyes as determined by external examination should be reported here. For the purpose of this examination edema of the lids and uncomplicated chemical conjunctivitis are to be considered normal findings and are not to be reported. This is an evaluation of static anatomy of the lids, sclera, conjunctiva, cornea, iris and, insofar as possible, of the orbit and globe. Abnormalities of size and position of the latter, scleral or conjunctival hemorrhage, coloboma and cataract are among the abnormalities that should be sought for and described here. Such dynamic functions as pupil reflexes and extraocular movements are to be reported elsewhere.

Items 45-48. Name of Examiner, Title or Position, Date of Exam. and Time Exam. Started. These items should be completed only if the ophthalmoscopic examination (Item 49) is done by a different examiner or at a different time than the rest of the Neonatal Neurological Examination. Instructions are the same as for Items 2-5 respectively.

Item 49. Eyes – Structure – Ophthalmoscopic Examination. The examination of the ocular fundi of the neonate deserves to be carefully done under optimal conditions and with adequate preparation. The pupils should be dilated for this examination (see paragraph II G, Preparation for Eye Examination). The examination should be done in a darkened room with adequate assistance as necessary to stabilize the child's head. The examination should be done within the first few days of the child's life, but need not be done at the same time as the rest of the Neonatal Neurological Examination. Regardless of when it is done, the first funduscopic examination should be recorded on the same form as the rest of the first examination.

If it was impossible to do the ophthalmoscopic examination at any time during the child's nursery stay, the category "Unable to evaluate" should be checked on the first PED-6 record, and an explanation for the omission given. On the forms reporting repeat neurological examinations the category "Not done" may be checked without explanation.

A clear description of abnormal findings should be given, including laterality and an indication of the amount of retinal hemorrhage, if any (three-point scale: minimal, moderate, marked).

Items 50-55. Tone. The tone of the child's muscles should be observed throughout the course of the examination. It is recognized that there are many aspects to muscle tone, but it is not considered worthwhile for this examination to attempt separate recording of these. The evaluation of muscle tone includes:

a. palpating the muscles when the child is at rest;

b. feeling the resistance to passive movements;

c. observing the extensibility of the muscles through full range of passive movement;

d. observing the spontaneous posturing and active movements for tone and balance of antagonist muscles.

The emphasis in these observations should be on detecting asymmetry and differences in tone from one muscle group to another.

For clarity in recording, the evaluation is broken down into gross body areas: upper extremity, lower extremity, neck flexor, neck extensor and trunk. The recording is made by entering the code number from the key given on the form (ranging from 1 = definitely hypotonic to 5 = definitely hypertonic) in the "Bilateral" blank if symmetrical, or in the "Right" and "Left" blanks if there is asymmetry. No further qualification or description is necessary unless the examiner feels the code number does not clearly indicate the situation. Opistotonus should be described opposite Items 54-55.

Item 56. Comments. Same as Item 17.

Item 57. Patient Identification. Same as Item 1.

Item 58. Transillumination. This examination is to be performed in a darkened room, or in a small area darkened with an opaque hood. The examiner's vision should be dark-adapted in order to properly interpret the observation. The light source for transillumination will be a standard flashlight with an opaque rubber adapter to prevent surface light scatter. A

penlight or flashlight without a flexible adapter is not acceptable. Care must be taken to adequately illuminate all areas of the head in succession. Two centimeters or less of light scatter from the inner margin of the opaque adapter in a totally darkened room will be considered normal. In interpreting the observation, the examiner must consider the thickness of the adapter ring, the darkness of the room and his own adaptation to the dark. Areas of increased density as well as areas of decreased density (increased transillumination) should be noted. If abnormality is suspected or definitely present, the appropriate box should be checked and the abnormality clearly described in the "Comments" section.

Items 59-72. Tonic Neck Reflex (Optional). This is an optional test and no recording or explanation is necessary if it is not completed. Since there is a great deal of interest in this test, and the significance or predictive value of it is still being debated, it is included in this protocol for the express purpose of gathering data in a prospective fashion on a large number of cases in order to contribute facts to this debate.

In order for the data to fulfill this purpose, it is necessary that the test be done carefully and routinely. Therefore, any particular institution or group within an institution should perform the test carefully and routinely or not bother.

An obligatory, classical tonic neck reflex pattern is generally assumed to be abnormal, and if seen may be reported here as an abnormality even if the test is not done routinely for the purpose stated above.

The following quotation from the Minutes of the Groningen Meeting of the Little Club, July 3-9, 1960, (unpublished) is included as instruction and explanation for this test.

"Asymmetrical tonic neck reflex. This is frequently loosely called the tonic neck reflex. The test is performed by turning the head of the child slowly to one side and holding it in this position for approximately 15 seconds. Three to five attempts should be made to obtain this response on either side.

"It is difficult to obtain this response in very active and crying children and it is more often elicited in sleeping children. The response is very variable. It is possible that a spontaneous tonic neck reflex is seen in sleeping new borns, but it is difficult to be sure whether this is a true tonic neck reflex or merely a chance position the child has taken up. When the child is in the classical pose while sleeping, the head can often be turned over to the other side without altering the position of the baby's arms.

"The classical response of extension of the jaw arm with flexion of the occiput arm after active movement by the examiner of the infant's head is rarely seen.

"The interpretation of these responses is very difficult. It is believed to originate in proprioceptive impulses coming from the neck muscles. Magoun in animal studies revealed that this test could be observed at the level of the red nucleus below which the pattern disappears in the experimental animal. It is sometimes seen in new borns who later have complex dyplegias but it has also been observed in new borns who appear perfectly normal later on in life."

Record the ease and consistency with which a response was obtained; record in Item 60 if symmetrical, record in Items 61 and 62 if asymmetrical. A definite flexion or extension movement in one or more extremities is to be considered a response. The same pattern of response on 3 out of 3 trials is to be recorded "Obtained with ease". The same pattern of response on 2 out of 3 trials is to be recorded "Obtained with difficulty". A response on only 1 out of 3 trials, or a different pattern of response on each trial is to be recorded "No constant pattern". If there is no definite flexion or extension in any of the extremities in response to the stimulus, check the category "No response".

If a pattern of response was obtained, on rotation to one or both sides, code the pattern of the response under Items 35 and 40. The key to the three columns of boxes under these items is: Fl. = flexion, Ext. = extension, O. = other movement or no movement. If there was no constant pattern or no response on head rotation to the right, leave Item 63 (Items 64-67) blank. If there was no constant pattern or no response on head rotation to the left, leave Item 68 (Items 69-72) blank.

The stimulus for the tonic neck reflex will often make the child struggle and cry. It is recommended the child be given a sugarball

or nipple pacifier as an aid to the performance of this test.

Item 73. Other Signs, Reflexes, Tests, etc. If other neurological examination items or screening tests are performed as an integral part of this examination, they will properly be included in the synthesis of the IMPRESSION, and should be mentioned briefly. If any was performed check the box "Yes" and identify the test or observation and the results.

Additional tests performed on referral or follow-up, and repeat or additional examinations performed after consideration of the case record are not to be included in the synthesis of the IMPRESSION and should not be reported on this page. Such additional follow-up tests, or biased examination findings should be reported on a CP-5 sheet and attached to this form as extra information. Repeat examinations should be reported on separate PED-6 forms (see instructions for Item 77).

The blank space below this item on the form may be used for additional items that one or more institutions may wish to investigate systematically. If an institution plans to overprint certain items for this purpose, written communication with the Pediatrics-Neurology unit, PRB, would be desirable, both in order that the items might be recognized and perhaps coded centrally and that other institutions interested in the same item might be encouraged to participate.

Item 74. Neurological Abnormalities. Here the examiner should state his clinical impression of the child's neurological status at present, based on his evaluation of the significance or lack of significance of the itemized and overall findings on this examination.

If the examiner considers the child to be completely normal neurologically, the first box "None" should be checked.

If, on the basis of his examination, the examiner has reason to feel that the child is not completely normal neurologically, but cannot be classified as a definite clinical syndrome or "Neurologically abnormal child," the second box "Neurologically suspicious ...." should be checked.

If the examiner is able to state a definite or provisional diagnosis of a recognized syndrome, or feels the child is definitely neurologically abnormal but doesn't at this time fit into any diagnostic category, the third box "Neurologically abnormal child" should be checked.

If it is the examiner's impression that the child has a definite or suspect neurological abnormality, he should clearly identify the findings and summarize the reasoning on which this impression is based.

For the purpose of this examination, report under "Neurologically suspicious but no definite abnormalities" conditions, which may not in themselves be neurological but are often related to CNS disorders, such as abnormalities of skull size and shape, spinal anomalies, hemagiomas on the face and head, positional deformities of the feet and unusual facies.

Item 75, Non-Neurological Abnormalities. This examination is primarily for the detection and description of neurological abnormalities. However, examiner should not overlook other conditions or abnormalities present in the child. Since there are at least two rather detailed pediatric examinations performed on the child during the nursery stay, the neurologist need not feel compelled to describe static non-neurological abnormalities in detail. It is assumed that these would have been detected and described on the PED-2 examinations. Obvious static conditions such as nevi, cleft lip, etc., may be passed off with a word. Conditions which might possibly have been overlooked on a previous examination or transient but possibly important conditions such as subconjunctival hemorrhage should be noted. Minor or trivial conditions such as diaper rash, uncomplicated umbilical hernia, Mongolian spots, etc., should not be reported in any case.

Item 76, Unsatisfactory Conditions for Examination. This provides the examiner the opportunity to indicate the presence of conditions in the child or the environment which may have interfered with performance and accurate assessment of any portion of the examination. In addition to identifying the condition (such as "child in Isolette", "excessively irritable child"), indicate which of the findings reported above might have been significantly influenced by the unsatisfactory condition.

Item 77. Repeat Examination Scheduled for Verification of Abnormality. It is strongly recommended that every child judged to be neurologically other-than-normal on the basis of the Neonatal Neurological Examination be subjected to a repeat examination by a second examiner who is unaware of the findings of the initial examination. Confirmatory re-examination for isolated unusual or abnormal findings would be interesting but is not requested.

If a repeat examination is to be done, check this item "Yes"

Item 78. Comments. Same as Item 17.

PHS-0000-0
REV. 11-00

NEONATAL NEUROLOGICAL EXAMINATION

blue

1. Patient Identification

Superseded by COL R-3004-6 rev. 6-61

INSTRUCTIONS: Every item should be checked (✓). If not normal, findings should be checked (✓) and described in margin at right.

2. Examined By	3. Status
4. Time Examination Started (24-hr. clock)	5. Date (Mo-Day-Yr)
6. Date of Birth (Mo-Day-Yr)	7. Hour of Birth (24 hr. clock)
8. Sex ☐M 1 ☐F 2	9. Race (of mother)
10. Birth wt. (gms.)	11. Time of Last Feeding (to nearest 15 min.)

12. SPONTANEOUS MOVEMENTS

13. Eyes - Position at Rest
(Draw Position of Pupils)
☐ Not observed *(state reason in detail)* 99

14. Right			15. Left		
2		1	2		1
3		4	3		4

16. Movements of Face
☐ Present and Symmetrical 0

Abnormal
☐ Absent 1
☐ Asymmetrical *(describe)* 2
☐ Other *(describe)* 8

17. General Body Movements
☐ Normal 0
☐ Questionable abnormality *(describe)* 1

Abnormal
☐ Rapid jittery movements *(describe)* 2
☐ Writhing movements *(describe)* 3

Convulsions
☐ Local *(describe)* 4
☐ Generalized *(describe)* 5
☐ Other *(describe)* 8

18. Extremity Movements
☐ Normal *(e.g., all joints have full range of motion)* 0
☐ Questionable abnormality *(describe)* 1
☐ Abnormal *(describe)* 2

19. Cry *(quality)*
☐ Normal 0
☐ Questionable abnormality *(describe)* 1
☐ Abnormal *(describe)* 2
☐ Not heard 3

20. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3004-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION
(Continued)

21. Patient Identification

Superseded by COLR-3004-6 rev. 6-61

22. RESPONSES TO STIMULI

23. Blink Reflex *(light stimulus)*
- ☐ 0 Present and symmetrical both eyes
- ☐ 1 Questionable response *(describe)*
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 3 Absent both eyes
- ☐ 8 Other *(describe)*

24. Palmar Grasp *(Stimulus - Finger applied to ulnar side of palm)*
- ☐ 0 Strong symmetrical response
- ☐ 1 Weak symmetrical response
- ☐ 2 Absent bilaterally
- ☐ 3 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

25. Plantar Grasp *(Stimulus - Finger applied to medial side of sole.)*
- ☐ 0 Symmetrical response present
- ☐ 1 Absent bilaterally
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

26. Patellar Jerk *(With head in midline)*
- ☐ 0 Symmetrical response present
- ☐ 1 Absent bilaterally
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

27. Ankle Clonus *(Stimulus - Finger to sole of foot with knees flexed at 45°. Count number of clonic movements)*

28. Right	29. Left
☐ 0 None	☐ 0 None
☐ 1 Under 5	☐ 1 Under 5
☐ 2 5 or more	☐ 2 5 or more

30. Suck *(Evaluate with sterile nipple)*
- ☐ 0 Strong
- ☐ 1 Weak
- ☐ 2 Absent

31. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3004-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION (Continued)

32. Patient Identification

Superseded by COLR-3004-6 rev. 6-61

33. Rooting Response *(Stimulus - Touch a corner of lips. Record movement toward stimulus)*

- ☐ 0 Movement toward stimulus
- ☐ 1 No movement
- ☐ 2 Asymmetrical response *(describe)*
- ☐ 8 Other *(describe)*

34. Prone Position

- ☐ 0 Normal *(Child lifts chin up or turns head to side or makes crawling movements)*
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal *(No chin up, no head to side, no crawl)*
- ☐ 8 Other *(describe)*

35. Eye movements *(Evaluate by moving child's head horizontally)*

- ☐ 0 Normal *(horizontal)*
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal *(describe)*

36. Labyrinthine *(The child is to be held vertically at arms length by examiner. The examiner then rotates with the child to first his own right and then his own left. In recording this item the examiners rotation is identical to the childs rotation. Eye movements are recorded in relation to the childs own right and left.*

	None	R	L	Asymm.
37. Right Rotation				
38. During Rotation				
39. Deviation	☐ 0	☐ 1	☐ 2	☐ 3
40. Nystagmus	☐ 0	☐ 1	☐ 2	☐ 3
41. After Rotation				
42. Deviation	☐ 0	☐ 1	☐ 2	☐ 3
43. Nystagmus	☐ 0	☐ 1	☐ 2	☐ 3
44. Left Rotation	None	R	L	Asymm.
45. During Rotation				
46. Deviation	☐ 0	☐ 1	☐ 2	☐ 3
47. Nystagmus	☐ 0	☐ 1	☐ 2	☐ 3
48. After Rotation				
49. Deviation	☐ 0	☐ 1	☐ 2	☐ 3
50. Nystagmus	☐ 0	☐ 1	☐ 2	☐ 3

51. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3004-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION
(Continued)

52. Patient Identification

Superseded by CDLR-3004-6 Nov. 6-61

53. Tonic Neck Reflex *(Elicit by turning head slowly to child's right or child's left and maintaining this position for approximately 30 seconds. The most constant pattern developed is noted. If pattern can be reproduced record in appropriate boxes after a minimum of 3 attempts. If there is no definite or reproducible pattern check "No constant pattern," and skip to item 62.*

54. Response
- ☐ 1 Obtained with ease
- ☐ 2 Obtained with difficulty
- ☐ 3X No constant pattern
- ☐ 4X No response *(Skip to item 62)*

55. Head Movement to:

56. Right		57. Left	
58. Flexion	59. Extension	60. Flexion	61. Extension
☐ 0 Absent	☐ 0 Absent	☐ 0 Absent	☐ 0 Absent
Present in		Present in	
☐ 1 Jaw Arm	☐ 1	☐ 1 Jaw Arm	☐ 1
☐ 2 Jaw Leg	☐ 2	☐ 2 Jaw Leg	☐ 2
☐ 3 Occiput Arm	☐ 3	☐ 3 Occiput Arm	☐ 3
☐ 4 Occiput Leg	☐ 4	☐ 4 Occiput Leg	☐ 4
☐ 8 Other	☐ 8	☐ 8 Other	☐ 8

62. Traction Response *(Elicit by lifting child from supine position by pulling arms)*
- ☐ 0 Normal *(Neck flexes, head controlled and shoulder muscles assist movement)*
- ☐ 1 Questionable *(describe)*
- ☐ 2 Abnormal *(Check all that apply below)*
  - ☐ 3 No head control
  - ☐ 4 No neck flexion
  - ☐ 5 No shoulder muscle assistance

63. Withdrawal *(Stimulus - Noxious Pin Prick to both soles)*
- ☐ 0 Movement of extremities bilaterally
- ☐ 1 Response other than movement elicited bilaterally *(describe)*
  - ☐ 2 No response
  - ☐ 3 Asymmetrical *(describe)*
  - ☐ 4 Questionable response *(describe)*
  - ☐ 8 Other *(describe)*

64. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3004-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION
(Continued)

65. Patient Identification

Superseded by COLR-3004-6 mar-6-61

66. Stepping *(Child erect, sole of foot on surface, and trunk and head inclined forward)*

- 0 ☐ Present bilaterally and symmetrically
- 1 ☐ Questionable response *(describe)*
- 2 ☐ Absent bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

67. Placing *(Child held erect and dorsum of foot drawn under lower edge of surface)*

- 0 ☐ Present bilaterally and symmetrically
- 1 ☐ Questionable response *(describe)*
- 2 ☐ Absent bilaterally
- 3 ☐ Asymmetrical *(describe)*
- 8 ☐ Other *(describe)*

68. Inversion of Trunk *(Child prone, stroke or tap paravertebral area)*

- 0 ☐ Normal
- 1 ☐ Questionable response *(describe)*
- 2 ☐ No response
- 8 ☐ Other *(describe)*

69. Move *(Support child under back and head - let child's head drop back about 50° and note pattern of response. If pattern can be reproduced record in appropriate boxes after a minimum of 3 attempts. If there is no definite or reproducible pattern check "No constant pattern" and skip to item 75.)*

70. Response
- 1 ☐ Obtained with ease
- 2 ☐ Obtained with difficulty
- 3X ☐ No constant pattern
- 4X ☐ No response *(Skip to item 75)*

71. Response of Arms
- 0 ☐ Normal *(Extensor and flexor components symmetrically present)*
- 1 ☐ Flexor component absent
- 2 ☐ Asymmetrical
- 8 ☐ Other

72. Response of Legs
- 0 ☐ Movement
- 1 ☐ No movement

73. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reasons for not evaluating any item.

PHS-3064-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION (Continued)

74. Patient Identification

superseded by COLR-3004-6 rev. 6-61

75. Tone - Use the following code which will indicate a gradation from flaccid to rigid in items 76 through 79.

1 - Flaccid *(limp)*

2 - Questionable flaccidity

3 - Normal

4 - Questionable hypertonicity

5 - Hypertonic *(rigid)*

76. Neck _____ 77. Trunk _____

78. Upper extremity _____ 79. Lower extremity _____

80. Transillumination
- ☐ 0 Absent
- ☐ 1 Doubtful or questionable *(describe)*
- ☐ 2 Present *(describe in detail with drawing)*

81. Pupils - direct reaction to light
- ☐ 0 Present and rapid bilaterally
- ☐ 1 Present but sluggish bilaterally
- ☐ 2 Absent bilaterally
- ☐ 3 Asymmetrical response *(describe)*

82. Pupil - size
- ☐ 0 Normal and equal bilaterally
- ☐ 1 Questionable abnormality *(describe)*
- ☐ 2 Abnormal bilaterally *(describe in detail with drawing)*
- ☐ 3 Asymmetrical *(describe)*

83. Eyes - Cornea

84. Right	85. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious *(describe)*	☐ 1
☐ 2 Abnormal *(describe)*	☐ 2
☐ 3 Not observed *(state reason)*	☐ 3

86. Eyes - Anterior Chamber

87. Right	88. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious *(describe)*	☐ 1
☐ 2 Abnormal *(describe)*	☐ 2
☐ 3 Not observed *(state reason)*	☐ 3

89. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3008-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION
(Continued)

90. Patient Identification

superseded by
COLR-3004-6
rev. 6-61

91. Eyes - Iris

92. Right	93. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious (describe)	☐ 1
☐ 2 Abnormal (describe)	☐ 2
☐ 9 Not observed (state reason)	☐ 9

94. Eyes - Lens

95. Right	96. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious (describe)	☐ 1
☐ 2 Abnormal (describe)	☐ 2
☐ 9 Not observed (state reason)	☐ 9

97. Eyes - Vitreous

98. Right	99. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious (describe)	☐ 1
☐ 2 Abnormal (describe)	☐ 2
☐ 9 Not observed (state reason)	☐ 9

100. Eyes - Optic disc

101. Right	102. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious (describe)	☐ 1
☐ 2 Abnormal (describe)	☐ 2
☐ 9 Not observed (state reason)	☐ 9

103. Eyes - Fundus

104. Right	105. Left
☐ 0 Normal	☐ 0
☐ 1 Suspicious (describe)	☐ 1
☐ 2 Abnormal (describe)	☐ 2
☐ 9 Not observed (state reason)	☐ 9

106. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

PHS-3004-6
REV. 11-59

NEONATAL NEUROLOGICAL EXAMINATION
(Continued)

107. Patient Identification

Superseded by
COLR-3004-6
APR. 6-61

108. Neurological Diagnosis *(Include suspected and proven findings)*

- ☐ 0 Neurologically normal newborn
- ☐ 1 Neurologically suspicious *(state reason for suspicions)*
- ☐ 2 Neurologically abnormal child *(describe in detail)*

109. Associated physical defect *(other than neurological)*

- ☐ 0 None
- ☐ 1 Minor or suspicious abnormalities *(describe in detail)*
- ☐ 2 Abnormalities *(describe in detail)*

110. Conditions during examination

- ☐ 0 Normal and satisfactory
- ☐ 8 Other *(describe)*

111. Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

[illegible]

NEONATAL NEUROLOGICAL EXAMINATION

white

superseded by rev. 1159

INSTRUCTIONS: Every numbered item should be checked (√). If not normal, findings should be checked (√) and described in margin at right.

EXAMINED BY	TIME
STATUS	DATE *(Mo-Da-Yr)*

OBSERVATIONS REQUIRING MINIMAL HANDLING OR STIMULATION OF CHILD

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

I – SPONTANEOUS MOVEMENTS

EYES

1. Position at Rest
   (Draw Position of Pupils)

   RT. LT.

2. MOVEMENTS OF FACE
   - ☐ Present and Symmetrical
   - Abnormal
     - ☐ Absent
     - ☐ Asymmetrical
     - ☐ Other

3. PALPEBRAL FISSURE
   - ☐ Equal
     - ☐ Unequal

4. BODY MOVEMENTS
   - ☐ Normal
   - Abnormal
     - ☐ Tremulous
     - ☐ Rapid, Jerky Movements
     - ☐ Writhing Movements
     - Convulsions
       - ☐ Local
       - ☐ Generalized
     - ☐ Other

5. MOVEMENTS OF UPPER EXTREMITIES
   - ☐ Normal (Symmetrical with Normal Range of Motion)
     - ☐ Abnormal

6. MOVEMENTS OF LOWER EXTREMITIES
   - ☐ Normal (Symmetrical with Normal Range of Motion)
     - ☐ Abnormal

II – RESPONSES TO STIMULI

7. BLINK REFLEX (Stimulus – Welch-Allen Light)

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Asymmetrical	☐ Asymmetrical

8. AUDITORY RESPONSE (Stimulus – "Clacker")

☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Asymmetrical	☐ Asymmetrical

9. PALMAR GRASP (Stimulus – Finger Applied to Ulnar Side of Palm)

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Asymmetrical	☐ Asymmetrical

PHS-3064-6
1-68

NEONATAL NEUROLOGICAL EXAMINATION

Reproduced by NLM, 1159

OBSERVATIONS REQUIRING MINIMAL HANDLING OR STIMULATION OF CHILD (Continued)

II – RESPONSES TO STIMULI (Continued)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

10. PLANTAR GRASP *(Stimulus – Finger Applied to Medial Side of Sole)*

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Asymmetrical	☐ Asymmetrical

11. PATELLAR JERK *(With Head in Midline)*

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Asymmetrical	☐ Asymmetrical

12. ANKLE CLONUS *(Stimulus – Finger to Sole of Foot with Knees Flexed at 45°)*

RIGHT	LEFT
☐ None	☐ None
___ Number under 8 Movements	___ Number under 8 Movements
☐ 8 or more movements	☐ 8 or more movements

13. ROOTING RESPONSE *(Stimulus – Touch a corner of lips. Record movement toward stimulus)*

RIGHT	LEFT
☐ Movement of face and head	☐ Movement of face and head
☐ Movement of face only	☐ Movement of face only
☐ No movement	☐ No movement

14. SUCK *(Evaluate With Finger)*
- ☐ Strong
- ☐ Weak
- ☐ Absent

15. PRONE POSITION
- ☐ Normal *(Child lifts chin up, turns head to side, makes crawling movements)*
- ☐ Abnormal *(No chin up, no head to side. No crawl)*

OBSERVATIONS REQUIRING MAXIMAL HANDLING OR STIMULATION OF CHILD

Identify remarks by date and number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

16. EYE MOVEMENTS *(Evaluate by moving child's head vertically and horizontally)*
- ☐ Normal *(Vertical and Horizontal)*
- ☐ Abnormal

17. LABYRINTHINE REFLEX *(Child to be held vertically facing examiner. Both examiner and child rotate)*

Rotation to Child's RIGHT	Rotation to Child's LEFT
☐ No eye movement	☐ No eye movement
During rotation eyes deviate to ____	During rotation eyes deviate to ____
After stopping eyes deviate to ____	After stopping eyes deviate to ____

PHS-3004-6
1-59

NEONATAL NEUROLOGICAL EXAMINATION

superseded by rev. 11-59

OBSERVATIONS REQUIRING MAXIMAL HANDLING OR STIMULATION OF CHILD (Continued)

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

18. TONIC NECK REFLEX *(Elicit by turning head slowly to Child's right or Child's left. Note position 30 to 60 seconds after head movements.)*

Head Movement to RIGHT	Head Movement to LEFT
EXTENSION present in	EXTENSION present in
☐ Jaw Arm	☐ Jaw Arm
☐ Jaw Leg	☐ Jaw Leg
☐ Occiput Arm	☐ Occiput Arm
☐ Occiput Leg	☐ Occiput Leg
☐ Absent	☐ Absent
FLEXION present in	FLEXION present in
☐ Jaw Arm	☐ Jaw Arm
☐ Jaw Leg	☐ Jaw Leg
☐ Occiput Arm	☐ Occiput Arm
☐ Occiput Leg	☐ Occiput Leg
☐ Absent	☐ Absent
PELVIC ROTATION	PELVIC ROTATION
☐ Away from Jaw	☐ Away from Jaw
☐ Toward Jaw	☐ Toward Jaw
☐ Absent	☐ Absent

RESPONSE
- ☐ Obtained with Ease
- ☐ Obtained with Difficulty
- ☐ No Consistent Pattern

19. TRACTION RESPONSE *(Elicit by lifting Child from Supine position by pulling Arms*
- ☐ Normal
  - ☐ With Assistance from Shoulder Muscles
  - ☐ No Flexor Action of Neck Muscles

20. WITHDRAWAL *(Stimulus — Pin Prick to Sole)*

RIGHT	LEFT
☐ Withdrawal of Stimulated Limb Only	☐ Withdrawal of Stimulated Limb Only
☐ No Response	☐ No Response
☐ Other	☐ Other

21. STEPPING *(Child Erect, Sole of Foot on Surface, and Trunk and Head Inclined Forward.)*

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Other *(Include Asymmetry)*	☐ Other *(Include Asymmetry)*

22. PLACING *(Child Held Erect and Dorsum of Foot Drawn Under Lower Edge of Surface)*

RIGHT	LEFT
☐ Present	☐ Present
☐ Absent	☐ Absent
☐ Other *(Include Asymmetry)*	☐ Other *(Include Asymmetry)*

PHS-2854-6
1-59

NEONATAL NEUROLOGICAL EXAMINATION

superseded by rev. 11-59

OBSERVATIONS REQUIRING MAXIMAL HANDLING OR STIMULATION OF CHILD (Continued)

23. INCURVATION OF TRUNK *(Child prone, stroke paravertebral areas)*
- ☐ Normal
- ☐ No Response
- ☐ Other

24. MORO *(Support child under back and head -- Let child's head drop back about 30°)*

RESPONSE OF ARMS
- ☐ Normal *(Flexor and Extensor components symmetrically present)*
- ☐ Flexor Component Absent
- ☐ Asymmetrical
- ☐ Other

RESPONSE OF LEGS
- ☐ Flexor
- ☐ Other

RESPONSE
- ☐ Obtained with Ease
- ☐ Obtained with Difficulty
- ☐ No Constant Pattern

25. TONE

NECK	TRUNK
☐ Normal	☐ Normal
☐ Flaccid *(Limp)*	☐ Flaccid *(Limp)*
☐ Hypertonic *(Rigid)*	☐ Hypertonic *(Rigid)*

UPPER EXTREMITY	LOWER EXTREMITY
☐ Normal	☐ Normal
☐ Flaccid *(Limp)*	☐ Flaccid *(Limp)*
☐ Hypertonic *(Rigid)*	☐ Hypertonic *(Rigid)*

26. TRANSILLUMINATION
- ☐ Absent
- ☐ Supratentorial
- ☐ Infratentorial

27. PUPILS

RIGHT	LEFT
Direct Reaction to Light	Direct Reaction to Light
☐ Present	☐ Present
☐ Absent	☐ Absent
REACTION	REACTION
☐ Rapid	☐ Rapid
☐ Sluggish	☐ Sluggish
SIZE *(Use disc)*	SIZE *(Use disc)*

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reasons for not evaluating any item.

PHS-2004-6
1-58

NEONATAL NEUROLOGICAL EXAMINATION

superseded by rev. 11-59

OBSERVATIONS REQUIRING MAXIMAL HANDLING OR STIMULATION OF CHILD *(Continued)*

28. EYES

RIGHT	LEFT
☐ Normal	☐ Normal
Abnormal	Abnormal
☐ Abnormal Pupil	☐ Abnormal Pupil
☐ Abnormal Cornea	☐ Abnormal Cornea
☐ Abnormal Lens	☐ Abnormal Lens
☐ Other	☐ Other

29. FUNDUSCOPIC

RIGHT	LEFT
☐ Normal	☐ Normal
☐ Abnormal Vitreous	☐ Abnormal Vitreous
☐ Abnormal Disc	☐ Abnormal Disc
☐ Abnormal Fundus	☐ Abnormal Fundus
☐ Other	☐ Other

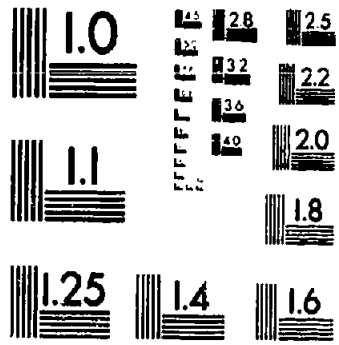
30. CONDITIONS DURING EXAMINATION

☐ Normal and Satisfactory
☐ Other

31. DIAGNOSIS *(Include Suspected and Proven Findings)*

☐ Normal
☐ Other

Identify remarks by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.



MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No 2)

CONTINUED ON NEXT FICHE


THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
SCRIPTA
MANET
★ 1934 ★

PED-2 Neonatal Examination

Form PED-2 was used to record evidence of stress, injury, congenital malformations and disease in the infant detected during the neonatal exam following the first few days subsequent to birth. First implemented in January 1959, the form was revised in May 1960 and changed in February 1963. The January 1959 form differed from later forms both in wording and itemization; the later two revisions are the same in content. Cards punched from all three versions of the form are included in the master file (see definition of codes for column 5 of the card). Data from PED-2 were punched onto five cards in the master file (Table PED-2.1).

TABLE PED-2.1 Cards and Data Records by Revision for Form PED-2

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-2: Respiratory Rate, Skin, Head, Subcutaneous Tissue	1402		
		0	6,188
		1	46,749
			52,937
PED-2: Fontanelles, Respiration and Heart	2402		
		0	6,188
		1	46,752
			52,940
PED-2: Moro Response and Motor Activity	3402		
		0	6,188
		1	46,718
			52,906
PED-2: Tone of Extremities, Neck and Trunk	4402		
		1	46,715
			46,715
PED-2: Respiration, Head, Tone	5402		
		0	6,129
			6,129
total for form			211,627

Data Items Reference; Form PED-2, Neonatal Examination

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
1841.....		1402	1	5	Card number (sequence, form type, form number, revision number)
1842.....		1402	6	14	NINDB case number
1843..PED-2	1	1402	15	16	Birth date (mo)
1844..PED-2	1	1402	17	18	Birth date (day)
1845..PED-2	1	1402	19	20	Birth date (yr)
1846..PED-2		1402	21	22	Age at examination, exam 1 (hrs)
1847..PED-2		1402	23	24	Age at examination, exam 2 (hrs)
1848..PED-2		1402	25	27	Age at examination, exam 3 (hrs)
1849..PED-2		1402	28	30	Age at examination, exam 4 (hrs)
1850..PED-2		1402	31	33	Age at examination, exam last (hrs)
1851..PED-2		1402	34	35	Examinations, total number
1852..PED-2	7	1402	36	37	Length: body (cm)
1853..PED-2	8	1402	38	39	Head circumference (cm)
1854..PED-2		1402	40	41	Head circumference, change (cm)
1855..PED-2	9	1402	42	43	Chest circumference (cm)
1856..PED-2	10	1402	44	45	Respiratory rate, exam 1
1857..PED-2	10	1402	46	47	Respiratory rate, exam 2
1858..PED-2	10	1402	48	49	Respiratory rate, exam 3
1859..PED-2	10	1402	50	51	Respiratory rate, exam 4
1860..PED-2	11	1402	52	53	Cyanosis, peripheral/generalized
1861..PED-2	11	1402	54	54	Cyanosis, other
1862..PED-2	12	1402	55	56	Jaundice
1863..PED-2	13	1402	57	57	Skin: parchment
1864..PED-2	13	1402	58	58	Skin: rash
1865..PED-2	13	1402	59	59	Skin: petechiae
1866..PED-2	13	1402	60	60	Skin: inflammation
1867..PED-2	13	1402	61	61	Skin: scleroma
1868..PED-2	13	1402	62	62	Skin: staining
1869..PED-2	13	1402	63	63	Skin, other
1870..PED-2	14	1402	64	64	Nails
1871..PED-2	15	1402	65	66	Subcutaneous tissue: diminished
1872..PED-2	15	1402	67	68	Subcutaneous tissue: edema
1873..PED-2	15	1402	69	70	Subcutaneous tissue: dehydration
1874..PED-2	15	1402	71	72	Subcutaneous tissue, other
1875..PED-2	16	1402	73	73	Facies
1876..PED-2	19	1402	74	74	Head: sutures separated
1877..PED-2	19	1402	75	75	Head: molding
1878..PED-2	19	1402	76	76	Head: cephalhematoma
1879..PED-2	19	1402	77	77	Head, other
1880.....		1402	78	80	Blank
1881.....		2402	1	5	Card number (sequence, form type, form number, revision number)
1882.....		2402	6	14	NINDB case number

Data Items Referencing Form PED-2, Neonatal Examination

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
3883..PED-2	1	2402	15	16	Birth date (mo)
3884..PED-2	1	2402	17	18	Birth date (day)
3885..PED-2	1	2402	19	20	Birth date (yr)
3886..PED-2		2402	21	22	Age at examination, exam 1 (hrs)
3887..PED-2		2402	23	24	Age at examination, exam 2 (hrs)
3888..PED-2		2402	25	27	Age at examination, exam 3 (hrs)
3889..PED-2		2402	28	30	Age at examination, exam 4 (hrs)
3890..PED-2		2402	31	33	Age at examination, exam last (hrs)
3891..PED-2		2402	34	35	Examinations, total number
3892..PED-2	21	2402	36	36	Fontanelle, anterior closed/open
3893..PED-2	21	2402	37	38	Fontanelle, anterior a-p size (cm)
3894..PED-2	21	2402	39	40	Fontanelle, anterior lateral size (cm)
3895..PED-2	21	2402	41	41	Fontanelle, posterior closed/open
3896..PED-2	21	2402	42	43	Fontanelle, posterior a-p size (cm)
3897..PED-2	21	2402	44	45	Fontanelle, posterior lateral size (cm)
3898..PED-2	22	2402	46	46	Fontanelle, anterior, tension
3899..PED-2	22	2402	47	47	Fontanelle, posterior, tension
3900..PED-2	23	2402	48	48	Ears
3901..PED-2	24	2402	49	49	Nose
3902..PED-2	25	2402	50	50	Mouth: pharynx
3903..PED-2	26	2402	51	51	Neck
3904..PED-2	27	2402	52	52	Thorax
3905..PED-2	28	2402	53	54	Respiration: labored
3906..PED-2	28	2402	55	56	Respiration: retractions
3907..PED-2	28	2402	57	58	Respiration: disorganized
3908..PED-2	28	2402	59	60	Respiration: shallow
3909..PED-2	28	2402	61	62	Respiration: grunting
3910..PED-2	28	2402	63	64	Respiration: rales
3911..PED-2	28	2402	65	66	Respiration: breath sounds altered
3912..PED-2	28	2402	67	68	Respiration, other
3913..PED-2	31	2402	69	72	Heart: tachycardia
3914..PED-2	31	2402	73	76	Heart: bradycardia
3915..PED-2	31	2402	77	77	Heart: rhythm, irregular
3916..PED-2	31	2402	78	78	Heart: murmur
3917..PED-2	31	2402	79	79	Heart: thrill
3918..PED-2	31	2402	80	80	Heart, other
3919.....		3402	1	5	Card number (sequence, form type, form number, revision number)
3920.....		3402	6	14	NINDB case number
3921..PED-2	1	3402	15	16	Birth date (mo)
3922..PED-2	1	3402	17	18	Birth date (day)
3923..PED-2	1	3402	19	20	Birth date (yr)
3924..PED-2		3402	21	22	Age at examination, exam 1 (hrs)
3925..PED-2		3402	23	24	Age at examination, exam 2 (hrs)

Data Items Referencing Form PEN-2, Neonatal Examination

DATA ITEM ID	ITEM JN FROM	CARD NUM	FROM	TO	DATA ITEM NAME
1926..PEN-2		3402	25	27	Age at examination, exam 3 (wks)
1927..PEN-2		3402	28	30	Age at examination, exam 4 (wks)
1928..PEN-2		3402	31	33	Age at examination, exam last (hrs)
1929..PEN-2		3402	34	35	Examinations, total number
1930..PEN-2	12	3402	36	36	Pulses; femoral
1931..PEN-2	13	3403	37	37	Abdomen
1932..PEN-2	14	3402	38	38	Genitalia
1933..PEN-2	15	3402	39	39	Spine
1934..PEN-2	16	3402	40	40	Extremities; colors
1935..PEN-2	17	3402	41	42	Suck
1936..PEN-2	18	3402	43	44	Grasp; palmar
1937..PEN-2	19	3402	45	46	Grasp; plantar
1938..PEN-2	46	3402	47	47	Moro response, exam 1
1939..PEN-2	47	3402	48	48	Moro response, exam 2
1940..PEN-2	48	3402	49	49	Moro response, exam 3
1941..PEN-2	49	3402	50	50	Moro response, exam 4
1942..PEN-2	41	3402	51	51	Moro response, arms, exam 1
1943..PEN-2	11	3402	52	52	Moro response, arms, exam 2
1944..PEN-2	41	3402	53	53	Moro response, arms, exam 3
1945..PEN-2	41	3402	54	54	Moro response, arms, exam 4
1946..PEN-2	42	3402	55	56	Moro response, legs
1947..PEN-2	43	3402	57	58	Cry
1948..PEN-2	45	3402	59	60	Motor activity; tremulous
1949..PEN-2	46	3402	61	62	Motor activity; movements; jerky, rapid
1950..PEN-2	45	3402	63	64	Motor activity; myoclonic
1951..PEN-2	46	3402	65	66	Motor activity; movements; writhing
1952..PEN-2	56	3402	67	68	Motor activity, asymmetrical
1953..PEN-2	46	3402	69	70	Motor activity; convulsions, local
1954..PEN-2	46	3402	71	72	Motor activity; convulsions, general
1955..PEN-2	46	3402	73	74	Motor activity, other
1956.....		3402	75	80	Blank
1957.....		4402	1	5	Card number (sequence, form type, form number, revision number)
1958.....		4402	6	14	NINDB case number
1959..PEN-2		4402	15	16	Birth date (mo)
1960..PEN-2		4402	17	18	Birth date (day)
1961..PEN-2		4402	19	20	Birth date (yr)
1962..PEN-2		4402	21	22	Age at exam, exam 1 (hrs)
1963..PEN-2		4402	23	24	Age at exam, exam 2 (hrs)
1964..PEN-2		4402	25	27	Age at exam, exam 3 (hrs)
1965..PEN-2		4402	28	30	Age at exam, exam 4 (hrs)
1966..PEN-2		4402	31	33	Age at exam, exam last (hrs)
1967..PEN-2		4402	34	35	Examinations, total number
1968..PEN-2	48	4402	36	36	Tone; extremity, upper, right, exam 1

Data Items Referencing Form PED-2, Neonatal Examination

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
1969..PED-2	48	4402	37	37	Tone; extremity, upper, right, exam 2
1970..PED-2	48	4402	38	38	Tone; extremity, upper, right, exam 3
1971..PED-2	48	4402	39	39	Tone; extremity, upper, right, exam 4
1972..PED-2	48	4402	40	40	Tone; extremity, upper, left, exam 1
1973..PED-2	48	4402	41	41	Tone; extremity, upper, left, exam 2
1974..PED-2	48	4402	42	42	Tone; extremity, upper, left, exam 3
1975..PED-2	48	4402	43	43	Tone; extremity, upper, left, exam 4
1976..PED-2	49	4402	44	44	Tone; extremity, lower, right, exam 1
1977..PED-2	49	4402	45	45	Tone; extremity, lower, right, exam 2
1978..PED-2	49	4402	46	46	Tone; extremity, lower, right, exam 3
1979..PED-2	49	4402	47	47	Tone; extremity, lower, right, exam 4
1980..PED-2	49	4402	48	48	Tone; extremity, lower, left, exam 1
1981..PED-2	49	4402	49	49	Tone; extremity, lower, left, exam 2
1982..PED-2	49	4402	50	50	Tone; extremity, lower, left, exam 3
1983..PED-2	49	4402	51	51	Tone; extremity, lower, left, exam 4
1984..PED-2	50	4402	52	52	Tone; neck flexor, exam 1
1985..PED-2	50	4402	53	53	Tone; neck flexor, exam 2
1986..PED-2	50	4402	54	54	Tone; neck flexor, exam 3
1987..PED-2	50	4402	55	55	Tone; neck flexor, exam 4
1988..PED-2	51	4402	56	56	Tone; neck extensor, exam 1
1989..PED-2	51	4402	57	57	Tone; neck extensor, exam 2
1990..PED-2	51	4402	58	58	Tone; neck extensor, exam 3
1991..PED-2	51	4402	59	59	Tone; neck extensor, exam 4
1992..PED-2	52	4402	60	60	Tone; trunk, exam 1
1993..PED-2	52	4402	61	61	Tone; trunk, exam 2
1994..PED-2	52	4402	62	62	Tone; trunk, exam 3
1995..PED-2	52	4402	63	63	Tone; trunk, exam 4
1996..PED-2	54	4402	64	64	Dysmaturity, stage
1997..PED-2	55	4402	65	66	CNS defect or injury, clinical impression
1998..PED-2	56	4402	67	67	CNS defect or injury, last exam; clinical impression
1999..PED-2	57	4402	68	69	Malformation; congenital, other than CNS; clinical impression
4000..PED-2	58	4402	70	71	Clinical impression, other
4001.....		4402	72	80	Blank
4002.....		5402	1	5	Card number (sequence, form type, form number, revision number)
4003.....		5402	6	14	NINDB case number
4004..PED-2	1	5402	15	16	Birth date (mo)
4005..PED-2	1	5402	17	18	Birth date (day)
4006..PED-2	1	5402	19	20	Birth date (yr)
4007..PED-2	6	5402	21	22	Age at examination, exam 1 (hrs)
4008..PED-2	6	5402	23	24	Age at examination, exam 2 (hrs)
4009..PED-2	6	5402	25	27	Age at examination, exam 3 (hrs)
4010..PED-2	6	5402	28	30	Age at examination, exam 4 (hrs)
4011..PED-2	11	5402	31	33	Age at examination, exam last (hrs)

Data Items Referencing Form PED-2, Neonatal Examination

DATA ITEM ID	ITEM OR FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4012..PED-2	1	5402	34	35	Cyanosis (rev 0 only)
4013..PED-2	1A	5402	36	37	Subcutaneous tissue, other (rev 0 only)
4014..PED-2	2A	5402	38	39	Respiration, irregular (rev 0 only)
4015..PED-2	2A	5402	40	41	Respiration, shallow (rev 0 only)
4016..PED-2	2A	5402	42	43	Respiration, grunting (rev 0 only)
4017..PED-2	2A	5402	44	45	Respiration, labored (rev 0 only)
4018..PED-2	2A	5402	46	47	Respiration, retractions (rev 0 only)
4019..PED-2	2A	5402	48	49	Respiration, other (rev 0 only)
4020..PED-2	31	5402	50	52	Heart rate, first (rev 0 only)
4021..PED-2	19	5402	53	53	Head; sutures, overriding (rev 0 only)
4022..PED-2	19	5402	54	54	Head; sutures, separated (rev 0 only)
4023..PED-2	19	5402	55	55	Head; molding severe (rev 0 only)
4024..PED-2	19	5402	56	56	Head; cephalhematoma (rev 0 only)
4025..PED-2	19	5402	57	57	Head, other (rev 0 only)
4026..PED-2	46	5402	58	59	Movements, body, other (rev 0 only)
4027..PED-2	47	5402	60	61	Moro response, less (rev 0 only)
4028..PED-2	50	5402	62	62	Tone; neck, exam 1 (rev 0 only)
4029..PED-2	50	5402	63	63	Tone; neck, exam 2 (rev 0 only)
4030..PED-2	50	5402	64	64	Tone; neck, exam 3 (rev 0 only)
4031..PED-2	50	5402	65	65	Tone; neck, exam 4 (rev 0 only)
4032..PED-2	20	5402	66	66	Tone; trunk, exam 1 (rev 0 only)
4033..PED-2	20	5402	67	67	Tone; trunk, exam 2 (rev 0 only)
4034..PED-2	20	5402	68	68	Tone; trunk, exam 3 (rev 0 only)
4035..PED-2	20	5402	69	69	Tone; trunk, exam 4 (rev 0 only)
4036..PED-2	20	5402	70	70	Tone; extremity, upper, exam 1 (rev 0 only)
4037..PED-2	20	5402	71	71	Tone; extremity, upper, exam 2 (rev 0 only)
4038..PED-2	20	5402	72	72	Tone; extremity, upper, exam 3 (rev 0 only)
4039..PED-2	20	5402	73	73	Tone; extremity, upper, exam 4 (rev 0 only)
4040..PED-2	20	5402	74	74	Tone; extremity, lower, exam 1 (rev 0 only)
4041..PED-2	20	5402	75	75	Tone; extremity, lower, exam 2 (rev 0 only)
4042..PED-2	20	5402	76	76	Tone; extremity, lower, exam 3 (rev 0 only)
4043..PED-2	20	5402	77	77	Tone; extremity, lower, exam 4 (rev 0 only)
4044..PED-2	23	5402	78	78	Maturity; dysmaturity (rev 0 only)
4045..PED-2	55	5402	79	79	Malformations; congenital (rev 0 only)
4046..PED-2	55	5402	80	80	Injury, signs of (rev 0 only)
5078....VAR	54		578	578	Dysmaturity, stage
5960....VAR	0		1157	1158	Chest circumference at birth (cms)
5961....VAR	0		1159	1160	Head circumference, neonatal (cms)
5962....VAR			1161	1161	Head circumference, neonatal (coded)
5976....VAR	7		1197	1198	Length; body, birth (cms)
5977....VAR	7		1199	1199	Length; body (coded)

NEONATAL EXAMINATION

2. NAME OF EXAMINER

3. DATE

4. DATE — MO. | DAY | YEAR | 5. TIME (Use 24 hr. clock) | 6. AGE

7. BODY LENGTH _____ Cms.

8. HEAD CIRCUMFERENCE _____ Cms.

9. CHEST CIRCUMFERENCE _____ Cms.

10. RESPIRATORY RATE (Baby in resting state) _____

11. EDEMA

- Absent
- Present
  - Slight
  - Moderate
  - Severe
- Other (specify)

12. JAUNDICE

- Absent
- Present
  - Slight
  - Moderate
  - Severe

13. RASH

- None (including congenital nevus and hemangioma)
- Petechiae
- Rash
- Petechiae or Ecchymosis
- Intertrigo
- Impetigo
- Vesicles (Herpes zoster)
- Other (specify)

14. NAILS

- Normal
- Shedding
- Excessive Length
- Other (specify)

15. SUBCUTANEOUS TISSUE

- Normal

	Slight	Moderate	Severe
Diminished			
Edema			
Consolidation			
Other (specify)			

16. COMMENTS

(PED-2)

NEONATAL EXAMINATION
(Continued)

DATE

FACIES

HEAD

FONTANELLES

EARS

NOSE

MOUTH AND PHARYNX

NECK

THORAX

RESPIRATIONS

29. COMMENTS

[illegible]

NEONATAL EXAMINATION
(Continued)

DATE

31. HEART

- ___ Normal
  - ___ Tachycardia (Over 180. Specify rate) __________
  - ___ Bradycardia (Under 100. Specify rate) __________
  - ___ Irregular Rhythm
  - ___ Murmur
  - ___ Thrill
  - ___ Other (Specify)

32. FEMORAL PULSES

- ___ Strong and Equal Bilaterally
  - ___ Weak or Asymmetrical

33. ABDOMEN

___ Normal ___ Other (Specify)

34. GENITALIA

___ Normal ___ Other (Specify)

35. SPINE

___ Normal ___ Other (Specify)

36. EXTREMITIES AND JOINTS

___ Normal ___ Other (Specify)

37. SUCK (Stimulate with finger)

___ Present ___ Absent

38. PALMAR GRASP

___ Present ___ Asymmetrical ___ Absent

39. PLANTAR GRASP

___ Present ___ Asymmetrical ___ Absent

MORO (Support child under back and head – LET child's head drop back about [illegible] and note pattern of response. If pattern can be reproduced [illegible] in [illegible] [illegible] after a minimum of [illegible] attempts. If there is no definite or reproducible pattern check "No consistent pattern" and skip to item 43.)

40. RESPONSE

- ___ Obtained with Ease
- ___ Obtained With Difficulty
- ___ No Consistent Pattern (Skip to item 43.)
- ___ No Response (Skip to item 43.)

41. RESPONSE OF ARMS

- ___ Normal (Extension and flexion components symmetrically present)
  - ___ Flexor component absent with [illegible] extension
  - ___ Flexor component absent with [illegible] extension
  - ___ Asymmetrical
  - ___ Other (Specify)

42. RESPONSE OF LEGS

___ Movement ___ No Movement

43. CRY

___ Normal ___ None ___ Other (Specify)

44. COMMENTS

NEONATAL EXAMINATION
(Continued)

DATE

46. MOTOR ACTIVITY

__ Normal

	Slight	Moderate	Marked
__ Tremulous or Jittery	__	__	__
__ Rapid Jerky Movements	__	__	__
__ Myoclonic Movements	__	__	__
__ Writhing Movements	__	__	__
__ Asymmetrical Movements	__	__	__

__ Convulsions

__ Local

__ Generalized

__ Other (specify)

47. TONE. [illegible]

1. Hypertonic
2. Questionable hypertonicity
3. [illegible]
4. Questionable hypotonicity
5. Hypotonic

	Both	Right	Left
48. Upper Extremity	____	____	____
49. Lower Extremity	____	____	____
50. Neck Flexor	____		
51. Neck Extensor	____		
52. Trunk	____		

DIAGNOSIS BY

53. WEIGHT

__ Term infant (birth weight over 2500 gms.)

__ Premature (birth weight 2500 gms. or less)

54. DYSMATURITY, STAGE OF

__ 0 – No sign of dysmaturity

__ 1 – Equivocal signs of dysmaturity

__ – Stage [illegible] dysmaturity

__ 2 – Stage [illegible] dysmaturity

__ 3 – Stage 3 dysmaturity

55. CLINICAL IMPRESSION

__ Normal

__ Central Nervous System Defect (specify)

__ Congenital Malformations Other Than Central Nervous System

__ Other (specify)

56. UNSATISFACTORY EXAM CONDITIONS __ Absent __ Present

57. COMMENTS

[illegible]

PED-2

Form item numbers linked to data items on PED-2, Neonatal Examination

ITEM NO.	DATA ITEM ID	CARD NUM	ANUM	ID	DATA ITEM NAME
	1967..PED-2	4402	21	22	Age at exam, exam 1 (hrs)
	1961..PED-2	4402	23	24	Age at exam, exam 2 (hrs)
	1964..PED-2	4402	25	27	Age at exam, exam 3 (hrs)
	1965..PED-2	4402	28	30	Age at exam, exam 4 (hrs)
	1966..PED-2	4402	31	31	Age at exam, exam last (hrs)
	1974..PED-2	3402	21	22	Age at examination, exam 1 (hrs)
	1986..PED-2	2402	21	22	Age at examination, exam 1 (hrs)
	1946..PED-2	1402	21	22	Age at examination, exam 1 (hrs)
	1925..PED-2	1402	23	24	Age at examination, exam 2 (hrs)
	1987..PED-2	2402	23	24	Age at examination, exam 2 (hrs)
	1947..PED-2	1402	23	24	Age at examination, exam 2 (hrs)
	1988..PED-2	1402	25	27	Age at examination, exam 3 (hrs)
	1976..PED-2	1402	25	27	Age at examination, exam 3 (hrs)
	1988..PED-2	2402	25	27	Age at examination, exam 3 (hrs)
	1989..PED-2	2402	28	30	Age at examination, exam 4 (hrs)
	1929..PED-2	3402	28	30	Age at examination, exam 4 (hrs)
	1949..PED-2	1402	28	30	Age at examination, exam 4 (hrs)
	1928..PED-2	3402	31	31	Age at examination, exam last (hrs)
	1950..PED-2	1402	31	31	Age at examination, exam last (hrs)
	1990..PED-2	2402	31	31	Age at examination, exam last (hrs)
	1960..PED-2	4402	17	18	Birth date (day)
	1959..PED-2	4402	15	16	Birth date (mo)
	1961..PED-2	4402	19	20	Birth date (yr)
	1951..PED-2	1402	14	15	Examinations, total number
	1929..PED-2	3402	34	35	Examinations, total number
	1991..PED-2	2402	34	35	Examinations, total number
	1967..PED-2	4402	34	35	Examinations, total number
	1956..PED-2	1402	60	61	Head circumference, gigante (cm)
	5002....VAR		1161	1161	Head circumference, neonatal (centi)
1	1905..PED-2	5402	17	18	Birth date (day)
1	1984..PED-2	2402	17	18	Birth date (day)
1	1922..PED-2	3402	17	18	Birth date (day)
1	1944..PED-2	1402	17	18	Birth date (day)
1	3921..PED-2	3402	15	16	Birth date (mo)
1	1981..PED-2	2402	15	16	Birth date (mo)
1	4904..PED-2	5402	15	16	Birth date (mo)
1	1941..PED-2	1402	15	16	Birth date (mo)
1	4906..PED-2	5402	19	20	Birth date (yr)
1	1985..PED-2	2402	19	20	Birth date (yr)
1	1923..PED-2	3402	19	20	Birth date (yr)
1	1945..PED-2	1402	19	20	Birth date (yr)
1	4912..PED-2	5402	34	35	Cyanosis (rev 0 only)

Form Item Numbers Index: Data Items on PPU=2, Neonatal examination

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
6	1007..PPU=2	5402	21	22	Age at examination, exam 1 (hrs)
6	4008..PPU=2	5402	23	24	Age at examination, exam 2 (hrs)
6	4009..PPU=2	5402	25	27	Age at examination, exam 3 (hrs)
6	4010..PPU=2	5402	28	30	Age at examination, exam 4 (hrs)
7	1052..PPU=2	1402	64	67	Length; body (cm)
7	5077....VAR		1101	1104	Length; body (cm)(1)
7	5078....VAR		1107	1110	Length; body, diff? (cm)
8	1051..PPU=2	1402	68	70	Head circumference (cm)
8	5081....VAR		1150	1153	Head circumference, abnormal (cm)
9	1055..PPU=2	1402	42	43	Chest circumference (cm)
9	5080....VAR		1154	1156	Chest circumference at birth (cm)
10	1050..PPU=2	1402	44	45	Respiratory rate, exam 1
10	1053..PPU=2	1402	46	47	Respiratory rate, exam 2
10	1054..PPU=2	1402	48	49	Respiratory rate, exam 3
10	1056..PPU=2	1402	50	51	Respiratory rate, exam 4
11	4011..PPU=2	5402	11	11	Age at examination, exam last (hrs)
11	1061..PPU=2	1402	54	55	Cyanosis, other
11	1060..PPU=2	1402	52	53	Cyanosis, peripheral/generalized
12	1062..PPU=2	1402	58	59	Jaundice
11	1063..PPU=2	1402	61	61	Skin, other
11	1066..PPU=2	1402	60	60	Skin; inflammation
13	1061..PPU=2	1402	57	57	Skin; petechiae
13	1065..PPU=2	1102	50	50	Skin; petechiae
13	1064..PPU=2	1402	58	58	Skin; rash
13	1067..PPU=2	1402	61	61	Skin; sclerema
13	1068..PPU=2	1402	62	62	Skin; staining
14	1070..PPU=2	1402	64	64	Nails
15	1074..PPU=2	1402	71	72	Subcutaneous tissue, other
15	4013..PPU=2	5402	16	17	Subcutaneous tissue, other (rev 0 only)
15	1071..PPU=2	1402	69	70	Subcutaneous tissue; induration
15	1073..PPU=2	1402	65	66	Subcutaneous tissue; diminished
15	1072..PPU=2	1402	67	68	Subcutaneous tissue; edema
16	1075..PPU=2	1402	73	73	Facies
17	1079..PPU=2	1402	77	77	Head, other
17	4025..PPU=2	5402	57	57	Head, other (rev 0 only)
17	1078..PPU=2	1402	76	76	Head; cephalohematoma
17	4024..PPU=2	5402	56	56	Head; cephalohematoma (rev 0 only)
17	1077..PPU=2	1402	75	75	Head; molding
17	4023..PPU=2	5402	55	55	Head; molding severe (rev 0 only)
17	1076..PPU=2	1402	74	74	Head; sutures separated
17	4021..PPU=2	5402	53	53	Head; sutures, overriding (rev 0 only)
17	4022..PPU=2	5402	54	54	Head; sutures, separated (rev 0 only)
20	4040..PPU=2	5402	71	71	Inner extremity, lower, exam 1 (rev 0 only)

Form Item Numbers linked to Data Items on PED-2, General Examination

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
20	4041..PED-2	5402	75	75	Tone: extremity, lower, exam 2 (rev 0 only)
20	4042..PED-2	5402	76	76	Tone: extremity, lower, exam 3 (rev 0 only)
20	4043..PED-2	5402	77	77	Tone: extremity, lower, exam 4 (rev 0 only)
20	4036..PED-2	5402	70	70	Tone: extremity, upper, exam 1 (rev 0 only)
20	4037..PED-2	5402	71	71	Tone: extremity, upper, exam 2 (rev 0 only)
20	4038..PED-2	5402	72	72	Tone: extremity, upper, exam 3 (rev 0 only)
20	4039..PED-2	5402	73	73	Tone: extremity, upper, exam 4 (rev 0 only)
20	4032..PED-2	5402	66	66	Tone: trunk, exam 1 (rev 0 only)
20	4033..PED-2	5402	67	67	Tone: trunk, exam 2 (rev 0 only)
20	4034..PED-2	5402	68	68	Tone: trunk, exam 3 (rev 0 only)
20	4035..PED-2	5402	69	69	Tone: trunk, exam 4 (rev 0 only)
21	3893..PED-2	2402	37	38	Fontanelle, anterior a-p size (cm)
21	3892..PED-2	2402	36	36	Fontanelle, anterior closed/open
21	3894..PED-2	2402	39	40	Fontanelle, anterior lateral size (cm)
21	3896..PED-2	2402	42	43	Fontanelle, posterior a-p size (cm)
21	3895..PED-2	2402	41	41	Fontanelle, posterior closed/open
21	3897..PED-2	2402	44	45	Fontanelle, posterior lateral size (cm)
22	3898..PED-2	2402	45	46	Fontanelle, anterior, tension
22	3899..PED-2	2402	47	47	Fontanelle, posterior, tension
23	3900..PED-2	2402	48	48	Ears
23	4044..PED-2	5402	78	78	Maturity: dysmaturity (rev 0 only)
24	3901..PED-2	2402	49	49	Nose
25	3902..PED-2	2402	50	50	Mouth: pharynx
26	3903..PED-2	2402	51	51	Neck
27	3904..PED-2	2402	52	52	Thorax
28	4016..PED-2	5402	37	43	Respiration, grunting (rev 0 only)
28	4014..PED-2	5402	38	39	Respiration, irregular (rev 0 only)
28	4017..PED-2	5402	44	45	Respiration, labored (rev 0 only)
28	3912..PED-2	2402	67	68	Respiration, other
28	4019..PED-2	5402	48	49	Respiration, other (rev 0 only)
28	4018..PED-2	5402	46	47	Respiration, retractions (rev 0 only)
28	4015..PED-2	5402	40	41	Respiration, shallow (rev 0 only)
28	3911..PED-2	2402	65	66	Respiration: breath sounds altered
28	3907..PED-2	2402	57	58	Respiration: disorganized
28	3909 .PED-2	2402	61	62	Respiration: grunting
28	3905..PED-2	2402	53	54	Respiration: labored
28	3910..PED-2	2402	63	64	Respiration: rales
28	3906..PED-2	2402	55	56	Respiration: retractions
28	3908..PED-2	2402	59	60	Respiration: shallow
31	4020..PED-2	5402	50	52	Heart rate, first (rev 0 only)
31	3913..PED-2	2402	80	80	Heart, other
31	3914..PED-2	2402	73	76	Heart: bradycardia
31	3916..PED-2	2402	78	78	Heart: murmur

Form Item Numbers Linked to Data Items on PED-2, Neonatal Examination

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
31	3915..PED-2	2402	77	77	Heart: rhythm, irregular
31	3913..PED-2	2402	69	72	Heart: tachycardia
31	3917..PED-2	2402	79	79	Heart: thrill
32	3930..PED-2	3402	36	36	Pulses: femoral
33	3931..PED-2	3402	37	37	Abdomen
34	3932..PED-2	3402	38	38	Genitalia
35	3933..PED-2	3402	39	39	Spine
36	3934..PED-2	3402	40	40	Extremities: infors
37	3935..PED-2	3402	41	42	Suck
38	3936..PED-2	3402	43	44	Grasp: palmar
39	3937..PED-2	3402	45	46	Grasp: plantar
40	3938..PED-2	3402	47	47	Moro response, exam 1
40	3939..PED-2	3402	48	48	Moro response, exam 2
40	3940..PED-2	3402	49	49	Moro response, exam 3
40	3941..PED-2	3402	50	50	Moro response, exam 4
41	3942..PED-2	3402	51	51	Moro response, arms, exam 1
41	3943..PED-2	3402	52	52	Moro response, arms, exam 2
41	3944..PED-2	3402	53	53	Moro response, arms, exam 3
41	3945..PED-2	3402	54	54	Moro response, arms, exam 4
42	3946..PED-2	3402	55	56	Moro response, legs
42	4027..PED-2	5402	60	61	Moro response, legs (rev 0 only)
43	3947..PED-2	3402	57	58	Cry
46	3952..PED-2	3402	67	68	Motor activity, asymmetrical
46	3955..PED-2	3402	73	74	Motor activity, other
46	3954..PED-2	3402	71	72	Motor activity: convulsions, general
46	3953..PED-2	3402	69	70	Motor activity: convulsions, local
46	3949..PED-2	3402	61	62	Motor activity: movements: jerky, rapid
46	3951..PED-2	3402	65	66	Motor activity: movements: writhing
46	3950..PED-2	3402	63	64	Motor activity: myoclonic
46	3948..PED-2	3402	59	60	Motor activity: tremulous
46	4026..PED-2	5402	58	59	Movements, body, other (rev 0 only)
48	3972..PED-2	4402	40	40	Tone: extremity, upper, left, exam 1
48	3973..PED-2	4402	41	41	Tone: extremity, upper, left, exam 2
48	3974..PED-2	4402	42	42	Tone: extremity, upper, left, exam 3
48	975..PED-2	4402	43	43	Tone: extremity, upper, left, exam 4
48	3968..PED-2	4402	36	36	Tone: extremity, upper, right, exam 1
48	3969..PED-2	4402	37	37	Tone: extremity, upper, right, exam 2
48	3970..PED-2	4402	38	38	Tone: extremity, upper, right, exam 3
48	3971..PED-2	4402	39	39	Tone: extremity, upper, right, exam 4
49	3980..PED-2	4402	48	48	Tone: extremity, lower, left, exam 1
49	3981..PED-2	4402	49	49	Tone: extremity, lower, left, exam 2
49	3982..PED-2	4402	50	50	Tone: extremity, lower, left, exam 3
49	3983..PED-2	4402	51	51	Tone: extremity, lower, left, exam 4

Form Item Numbers linked to Data Items on PED-2, Neonatal Examination

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
49	3976..PED-2	4402	44	44	Tone: extremity, lower, right, exam 1
49	3977..PED-2	4402	45	45	Tone: extremity, lower, right, exam 2
49	3978..PED-2	4402	46	46	Tone: extremity, lower, right, exam 3
49	3979..PED-2	4402	47	47	Tone: extremity, lower, right, exam 4
50	3984..PED-2	4402	52	52	Tone: neck flexor, exam 1
50	3985..PED-2	4402	53	53	Tone: neck flexor, exam 2
50	3986..PED-2	4402	54	54	Tone: neck flexor, exam 3
50	3987..PED-2	4402	55	55	Tone: neck flexor, exam 4
50	4029..PED-2	5402	62	62	Tone: neck, exam 1 (rev 0 only)
50	4029..PED-2	5402	63	63	Tone: neck, exam 2 (rev 0 only)
50	4030..PED-2	5402	64	64	Tone: neck, exam 3 (rev 0 only)
50	4031..PED-2	5402	65	65	Tone: neck, exam 4 (rev 0 only)
51	3988..PED-2	4402	56	56	Tone: neck extensor, exam 1
51	3989..PED-2	4402	57	57	Tone: neck extensor, exam 2
51	3990..PED-2	4402	58	58	Tone: neck extensor, exam 3
51	3991..PED-2	4402	59	59	Tone: neck extensor, exam 4
52	3992..PED-2	4402	60	60	Tone: trunk, exam 1
52	3993..PED-2	4402	61	61	Tone: trunk, exam 2
52	3994..PED-2	4402	62	62	Tone: trunk, exam 3
52	3995..PED-2	4402	63	63	Tone: trunk, exam 4
54	3996..PED-2	4402	64	64	Dysmaturity, stage
54	5406....VAR		578	578	Dysmaturity, stage
55	4000..PED-2	4402	70	71	Clinical impression, other
55	3998..PED-2	4402	67	67	CNS defect or injury, last exam; clinical impression
55	3997..PED-2	4402	66	66	CNS defect or injury; clinical impression
55	4046..PED-2	5402	80	80	Injury, stuns of (rev 0 only)
55	3999..PED-2	4402	68	69	Malformation; congenital, other than CNS; clinical impression
55	4045..PED-2	5402	79	79	Malformations; congenital (rev 0 only)

DEFINITION OF CODES
NEONATAL EXAMINATION
FORM PED-2 CARD 1402

FIELD		CARD COLUMN
1.	Card Number Code: 1	1
2.	Form Number Code: 402	2-4
3.	Revision Number* Code: 0 - Form Dated: 1/59 1 - Form Dated: Rev. 5/60 or changed 2/63	5
4.	NNDB Number Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Birth Item 1 Six-digit code for Month (cols. 15-16), Day (cols. 17-18), and Year (cols. 19-20) Code: As given	15-20
6.	Age Thirteen-digit code for: First Exam (cols. 21-22) Second Exam (cols. 23-24) Code for each two columns: 00 - Less than one hour 01-97 - As given in hours 98 - 98 hours or more 99 - Unknown, not applicable Third Exam (cols. 25-27) Fourth Exam (cols. 28-30) Last Exam (cols. 31-33) Code for each three columns: 000 - Less than one hour 001-997 - As given in hours 998 - 998 hours or more 999 - Unknown, not applicable	21-33
7.	Number of Examinations Code: As given	34-35

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Revision Number "1". Form Dated: changed 2/63.

FIELD		CARD COLUMN
8.	Body Length Item 7 Code: 15-60 - As given in cms. 99 - Not reported on any exam Additional codes reviewed and approved: 61, 63	36-37
9.	Head Circumference Item 8 Code: 15-42 - As given in cms. 99 - Not reported on any exam Additional codes reviewed and approved: 14, 43, 44, 46	38-39
10.	Head Circumference Change Code: 00 - No change, less than 1 cm. 01-10 - Increase as given in cms. 91-97 - Decrease of 1 to 7 cms. 98 - Decrease of 8 or more cms. 99 - Not reported on any exam Additional codes reviewed and approved: 11-14	40-41
11.	Chest Circumference Item 9 Code: Same as in Field 9 except: Additional codes reviewed and approved: 12, 43, 45, 48, 50	42-43
12.	Respiratory Rate Item 10 Eight-digit code for: First Exam (cols. 44-45) Second Exam (cols. 46-47) Third Exam (cols. 48-49) Fourth Exam (cols. 50-51) Code for each column: As given 98 - 98 and over 99 - No report	44-51

FIELD		CARD COLUMN
13.	Cyanosis (Revision "1" only) Item 11 Three-digit code for: Presence or Absence of Peripheral or Generalized Cyanosis (cols. 52-53)	52-54

Code:

Blank - Not on Rev. "0"
00 - peripheral and generalized absent on all exams
01 - peripheral on 1st only
02 - peripheral on 2nd only
03 - peripheral on 3rd only
04 - peripheral on 4th only
05 - peripheral on 1st and 2nd only
06 - peripheral on 1st and 3rd only
07 - peripheral on 1st and 4th only
08 - peripheral on 2nd and 3rd only
09 - peripheral on 2nd and 4th only
10 - peripheral on 3rd and 4th only
11 - peripheral on 1st, 2nd, and 3rd only
12 - peripheral on 1st, 2nd, and 4th only
13 - peripheral on 1st, 3rd, and 4th only
14 - peripheral on 2nd, 3rd, and 4th only
15 - peripheral on 1st, 2nd, 3rd, and 4th
16 - peripheral on more than 4
17 - generalized on 1st only
18 - generalized on 2nd only
19 - generalized on 3rd only
20 - generalized on 4th only
21 - generalized on 1st and 2nd only
22 - generalized on 1st and 3rd only
23 - generalized on 1st and 4th only
24 - generalized on 2nd and 3rd only
25 - generalized on 2nd and 4th only
26 - generalized on 3rd and 4th only
27 - generalized on 1st, 2nd, and 3rd only
28 - generalized on 1st, 2nd, and 4th only
29 - generalized on 1st, 3rd, and 4th only
30 - generalized on 2nd, 3rd, and 4th only
31 - generalized on 1st, 2nd, 3rd and 4th only
32 - generalized on more than 4
99 - Not reported on any

FIELD		CARD COLUMN
13.	Cyanosis (cont.) Presence or Absence of Other Cyanosis (col. 54) Code: Blank - Not on Rev. "C" 0 - Not reported on any exam 1 - Reported on at least one exam	
14.	Jaundice Item 12 Code: 00 - Absent on all exams 01 - Present on 1st only 02 - Present on 2nd only 03 - Present on 3rd only 04 - Present on 4th only 05 - Present on 1st and 2nd only 06 - Present on 1st and 3rd only 07 - Present on 1st and 4th only 08 - Present on 2nd and 3rd only 09 - Present on 2nd and 4th only 10 - Present on 3rd and 4th only 11 - Present on 1st, 2nd, and 3rd only 12 - Present on 1st, 2nd, and 4th only 13 - Present on 1st, 3rd, and 4th only 14 - Present on 2nd, 3rd, and 4th only 15 - Present on 1st, 2nd, 3rd, and 4th 16 - Present on more than 4 99 - Not reported on any exam	55-56
15.	Skin Item 13 Seven-digit code for: Parchment (col. 57) Code: 0 - Absent on all exams 1 - Present on at least one exam 2 - Not on Rev. "C" 9 - Not reported on any exam	57-63

FIELD		CARD COLUMN
15.	Skin (cont.)	57-63

Rash (col. 58)
Code: 0 - Absent on all exams
1 - Present on at least one exam
9 - Not reported on any exam

Petechiae or Ecchymosis (col. 59)
Code: 0 - Absent on all exams
1 - Present on at least one exam
2 - Reported as "petechiae" and not as "petechiae or ecchymosis" on at least one exam on Rev. "0" only
9 - Not reported on any exam

Inflammation (col. 60)
Code: Same as in col. 58

Sclerema (col. 61)
Code: Same as in col. 58

Staining (col. 62)
Code: Same as in col. 58

Other (col. 63)
Code: 0 - Absent on all exams
1 - Present on at least one exam
2 - "Other" on Rev. "0" includes "pallor" and "parchment"
9 - Not reported on any exam

DEFINITION OF CODES (Continued)

FORM PED-2
Card 1402

FIELD		CARD COLUMNS
16.	Nails (Revision "1" only) Item 14 Code: Blank - Not on Rev. "0" 0 - Normal on all exams 1 - Staining only on at least one exam 2 - Excessive length only on at least one exam 3 - Other only on at least one exam 4 - Staining and excessive length on at least one exam 5 - Staining and other on at least one exam 6 - Staining, excessive length, and other on at least one exam 7 - Excessive and other on at least one exam 9 - Not reported on any exam	64
17.	Subcutaneous Tissue: Diminished (Rev. "1" only) Item 15 Code: Blank - Not on Rev. "0" 00 - Normal on all exams 01 - present on 1st only 02 - present on 2nd only 03 - present on 3rd only 04 - present on 4th only 05 - present on 1st and 2nd only 06 - present on 1st and 3rd only 07 - present on 1st and 4th only 08 - present on 2nd and 3rd only 09 - present on 2nd and 4th only 10 - present on 3rd and 4th only 11 - present on 1st, 2nd, and 3rd only 12 - present on 1st, 2nd, and 4th only 13 - present on 1st, 3rd, and 4th only 14 - present on 2nd, 3rd, and 4th only 15 - present on 1st, 2nd, 3rd, and 4th 16 - present on more than 4 99 - not reported on any exam	65-66
18.	Subcutaneous Tissue: Edema Item 15 Code: Same as in Field 14	67-68
19.	Subcutaneous Tissue: Dehydration Item 15 Code: Same as in Field 14	69-70

DEFINITION OF CODES (Continued)

FORM PED-2
Card 1402

FIELD		CARD COLUMN
20.	Subcutaneous Tissue: Other (Rev. "1"only) Item 15 Code: Same as in Field 17	71-72
21.	Facies (Revision "1" only) Item 18 Code: Blank - Not on Rev. "0" 0 - Normal on all exams 1 - Asymmetrical on at least one 2 - Other only on at least one 3 - Asymmetrical and other on at least one 9 - Not reported on any exam	73
22.	Head (Revision "1" only) Item 19	74-77

Separated Sutures (col. 74)

Code: Blank - Not on Rev. "0"
0 - Normal on all exams
1 - Slight on at least one
2 - Marked or moderate on at least one
9 - Not reported on any exam

Molding (col. 75)
Code: Blank - Not on Rev. "0"
0 - Normal on all exams
1 - Slight on at least one
2 - Marked or moderate on at least one
9 - Not reported on any exam

Cephalhematoma (col. 76)
Code: Blank - Not on Rev. "0"

0 - Absent on all exams
1 - Right parietal only on at least one
2 - Left parietal only on at least one
3 - Occipital only on at least one
4 - Other only on at least one
5 - Combination of locations
9 - Not reported on any exam

FIELD		CARD COLUMN
22.	Head (Continued)	74-77

Other (col. 77)
Code: Blank - Not on Rev. "0"
0 - Absent on all exams
1 - Present on at least one exam
9 - Not reported on any exam

DEFINITION OF CODES (Continued)

FORM PED-2
Card 2402

FIELD		CARD COLUMNS
1.	Card Number Code: 2	1
2.	Basic Data * Code: Same as in columns 2-35 of Card 1	2-35
3.	Anterior Fontanelles (revision "1" only) Item 21 Open or Closed (column 36) Code: Blank - Not on Rev. "0" 0 - Closed 1 - Open 9 - Not reported AP Size (columns 37-38) Code: Blank - Not on Rev. "0" 00 - Palpable 01 - 10 - As given in cms. 99 - Unknown Additional codes revieved and approved: 11, 12, 15 Lat. Size (columns 39-40) Code: Same as in AP size except additional codes revieved and approved: 12	36-40
4.	Posterior Fontanelles (Revision "1" only) Item 21 Code: Same as in Field 3	41-45
5.	Tension (Revision "1" only) Item 22 Two-digit code for: Anterior (col. 46) Posterior (col. 47) Code for each column: Blank - Not on Rev. "0" 0 - Normal on all exams 1 - Other on at least one 9 - Not reported or not required on any	46-47
6.	Ears Item 23 Code: 0 - Normal on all exams 1 - Other on at least one exam 9 - Not reported on any exam	48

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Revision Number "1", Form Dated: Changed 2/63.

DEFINITION OF CODES (Continued)

FORM PED-2
Card 2 402

FIELD		CARD COLUMNS
7.	**Nose** Item 24 Code: same as in Field 6	49
8.	**Mouth and Pharynx** Item 25 Code: same as in Field 6	50
9.	**Neck** Item 26 Code: 0 - normal on all exams 1 - masses only on at least one 2 - restricted motion only on at least one 3 - other only on at least one 4 - masses and restricted motion on at least one 5 - masses and other on at least one 6 - masses, restricted motion, and other on at least one 7 - restricted motion and other on at least one 9 - not reported on any	51
10.	**Thorax** (Revision "1" only) Item 27 Code: Blank - Not on Revision "0" 0 - normal on all exams 1 - other on at least one 9 - not reported on any	52
11.	**Respiration: Labored** (Revision "1" only) Item 28 Code: Blank - Not on Revision "0" 00 - Normal on all exams 01 - highest value of slight on 1st only 02 - highest value of slight on 2nd only 03 - highest value of slight on 3rd only 04 - highest value of slight on 4th only	53-54

FIELD		CARD COLUMN
11.	Respiration: Labored (continued)	53-54

05 - highest value of slight on 1st and 2nd only
06 - highest value of slight on 1st and 3rd only
07 - highest value of slight on 1st and 4th only
08 - highest value of slight on 2nd and 3rd only
09 - highest value of slight on 2nd and 4th only
10 - highest value of slight on 3rd and 4th only
11 - highest value of slight on 1st, 2nd, and 3rd only
12 - highest value of slight on 1st, 2nd, and 4th only
13 - highest value of slight on 1st, 3rd, and 4th only
14 - highest value of slight on 2nd, 3rd, and 4th only
15 - highest value of slight on 1st, 2nd, 3rd and 4th
16 - highest value of slight on more than 4
17 - highest value of moderate on 1st only
18 - highest value of moderate on 2nd only
19 - highest value of moderate on 3rd only
20 - highest value of moderate on 4th only
21 - highest value of moderate on 1st and 2nd only
22 - highest value of moderate on 1st and 3rd only
23 - highest value of moderate on 1st and 4th only
24 - highest value of moderate on 2nd and 3rd only
25 - highest value of moderate on 2nd and 4th only
26 - highest value of moderate on 3rd and 4th only
27 - highest value of moderate on 1st, 2nd, and 3rd only
28 - highest value of moderate on 1st, 2nd, and 4th only
29 - highest value of moderate on 1st, 3rd, and 4th only
30 - highest value of moderate on 2nd, 3rd, and 4th only
31 - highest value of moderate on 1st, 2nd, 3rd and 4th
32 - highest value of moderate on more than 4
33 - highest value of marked on 1st only
34 - highest value of marked on 2nd only
35 - highest value of marked on 3rd only
36 - highest value of marked on 4th only
37 - highest value of marked on 1st and 2nd only
38 - highest value of marked on 1st and 3rd only
39 - highest value of marked on 1st and 4th only
40 - highest value of marked on 2nd and 3rd only
41 - highest value of marked on 2nd and 4th only
42 - highest value of marked on 3rd and 4th only
43 - highest value of marked on 1st, 2nd, and 3rd only
44 - highest value of marked on 1st, 2nd, and 4th only
45 - highest value of marked on 1st, 3rd, and 4th only
46 - highest value of marked on 2nd, 3rd, and 4th only
47 - highest value of marked on 1st, 2nd, 3rd, and 4th
48 - highest value of marked on more than 4
99 - not reported on any exam

FIELD		CARD COLUMN
12.	Respiration: Retractions (Rev. "1" only) Item 28 Code: Same as in Field 11	55-56
13.	Respiration: Disorganized (Rev. "1" only) Item 28 Code: Same as in Field 11	57-58
14.	Respiration: Shallow (Revision "1" only) Item 28 Code: Same as in Field 11	59-60
15.	Respiration : Grunting (Revision "1" only) Item 28 Code: Same as in Field 11	61-62
16.	Respiration: Rales (Revision "1" only) Item 28 Blank - Not on Rev. "0" 00 - normal on all exams 01 - present on 1st only 02 - present on 2nd only 03 - present on 3rd only 04 - present on 4th only 05 - present on 1st and 2nd only 06 - present on 1st and 3rd only 07 present on 1st and 4th only 08 - present on 2nd and 3rd only 09 - present on 2nd and 4th only 10 - present on 3rd and 4th only 11 - present on 1st, 2nd, and 3rd only 12 - present on 1st, 2nd, and 4th only 13 - present on 1st, 3rd, and 4th only 14 - present on 2nd, 3rd, and 4th only 15 - present on 1st, 2nd, 3rd, and 4th 16 - present on more than 4 99 - not reported on any exam	63-64

FIELD		CARD COLUMN
17.	Respiration: Altered Breath Sounds (Rev. "1" only) Item 28 Code: Same as in Field 16	65-66
18.	Respiration: Other (Rev. "1" only) Item 28 Code: Same as in Field 16	67-68
19.	Heart: Tachycardia Item 31 Four-digit code for: Abnormality (col. 69) Code: 0 - Normal on all exams 1 - Abnormal on one exam 2 - Abnormal on two or more (Rev. "1" only) 9 - Not reported on any Highest Rate Reported on Any Exam (cols. 70-72) Code: 100-250 - As given 999 - Not reported on any exam	69-72
20.	Heart: Bradycardia Item 31 Four-digit code for: Abnormality (col. 73) Code: Same as in Field 19 col. 69 Lowest Heart Rate on Any Exam (cols. 74-76) Code: 000 - None 001-099 - As given 999 - Not reported on any exam	73-76
21.	Heart: Irregular Rhythm Item 31 Code: 0 - Normal on all exams 1 - Abnormal on one exam 2 - Abnormal on two or more exams 9 - Not reported on any	77
22.	Heart: Murmur Item 31 Code: Same as in Field 21	78

DEFINITION OF CODES (Continued)

FORM PED-2
Card 24C2

FIELD		CARD COLUMN
23.	Heart: Thrill Item 31. Code: Same as in Field 21	79
24.	Heart: Other Item 31. Code: Same as in Field 21	80

DEFINITION OF CODES (Continued)

FORM PED-2
Card 3402

FIELD		CARD COLUMN
1.	Card Number Code: 3	1
2.	Basic Data * Code: Same as in columns 2-35 of Card 1	2-35
3.	Femoral Pulses (Revision "1" only) Item 32 Code: Blank - Not on Revision "0" 0 - Strong and equal bilaterally on all exams 1 - Weak, asymmetrical, or absent on at least one exam 9 - Not reported on any exam	36
4.	Abdomen Item 33 Code: 0 - Normal on all exams 1 - Other on at least one exam 9 - Not reported on any exam	37
5.	Genitalia Item 34 Code: Same as in Field 4	38
6.	Spine Item 35 Code: Same as in Field 4	39
7.	Extremities and Joints (Revision "1" only) Item 36 Code: Same as in Field 4 except Blank - Not on Revision "0"	40

* Unless specified, Fields, Codes and Card Columns refer to Revision Number "0" and "1". Item numbers refer to Revision "1", Form Dated: changed 2/63.

DEFINITION OF CODES (Continued)

FORM PED-2
Card 3402

FIELD		CARD COLUMN
8.	Suck	41-42

Item 37.
Code: 00 - present on all exams
01 - absent on 1st only
02 - absent on 2nd only
03 - absent on 3rd only
04 - absent on 4th only
05 - absent on 1st and 2nd only
06 - absent on 1st and 3rd only
07 - absent on 1st and 4th only
08 - absent on 2nd and 3rd only
09 - absent on 2nd and 4th only
10 - absent on 3rd and 4th only
11 - absent on 1st, 2nd, and 3rd only
12 - absent on 1st, 2nd, and 4th only
13 - absent on 1st, 3rd, and 4th only
14 - absent on 2nd, 3rd, and 4th only
15 - absent on 1st, 2nd, 3rd, and 4th
16 - absent on more than 4
99 - not reported on any exams.

9.	Palmar Grasp	43-44

Item 38
Code: 00 - present on all exams
01 - asymmetrical on 1st only
02 - asymmetrical on 2nd only
03 - asymmetrical on 3rd only
04 - asymmetrical on 4th only
05 - asymmetrical on 1st and 2nd only
06 - asymmetrical on 1st and 3rd only
07 - asymmetrical on 1st and 4th only
08 - asymmetrical on 2nd and 3rd only
09 - asymmetrical on 2nd and 4th only
10 - asymmetrical on 3rd and 4th only
11 - asymmetrical on 1st, 2nd, and 3rd only
12 - asymmetrical on 1st, 2nd, and 4th only
13 - asymmetrical on 1st, 3rd, and 4th only
14 - asymmetrical on 2nd, 3rd, and 4th only
15 - asymmetrical on 1st, 2nd, 3rd and 4th
16 - asymmetrical on more than 4

FIELD		CARD COLUMN
9.	Palmar Grasp (continued)	43-44

Code:
17 - absent on 1st only
18 - absent on 2nd only
19 - absent on 3rd only
20 - absent on 4th only
21 - absent on 1st and 2nd only
22 - absent on 1st and 3rd only
23 - absent on 1st and 4th only
24 - absent on 2nd and 3rd only
25 - absent on 2nd and 4th only
26 - absent on 3rd and 4th only
27 - absent on 1st, 2nd, and 3rd only
28 - absent on 1st, 2nd, and 4th only
29 - absent on 1st, 3rd, and 4th only
30 - absent on 2nd, 3rd, and 4th only
31 - absent on 1st, 2nd, 3rd and 4th
32 - absent on more than 4
99 - not reported on any

10. Plantar Grasp — 45-46

Item 39
Code: same as in Field 9

11. Moro: Response — 47-50

Item 40.
Four-digit code for:
1st Exam (col. 47)
2nd Exam (col. 48)
3rd Exam (col. 49)
4th Exam (col. 50)

Code for each column:
1 - obtained with ease
2 - obtained with difficulty
3 - no constant pattern
4 - no response (Revision "1" only)
9 - no report

FIELD		CARD COLUMN
12.	**Moro: Response of Arms** Item 41. Four-digit code for: 1st exam (column 51) 2nd exam (column 52) 3rd exam (column 53) 4th exam (column 54) Code for each column: 0 - normal 1 - flexor component absent with anterior extension (Revision "1" only) 2 - flexor component absent with lateral extension (Revision "1" only) 3 - asymmetrical 4 - other 5 - flexor component absent (Revision "0" only) 9 - not reported	51-54
13.	**Moro: Response of Legs** Item 42 Code: Blank - Not on Rev. "0" 00 - movement on all exams 01 - no movement on 1st only 02 - no movement on 2nd only 03 - no movement on 3rd only 04 - no movement on 4th only 05 - no movement on 1st and 2nd only 06 - no movement on 1st and 3rd only 07 - no movement on 1st and 4th only 08 - no movement on 2nd and 3rd only 09 - no movement on 2nd and 4th only 10 - no movement on 3rd and 4th only 11 - no movement on 1st, 2nd, and 3rd only 12 - no movement on 1st, 2nd, and 4th only 13 - no movement on 1st, 3rd, and 4th only 14 - no movement on 2nd, 3rd, and 4th only 15 - no movement on 1st, 2nd, 3rd, and 4th 16 - no movement on more than - 99 - not reported on any	55-56

FIELD		CARD COLUMN
14.	Cry (Revision "1" only) Item 43 Code: Blank - Not on Rev. "0" 00 - normal on all exams 01 - none on 1st only 02 - none on 2nd only 03 - none on 3rd only 04 - none on 4th only 05 - none on 1st and 2nd only 06 - none on 1st and 3rd only 07 - none on 1st and 4th only 08 - none on 2nd and 3rd only 09 - none on 2nd and 4th only 10 - none on 3rd and 4th only 11 - none on 1st, 2nd, and 3rd only 12 - none on 1st, 2nd, and 4th only 13 - none on 1st, 3rd, and 4th only 14 - none on 2nd, 3rd, and 4th only 15 - none on 1st, 2nd, 3rd, and 4th 16 - none on more than 4 17 - other on 1st only 18 - other on 2nd only 19 - other on 3rd only 20 - other on 4th only 21 - other on 1st and 2nd only 22 - other on 1st and 3rd only 23 - other on 1st and 4th only 24 - other on 2nd and 3rd only 25 - other on 2nd and 4th only 26 - other on 3rd and 4th only 27 - other on 1st, 2nd, and 3rd only 28 - other on 1st, 2nd, and 4th only 29 - other on 1st, 3rd, and 4th only 30 - other on 2nd, 3rd, and 4th only 31 - other on 1st, 2nd, 3rd, and 4th 32 - other on more than 4 99 - no report on any exam	57-58
15.	Motor Activity: Tremulous Item 46. Code: 00 - normal on all exams 01 - abnormal on 1st only 02 - abnormal on 2nd only 03 - abnormal on 3rd only 04 - abnormal on 4th only	59-60

FIELD		CARD COLUMN
15.	Motor Activity: Tremulous (continued) Code: 05 - abnormal on 1st and 2nd only 06 - abnormal on 1st and 3rd only 07 - abnormal on 1st and 4th only 08 - abnormal on 2nd and 3rd only 09 - abnormal on 2nd and 4th only 10 - abnormal on 3rd and 4th only 11 - abnormal on 1st, 2nd, and 3rd only 12 - abnormal on 1st, 2nd, and 4th only 13 - abnormal on 1st, 3rd, and 4th only 14 - abnormal on 2nd, 3rd, and 4th only 15 - abnormal on 1st, 2nd, 3rd, and 4th 16 - abnormal on more than 4 99 - not reported on any exam	59-60
16.	Motor Activity: Rapid Jerky Item 46. Code: same as in Field 15	61-62
17.	Motor Activity: Myoclonic (Revision "1" only) Item 46 Code: Same as in Field 15, except Blank - Not on Revision "0"	63-64
18.	Motor Activity: Writhing Item 46. Code: same as in Field 15	65-66
19.	Motor Activity: Asymmetrical (Revision "1" only) Item 46 Code: Same as in Field 15 except Blank - Not on Revision "0"	67-68
20.	Motor Activity: Local Convulsions Item 46. Code: same as in Field 15	69-70

FIELD		CARD COLUMN
21.	Motor Activity: Generalized Convulsions Item 46. Code: same as in Field 15	71-72
22.	Motor Activity: Other (Rev. "1" only) Item 46 Code: Same as in Field 15, except Blank - Not on Revision "0"	73-74

DEFINITION OF CODES (Continued)

FORM PED-2
Card 4402

FIELD		CARD COLUMN
1.	Card Number Code: 4	1
2.	Basic Data* Code: Same as in cols. 2-35 of Card 1, except, col. 5 is Rev. "1" only	2-35
3.	Tone: Upper Extremity Item 48 Eight-digit code for: Right Upper Extremity, 1st Exam (col. 36) Right Upper Extremity, 2nd Exam (col. 37) Right Upper Extremity, 3rd Exam (col. 38) Right Upper Extremity, 4th Exam (col. 39) Left Upper Extremity, 1st Exam (col. 40) Left Upper Extremity, 2nd Exam (col. 41) Left Upper Extremity, 3rd Exam (col. 42) Left Upper Extremity, 4th Exam (col. 43) Code for each column: 1 - Hypotonic 2 - Questionable hypotonicity 3 - Normal 4 - Questionable hypertonicity 5 - Hypertonic 9 - Not reported	36-43
4.	Tone: Lower Extremity Item 49 Eight-digit code for: Right Lower Extremity, 1st Exam (col. 44) Right Lower Extremity, 2nd Exam (col. 45) Right Lower Extremity, 3rd Exam (col. 46) Right Lower Extremity, 4th Exam (col. 47) Left Lower Extremity, 1st Exam (col. 48) Left Lower Extremity, 2nd Exam (col. 49) Left Lower Extremity, 3rd Exam (col. 50) Left Lower Extremity, 4th Exam (col. 51) Code for each column: Same as in Field 3	44-51
5.	Tone: Neck Flexor Item 50 Four-digit code for: 1st Exam (col. 52) 2nd Exam (col. 53) 3rd Exam (col. 54) 4th Exam (col. 55) Code: Same as in Field 3	52-55

* Item numbers, Fields, Codes and Card Columns refer to Rev. "1"

FIELD		CARD COLUMN
6.	**Tone: Neck Extensor** Item 51 Four-digit code for: 1st Exam (col. 56) 2nd Exam (col. 57) 3rd Exam (col. 58) 4th Exam (col. 59) Code for each column: Same as in Field 3	56-59
7.	**Tone: Trunk** Item 52 Four-digit code for: 1st Exam (col. 60) 2nd Exam (col. 61) 3rd Exam (col. 62) 4th Exam (col. 63) Code for each column: Same as in Field 3	60-63
8.	**Dysmaturity** Item 54 Code: 0 - None on all reports 1 - Stage 1 dysmaturity on at least one 2 - Stage 2 dysmaturity on at least one 3 - Stage 3 dysmaturity on at least one 4 - Equivocal signs of dysmaturity on at least one 9 - Not reported on any exam	64
9.	**Clinical Impression** Item 55 Seven-digit code for: **Presence or Absence of Central Nervous System Defect or Injury** (cols. 65-66) Code: 00 - Normal on all exams 01 - Abnormal on 1st only 02 - Abnormal on 2nd only 03 - Abnormal on 3rd only 04 - Abnormal on 4th only 05 - Abnormal on 1st and 2nd only 06 - Abnormal on 1st and 3rd only 07 - Abnormal on 1st and 4th only 08 - Abnormal on 2nd and 3rd only 09 - Abnormal on 2nd and 4th only 10 - Abnormal on 3rd and 4th only	65-71

DEFINITION OF CODES (Continued)

FORM PED-2
Card 4402

FIELD		CARD COLUMN
9.	Presence or Absence of Central Nervous System Defect or Injury (continued) 11 - Abnormal on 1st, 2nd and 3rd only 12 - Abnormal on 1st, 2nd and 4th only 13 - Abnormal on 1st, 3rd and 4th only 14 - Abnormal on 2nd, 3rd and 4th only 15 - Abnormal on 1st, 2nd, 3rd and 4th 16 - Abnormal on more than 4 17 - Normal on first 4, abnormal later 99 - Not reported on any exam Report of Central Nervous System Defect or Injury - Last Exam (col. 67) Code: 0 - Normal CNS 1 - Abnormal CNS 9 - Not reported Congenital Malformations Other Than Central Nervous System (cols. 68-69) Code: Same as in cols. 65-66 Other Clinical Impressions (cols. 70-71) Code: Same as in cols. 65-66	65-71

DEFINITION OF CODES (Continued)

FORM PED-2
Card 5402

NOTE: This card should not be used in Tabulations.

FIELD		CARD COLUMN
1.	Card Number Code: 5	1
2.	Basic Data * Code: Same as in columns 2-33 of Card 1 except column 5 is Rev. "0" only.	2-33
3.	Cyanosis Item 1 Code: 00 - Absent on all exams 01 - Present on 1st only 02 - Present on 2nd only 03 - Present on 3rd only 04 - Present on 4th only 05 - Present on 1st and 2nd only 06 - Present on 1st and 3rd only 07 - Present on 1st and 4th only 08 - Present on 2nd and 3rd only 09 - Present on 2nd and 4th only 10 - Present on 3rd and 4th only 11 - Present on 1st, 2nd, and 3rd only 12 - Present on 1st, 2nd, and 4th only 13 - Present on 1st, 3rd, and 4th only 14 - Present on 2nd, 3rd, and 4th only 15 - Present on 1st, 2nd, 3rd, and 4th only 16 - Present on more than 4 99 - Not reported on any exam	34-35
4.	Subcutaneous Tissue: Other Item 4 Code: Same as in Field 3, except 00 - Normal on all exams	36-37
5.	Respiration: Irregular Item 6 Code: Same as in Field 4	38-39

* Item numbers, Fields, Codes and Card Columns refer to Revision "0".

DEFINITION OF CODES (Continued)

FORM PED-2
Card 5402

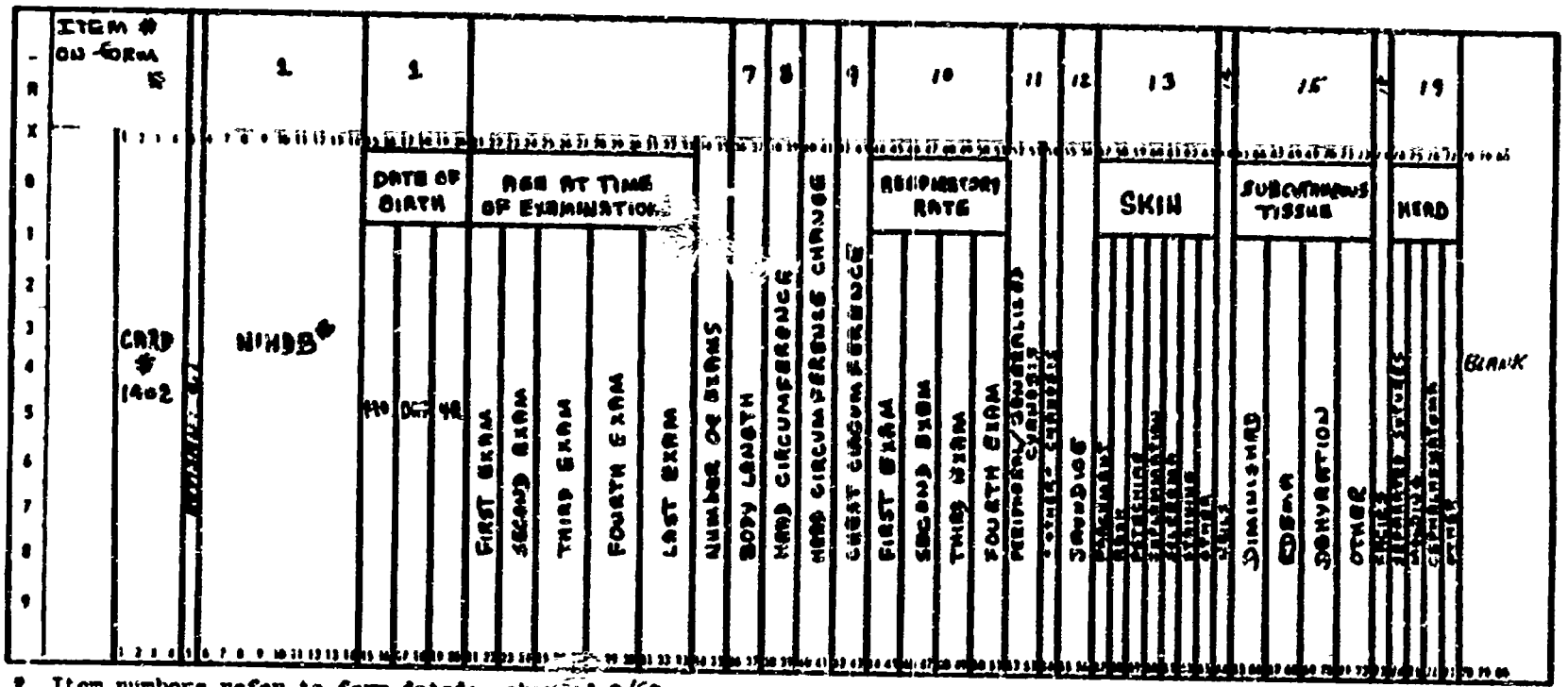
FIELD		CARD COLUMN
6.	Respiration: Shallow Item 6 Code: Same as in Field 4	40-41
7.	Respiration: Grunting Item 6 Code: Same as in Field 4	42-43
8.	Respiration: Labored Item 6 Code: Same as in Field 4	44-45
9.	Respiration: Retractions Item 6 Code: Same as in Field 4	46-47
10.	Respiration: Other Item 6 Includes "Disorganized, Rales, and Altered Breath Sounds" Code: Same as in Field 4	48-49
11.	Heart Rate: First Rate Item 7 Code: 000 - None 001-250 - As given 999 - Not reported	50-52
12.	Head Item 11 Five-digit code for: Over-riding sutures (col. 53) Separated sutures (col. 54) Severe molding (col. 55) Cephalhematoma (col. 56) Other (col. 57) Code for each column: 0 - Normal on all exams 1 - Abnormal on at least one exam 9 - Not reported on any	53-57

FIELD		CARD COLUMN
13.	Body Movements: Other Item 18 Code: 00 - normal on all exams 01 - abnormal on 1st only 02 - abnormal on 2nd only 03 - abnormal on 3rd only 04 - abnormal on 4th only 05 - abnormal on 1st and 2nd only 06 - abnormal on 1st and 3rd only 07 - abnormal on 1st and 4th only 08 - abnormal on 2nd and 3rd only 09 - abnormal on 2nd and 4th only 10 - abnormal on 3rd and 4th only 11 - abnormal on 1st, 2nd, and 3rd only 12 - abnormal on 1st, 2nd, and 4th only 13 - abnormal on 1st, 3rd, and 4th only 14 - abnormal on 2nd, 3rd, and 4th only 15 - abnormal on 1st, 2nd, 3rd, and 4th 16 - abnormal on more than 4 99 - not reported on any exam	58-59
14.	Moro: Response of Legs Item 19 Code: 00 - Flexor on all exams 01 - other on 1st only 02 - other on 2nd only 03 - other on 3rd only 04 - other on 4th only 05 - other on 1st and 2nd only 06 - other on 1st and 3rd only 07 - other on 1st and 4th only 08 - other on 2nd and 3rd only 09 - other on 2nd and 4th only 10 - other on 3rd and 4th only 11 - other on 1st, 2nd, and 3rd only 12 - other on 1st, 2nd, and 4th only 13 - other on 1st, 3rd, and 4th only 14 - other on 2nd, 3rd, and 4th only 15 - other on 1st, 2nd, 3rd, and 4th only 16 - other on more than 4 exams 99 - not reported on any exams.	60-61

FIELD		CARD COLUMN
15.	Tone: Neck Item 20 Four-digit code for: 1st Exam (col. 62) 2nd Exam (col. 63) 3rd Exam (col. 64) 4th Exam (col. 65) Code for each column: 0 - Normal 1 - Flaccid (limp) 2 - Hypertonic (rigid) 9 - No report	62-65
16.	Tone: Trunk Item 20 Four-digit code for: 1st Exam (col. 66) 2nd Exam (col. 67) 3rd Exam (col. 68) 4th Exam (col. 69) Code for each column: Same as in Field 15	66-69
17.	Tone: Upper Extremity Item 20 Four-digit code for: 1st Exam (col. 70) 2nd Exam (col. 71) 3rd Exam (col. 72) 4th Exam (col. 73) Code for each column: Same as in Field 15	70-73
18.	Tone: Lower Extremity Item 20 Four-digit code for: 1st Exam (col. 74) 2nd Exam (col. 75) 3rd Exam (col. 76) 4th Exam (col. 77) Code for each column: Same as in Field 15	74-77
19.	Maturity Item 23 Code: 0 - Normal on all exams 1 - Premature on at least one 2 - Post mature on at least one 9 - Not reported on any	78

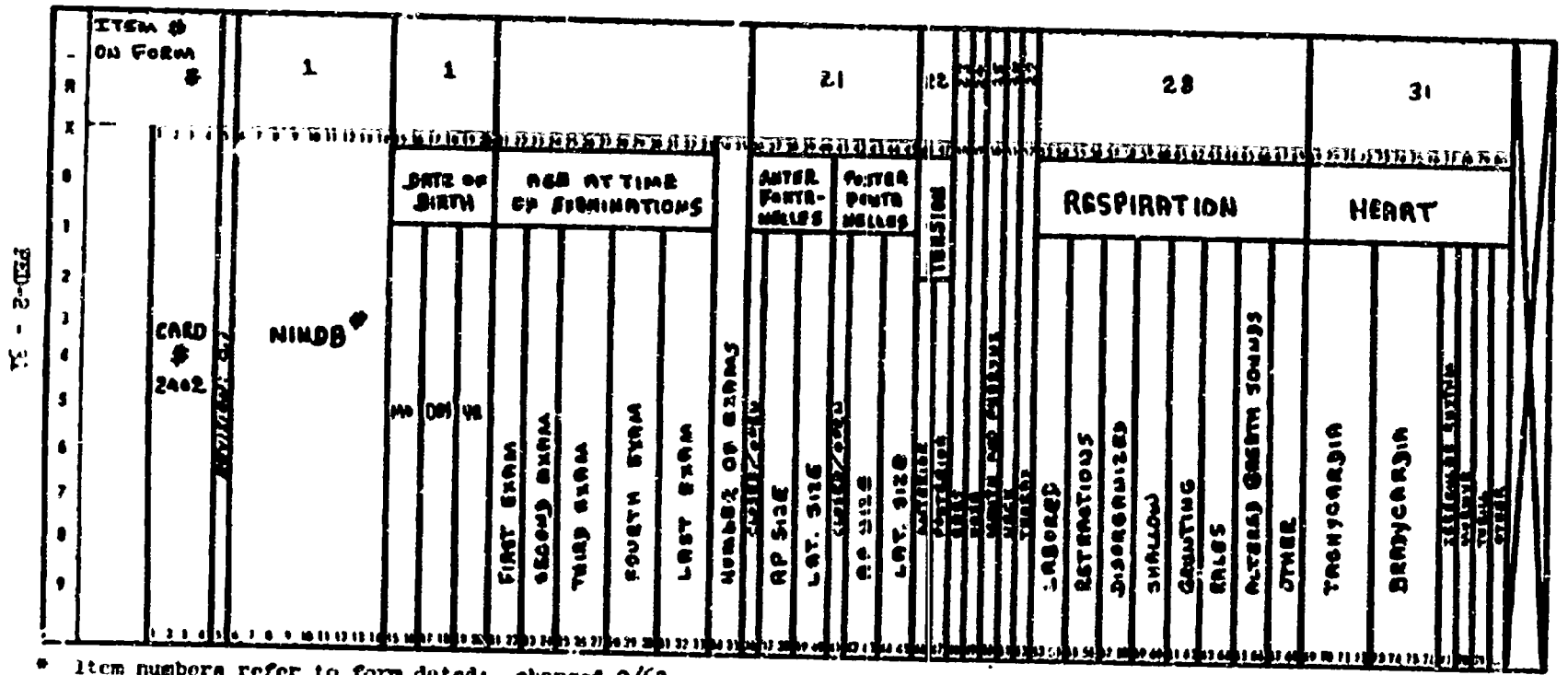
FIELD		CARD COLUMN
20.	Obvious Congenital Malformations Item 27 Code: 0 - No obvious congenital malformations 1 - Obvious congenital malformations 9 - Not reported	79
21.	Obvious Signs of Injury Item 28 Code: 0 - No obvious signs of injury 1 - Obvious signs of injury 9 - Not reported	80

NEONATAL EXAMINATION
FORM PED-2



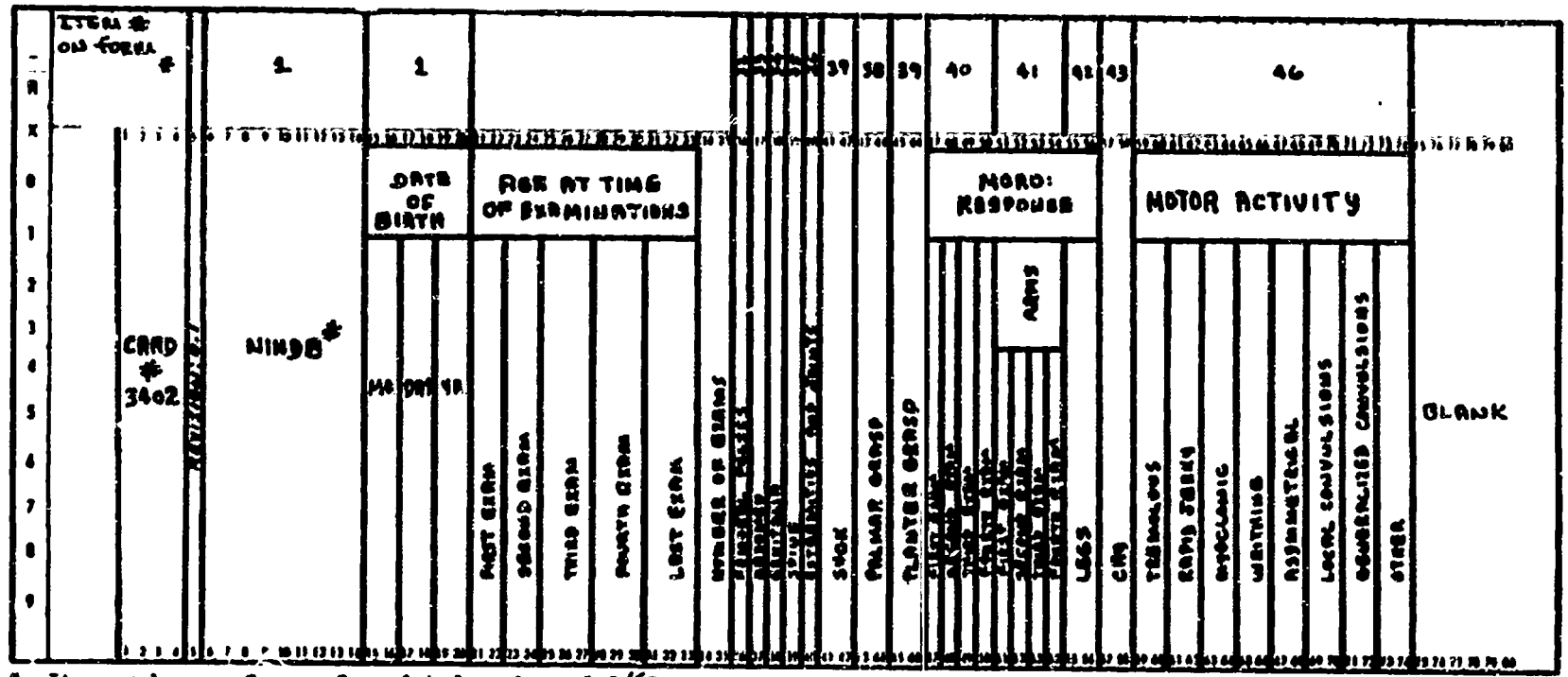
* Item numbers refer to form dated: changed 2/63

NEONATAL EXAMINATION
FORM PED-2



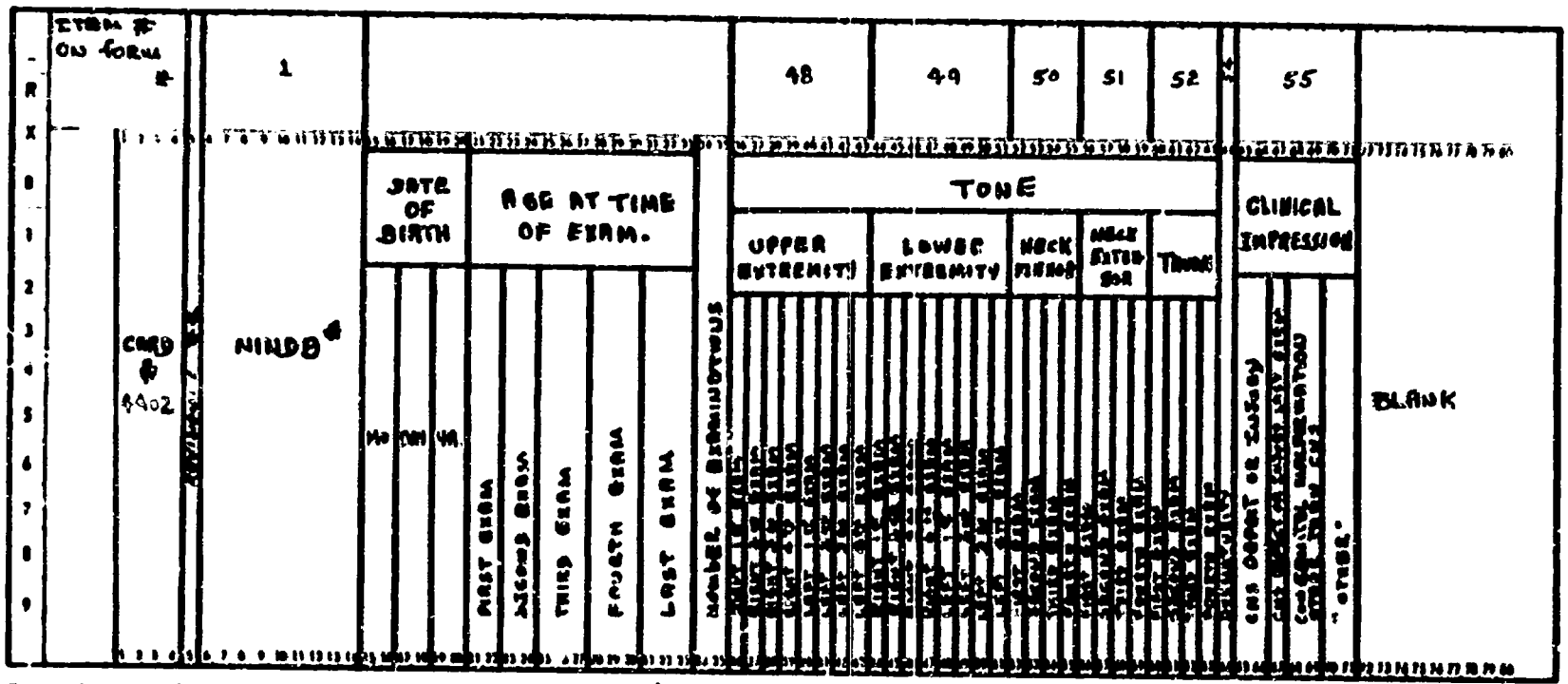
* Item numbers refer to form dated: changed 2/63

NEONATAL EXAMINATION
FORM PED-2



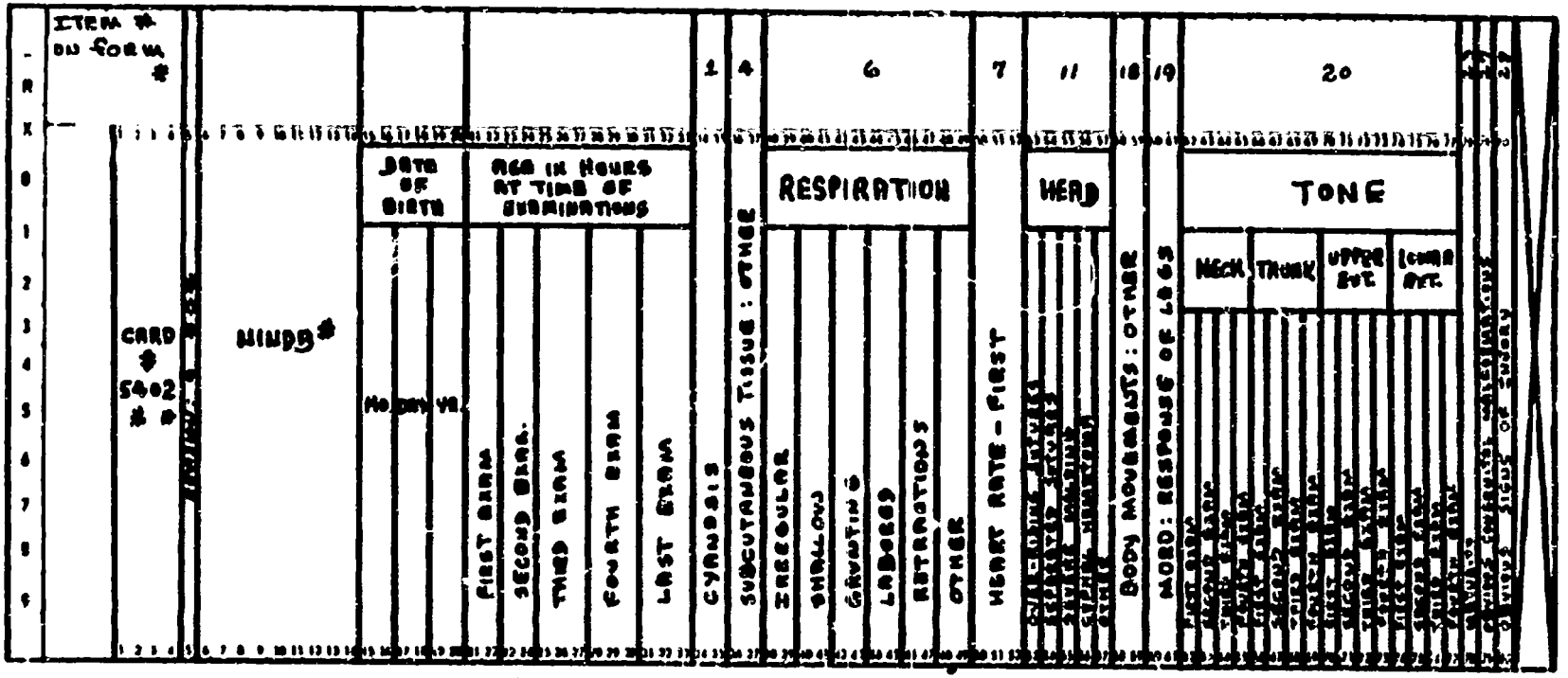
* Item numbers refer to form dated: changed 2/63

NEONATAL EXAMINATION
FORM PED-2



* Item numbers refer to form dated: changed 2/63
** Card exists for Rev. "1" only.

NEONATAL EXAMINATION
FORM PED-2



* Item numbers refer to form dated: 1/59
** This card should not be used in tabulations.
*** This card exists for Rev. "0" only.

PHS-3004-2: Manual for Neonatal Examinations

INTRODUCTION. The purpose of the Neonatal Examinations is to detect and record evidences of stress, injury, congenital malformation and disease in the infant in the first few days subsequent to birth. In addition to this, measurements and other pertinent observations will be recorded as baseline information against which subsequent observations and measurements can be compared. In areas where established norms are not available for evaluating the above, data will be collected to aid in establishing such norms.

A data transmittal sheet PED-2 has been created to facilitate the recording and coding of information obtained on these Neonatal Examinations. This manual has been prepared for use as a guide in performing the examinations and also to assist in the proper recording of the information obtained.

GENERAL INSTRUCTIONS

A. The Examiner. The examiner performing the neonatal examinations should be a pediatrician.

B. Timing of the Examination. The first Neonatal Examination should be performed between zero and twenty-four hours subsequent to birth with the hope that most examinations will center about 12 hours subsequent to birth. The second neonatal examination should be done between 36 and 60 hours of age centering around 48 hours. If an infant remains in the hospital more than 24 hours subsequent to the second examination, a third is to be done prior to discharge. Infants who have a prolonged hospital stay should have an examination weekly. Occasionally, because of severe illness, extreme prematurity, etc., the examination scheduled as described may not be accomplished. If such is the case, the examinations should be done as closely as possible to the prescribed schedule and a full explanation made in the right hand column of the form.

C. Elimination of Bias. Ideally, the examiner performing the neonatal examinations should be unaware of all events in the child's history, including pregnancy and previous physical findings so that the possibility of such knowledge biasing his evaluation can be avoided. It is obviously impossible to avoid all such information but every effort should be made to prevent the examiners access to information which could be an unnecessary source of bias for him.

D. Construction of the Form. The left hand side of the neonatal examination contains a list of numbered items. These items represent specific systems or areas which must be evaluated. "Normal" or its equivalent, if applicable is listed first for each item; variable or abnormal categories follow. Some variable or abnormal categories have three boxes labelled "slight," "moderate" and "marked"

following them. These are provided as a simple and standard way to record intensity of variable findings.

On the right-hand side of the page there is a large blank column which is provided for comments concerning the numbered items.

E. Recording Instructions. All items on this form are to be completed. If an item cannot be performed completely or if the results of a particular test cannot be satisfactorily evaluated a full explanation of such a failure must accompany this item or a group of items in the right-hand column.

If an item other than normal is checked ordinarily a description should accompany this item in the large blank space at the right. However, some items are constructed so that abnormal findings properly recorded require no further comment. For example "jaundice," "generalized cyanosis" and similar findings, ordinarily cannot be more thoroughly expressed other than to add the degree of intensity. Since items expressing "jaundice" and "generalized cyanosis" have boxes to record the degree usually no comment is necessary.

To insure identification of comments each should bear the number of the item it concerns. For items having "slight," "moderate" and "marked" boxes, the box to the left should be checked to signify that the item is present and then the proper qualifying box checked.

SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. This item is to be completed using the patient's name plate.

Item 2, Examiners Name. Here the examiner will record his name.

Item 3, Examiners Status. Here the examiner will record his status (intern, pediatrician, neurologist, etc.).

Item 4, Date. The date of the examination as recorded using the sequence—month, day, year.

Item 5, Time Examination Started. This should be recorded using a 24-hour clock.

Item 6, Age. Record the child's age to the nearest hour for the first week; after that to the nearest day.

Item 7, Body Length. The body length is measured with the child in supine position on a flat surface. Record in centimeters.

PHS-3004-2: Manual for Neonatal Examinations

Item 8, Head Circumference. The measurement of head circumference is done using a flexible measuring tape which is applied firmly over the glabella and supraorbital ridges anteriorly and that part of the occiput posteriorly which gives the maximum circumference. The measurement should be recorded in centimeters.

Item 9, Chest Circumference. The girth of the thorax is measured at the level of the nipples in a plane at right angles to the vertebral column. The measurement is to be recorded in centimeters.

Item 10, Respiratory Rate. The respiratory rate should be counted for 30 seconds with the child in as close to a resting state as possible. If child cannot be put in resting state do not count rate, record as "N.A." (not applicable).

Item 11, Cyanosis. Cyanosis must be distinguished as to type. Generalized cyanosis is considered cyanosis which involves the entire body. Peripheral cyanosis (acrocyanosis) refers to cyanosis involving only the hands and feet. Cyanosis which is neither peripheral nor generalized (circumoral cyanosis, regional cyanosis other than hands and feet, harlequin cyanosis, etc.) is to be recorded as "other" and a full description made in the right-hand column. In recording "generalized cyanosis" the degree should be expressed as "slight," "moderate" or "marked" in the boxes provided. Generalized cyanosis so recorded needs no comment in the right-hand column.

Item 12, Jaundice. The presence or absence of jaundice should be noted. If present, jaundice should be quantitated by checking the appropriate box "slight," "moderate" or "marked." No comment is required in the right-hand column concerning jaundice.

Item 13, Skin. This item calls for an observation of the color and texture of the skin as well as a search for specific lesions. Stork bites and Mongolian spots are to be considered normal findings. Stork bites are defined as those capillary clusters or nonelevated hemangiomas found frequently on the nape of the neck, the bridge of the nose or the eyelids. All findings other than "normal," "Mongolian spots" and "stork bites" should be described.

Item 14, Nails. The examination of the child's nails is important because it is related to the staging of dysmaturity. Both the configuration and the color should be noted. No comment is required if "excessive length" is checked. "Staining" and "other" require comments.

Item 15, Subcutaneous Tissue. The examiner's impression of the child's subcutaneous tissue as determined by observation and palpation is to be recorded under this Item. The findings of "diminished subcutaneous tissue," "edema" and "dehydration" are to be quantitated by checking the

appropriate "slight," "moderate" or "marked" box opposite the finding. No comment is required for these categories. If "other" is checked, however, a description should be made in the right-hand column.

Item 16, Comments. Here record comments, remarks or descriptions concerning the numbered items. Be careful to identify the comment with the number of the item it concerns.

Item 17, Patient Identification. Same as Item 1.

Item 18, Facies. This item provides the examiner with an opportunity to indicate unusual facial appearances of the child. If the facies definitely fits a diagnostic category such as Mongoloid facies, the observation should be recorded as such. However, if the facies is unusual but not categorically diagnostic it should be described as fully as possible in the right-hand column and it would be desirable if a photograph could taken in full face and both lateral views. The photos should be stamped on the back using the patient's name plate and attached to PED-2.

Item 19, Head. This item represents the examiner's impression of the child's head as obtained from inspection and palpation. If "separated sutures" or "molding" are found quantitate them by checking the appropriate "slight," "moderate" or "marked" box. If a cephalhematoma is found specify location.

Items 20 - 22, Fontanelles. Both size and tension of the fontanelles is to be evaluated. Record size of anterior and posterior fontanelles in appropriate spaces, giving both AP and lateral measurements. If fontanelle is closed check the appropriate box. If tension is other than normal, check appropriate "other" box and describe in right-hand column.

Items 23 - 25, Ears, Nose, Mouth and Pharynx. This examination should include a search for specific lesions, discharges or malformations. The eardrums need not be visualized. In examining the oropharynx a tongue blade or similar instrument should be used.

Item 26, Neck. This is the examiner's impression of the child's neck as obtained through inspection, palpation and manipulation.

Item 27, Thorax. This represents the examiner's impression of the thorax as obtained by inspection and palpation. Do not include abnormal respiratory movements.

Item 28, Respirations. This examination requires an observation of the child's respiration and also includes the examination of the chest and lungs by inspection, palpation, percussion and auscultation. If "labored," "retractions," "disorganized," "shallow" or "grunting" are checked, quantitate the observation by checking the appropriate "slight."

"moderate" or "marked" box. Ordinarily no comment is necessary for these categories. "Rales," "altered breath sounds" and "other" require comments in the right-hand column.

Item 29, Comments. Same as Item 16.

Item 30, Patient Identification. Same as Item 1.

Item 31, Heart. The examination of the heart consists of an evaluation of the cardiac rate and rhythm together with palpation and an auscultation. In evaluating the rate it is not absolutely necessary for the examiner to count the rate. If as the examiner listens to the child's heart he feels the rate excessively fast or slow he should then count the rate. If over 180 or under 100 it should be recorded as either tachycardia or bradycardia and the exact rate specified. Rates between 100 and 180 are not to be recorded as tachycardia or bradycardia.

Item 32, Femoral Pulses. Determine by palpation the strength and symmetry of the femoral pulse.

Item 33, Abdomen. The abdomen is examined using inspection, palpation and percussion.

Item 34, Genitalia. This represents the examiner's impressions of the child's external genitalia as determined from inspection and palpation.

Item 35, Spine. The child's spine is evaluated by inspection, palpation and manipulation.

Item 36, Extremities and Joints. The extremities are evaluated using inspection, palpation and manipulation. The extremity joints and joints contiguous to the extremities are to be included under this item.

Item 37, Suck. The child's sucking reflex should be evaluated with a finger covered with a sterile finger cot or a rubber nipple inserted into the child's mouth. Sometimes to induce this reflex it is desirable to press the finger or nipple against the roof of the child's mouth.

Item 38, Palmar Grasp. This represents the grasp response of the neonate's hand elicited by a stimulus applied to the palm. The suggested stimulus is the examiner's finger applied to the palm of the infant's hand from the ulnar side. It may be necessary to move the finger gently back and forth to elicit the response. If the response is not obtained, the finger should be inserted from the radial side. Many attempts using both methods should be made before the response is considered absent.

Item 39, Plantar Grasp. This represents the grasp response of the neonate's foot elicited by stimulation applied to the sole. The response is elicited

by the application of the examiner's finger to the medial side of the child's foot. It may be necessary to move the finger gently back and forth several times to produce the desired response. If the response is not readily obtained, several attempts should be made by the examiner before the reflex is considered absent.

Items 40 - 42, Moro Reflex. This represents the neonate's response to a specific sudden movement. There are numerous ways of eliciting the Moro response. The one to be used for the purposes of this study is as follows: The child is supported under the back and head. The head is allowed suddenly to drop backwards through approximately 30 degrees and the pattern of the arm and leg responses are noted. A minimum of three attempts should be made before recording.

The recording of this item is complex and requires careful attention. If the child's arms and legs fail to respond during all attempts "no response" should be checked under Item 40 and no further recording made. If a response is obtained but this response is not reproduced in at least two out of three attempts, the box "no constant pattern" should be checked under Item 40 and no further recording made. If a response is obtained which is reproduced in at least two out of three attempts, the box pertaining to the degree of ease with which the response was obtained should be checked under Item 40, and the character of the response should be recorded under Items 41 and 42. The response would be considered to be "obtained with ease" if all the attempts to elicit this reflex resulted in the same response. If the response was reproducible but not consistently reproducible, "obtained with difficulty" should be checked in Item 40. Care should be taken to note whether the extension is anterior or lateral.

This reflex is somewhat difficult to elicit and great care must be taken that the technique is performed in exactly the manner prescribed. The examiner may repeat the reflex as often as necessary to determine the true character of the response. If there is doubt as to whether a normal response is present, a normal type response probably should be checked.

Item 43, Cry. This represents the examiners impression of the child's cry. If the cry is considered abnormal the box "other" should be checked and if possible the specific abnormal quality of the cry described. If the cry is not present after maximum stimulation the box "none" should be checked. Considerable effort should be put forth in stimulating the child before the examiner terms the cry absent.

Item 44, Comments. Same as Item 16.

Item 45, Patient Identification. Same as Item 1.

Item 46, Motor Activity. The examiner should observe the spontaneous body movements of the neonate. This observation should not be limited to a

specific time but should be a general observation throughout the entire examination. For the purpose of this examination the following definitions are to be used:

1. Tremulousness or jittery movements—These represent tremorous movements occurring spontaneously or in response to a stimulus. They appear principally in the arms and are to be distinguished from the more coarse myoclonic movements.

2. Rapid, jerky movements—These are sudden, non-repetitive, purposeless twitches or jerks.

3. Myoclonic movements—These represent slow, gross, rhythmic movements usually symmetrical and usually triggered by a stimulus.

4. Writhing movements—These are sinuous, asymmetric, stretching movements independent of stimuli, commonly seen in small premature.

5. Asymmetrical movements—These are movements, which differ in degree of quality when one side of the body is compared to the other. This category is designed to elucidate conditions manifested by differences in body tone or paralyses.

6. Convulsions—These are usually clonic or tonic movements which are spontaneous in nature but this term also includes unconscious or atonic spells. Generalized clonic or tonic movements or unconscious or tonic spells are to be termed a generalized convulsion. If the convulsive movement is localized to a defineable area it is to be termed a localized convulsion.

Items 47 - 52, Tone. Muscle tone should be evaluated in each of four areas—the neck, trunk, upper and lower extremities. Tone is to be expressed using a gradient of one through five, each gradient defined in the code as it appears on the examination form.

Diagnosis by. Diagnosis has been divided in three distinct categories: weight, stage or dysmaturity, and clinical expression. The categories are defined and explained as follows:

Item 53, Weight. The first category, weight, asks for the classification of the infant as a term or premature infant based on birth weight only. This is done to separate the classification of "full term" or "premature" from the judgments below.

PHS-3004-2: Manual for Neonatal Examinations

Item 54, Dysmaturity. The dysmaturity category asks that the child be classified as to stage of dysmaturity. The stages as defined below:

"O" - No signs of dysmaturity.

"?" - Equivocal signs of dysmaturity.

"Stage 1" - The general appearance of the infants suggest the failure of the placenta to provide for normal growth and development and the infant's condition may suggest some malnutrition and loss of weight. The skin is unstained and generally is cracked, parchment-like and peeling. These signs are also combined with prolonged gestation, the infant may appear much older than the usual newborn and be open eyed and alert.

"Stage 2" - The infant exhibits the characteristics noted for Stage 1, but in addition the infant has liberated quantities of meconium sufficient to stain the skin, umbilical cord, nails, amniotic fluid and the placental membranes. The infant may give evidence of having aspirated meconium.

"Stage 3" - The infant is assumed to have passed through the earlier stages in utero. At birth the infant's desquamating skin is stained a golden yellow and the child exhibits all of the preceding findings but to a more marked degree.

Item 55, Clinical Impression. The item "clinical impression" is designed to record the examiner's impression of the child independent of the factors of weight and dysmaturity. Thus the baby exhibiting normal findings other than prematurity or dysmaturity can be checked "normal" under clinical impressions. Do not classify an infant as other than normal if prematurity or dysmaturity are the only findings.

Item 56, Unsatisfactory Examination Conditions. This provides the examiner with the opportunity to express any unsatisfactory conditions which may have existed during the examinations such as unusually irritable child, interfering maternal hostility, etc. If "present" is checked, state whether condition might have altered the results significantly.

Item 57, Comments. Same as Item 16.

COLR-3009-2
REV. 5-60 (?)

NEONATAL EXAMINATION

green

1. PATIENT'S IDENTIFICATION

superseded by black & white printing COLR-3009-2 rev. 5-60 (changed 2-65)

2. NAME OF EXAMINER

3. STATUS

4. DATE MO. | DAY | YEAR	5. TIME (Use 24 hr. clock)	6. AGE

16. COMMENTS

7. BODY LENGTH ______ Cm.

8. HEAD CIRCUMFERENCE ______ Cm.

9. CHEST CIRCUMFERENCE ______ Cm.

10. RESPIRATORY RATE ______
(Baby in resting state)

11. CYANOSIS
- ☐ Absent
- ☐ Peripheral Only
- ☐ Generalized
  - ☐ Slight ☐ Moderate ☐ Severe
- ☐ Other (Specify)

12. JAUNDICE
- ☐ Absent
- ☐ Present
  - ☐ Slight ☐ Moderate ☐ Severe

13. SKIN
- ☐ Normal (Including Mongolian Spots and Stork Bites)
- ☐ Parchment
- ☐ Rash
- ☐ Petechiae or Ecchymosis
- ☐ Inflammation
- ☐ Sclerema
- ☐ Staining (Describe color)
- ☐ Other (Specify)

14. NAILS
- ☐ Normal
- ☐ Staining
- ☐ Excessive Length
- ☐ Other (Specify)

15. SUBCUTANEOUS TISSUE
- ☐ Normal

	Slight	Moderate	Marked
☐ Diminished	☐	☐	☐
☐ Edema	☐	☐	☐
☐ Dehydration	☐	☐	☐
☐ Other (Specify)			

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(PED-2) PAGE 1 OF 4

COLR-0004
REV. 5-60 (3)

NEONATAL EXAMINATION (Continued)

DATE

17. PATIENT'S IDENTIFICATION

Superseded by COLR-3004-2 REV. 5-60 (changed 2-65)

18. FACIES
- Normal
- Asymmetrical
- Other (Specify)

19. HEAD
- Normal
- Separated Sutures — Slight / Moderate / Marked
- Molding — Slight / Moderate / Marked
- Caput/Hematoma (Specify location)
  - R. Parietal
  - L. Parietal
  - Occipital
  - Other (Specify)
- Other (Specify)

20. FONTANELLES

21. Size (In cms.)

	AP	Lat.	Closed
Anterior			
Posterior			

22. Tension

	Normal	Other
Anterior		
Posterior		

23. EARS
- Normal
- Other (Specify)

24. NOSE
- Normal
- Other (Specify)

25. MOUTH AND PHARYNX
- Normal
- Other (Specify)

26. NECK
- Normal
- Restricted Motion
- Masses
- Other (Specify)

27. THORAX
- Normal
- Other (Specify)

28. RESPIRATIONS
- Normal
- Labored — Slight / Moderate / Marked
- Retractions — Slight / Moderate / Marked
- Grunting — Slight / Moderate / Marked
- Stridor — Slight / Moderate / Marked
- Cyanosis — Slight / Moderate / Marked
- Rales — Slight / Moderate / Marked
- Altered Breath Sounds — Slight / Moderate / Marked
- Other (Specify) — Slight / Moderate / Marked

29. COMMENTS

Collaborative Research
Perinatal Research Branch, NINDS, NIH
Software Inc, Md.

(PED-2) PAGE 1 OF 4

COLR-2004-2
REV. 5-60 (2)

NEONATAL EXAMINATION
(Continued)

DATE

31. HEART

- ☐ Normal
  - ☐ Tachycardia (Over [illegible]. Specify rate) ____________
  - ☐ Bradycardia (Under [illegible]. Specify rate) ____________
  - ☐ Irregular Rhythm
  - ☐ Murmur
  - ☐ Thrill
  - ☐ Other (Specify)

32. FEMORAL PULSES

- ☐ Strong and Equal Bilaterally
  - ☐ Weak or Asymmetrical

33. ABDOMEN

☐ Normal ☐ Other (Specify)

34. GENITALIA

☐ Normal ☐ Other (Specify)

35. SPINE

☐ Normal ☐ Other (Specify)

36. EXTREMITIES AND JOINTS

☐ Normal ☐ Other (Specify)

37. SUCK *(Evaluate with finger)*

☐ Present ☐ Absent

38. PALMAR GRASP

☐ Present ☐ Asymmetrical ☐ Absent

39. PLANTAR GRASP

☐ Present ☐ Asymmetrical ☐ Absent

MORO *(Support child under back and head — LET child's head drop back about 30° and note pattern of response. If pattern can be reproduced record in appropriate boxes after a minimum of 3 attempts. If there is no definite or reproducible pattern check "No consistent pattern" and skip to item 43.)*

40. RESPONSE

- ☐ Obtained With Ease
- ☐ Obtained With Difficulty
- ☐ No Consistent Pattern *(Skip to item 43)*
- ☐ No Response *(Skip to item 43)*

41. RESPONSE OF ARMS

- ☐ Normal *(Extensor and flexor components symmetrically present)*
  - ☐ Flexor component absent with anterior extension
  - ☐ Flexor component absent with lateral extension
  - ☐ Asymmetrical
  - ☐ Other (Specify)

42. RESPONSE OF LEGS

☐ Movement ☐ No Movement

43. CRY

☐ Normal ☐ None ☐ Other (Specify)

30. PATIENT'S IDENTIFICATION

superseded by COLR-2004-2 rev. 5-64 (change 2-63)

44. COMMENTS

Collaborative Research
Perinatal Research Branch, NINDB, NIH
Bethesda 14, Md.

(PED-2) PAGE 3 OF 4

COLR-1500-6
REV. 8-80 (2)

NEONATAL EXAMINATION
(Continued)

DATE

45. PATIENT'S IDENTIFICATION

Deferred by COLR-3001-2 pp. 5-60 (changed 2-83)

46. MOTOR ACTIVITY

- 0 Normal
- Tremulous or Jittery — 1 Slight, 2 Moderate, 3 Marked
- Rapid Jerky Movements — 4 Slight, 5 Moderate, 6 Marked
- Myoclonic Movements — 7 Slight, 8 Moderate, 9 Marked
- Writhing Movements — 10 Slight, 11 Moderate, 12 Marked
- Asymmetrical Movements — 13 Slight, 14 Moderate, 15 Marked
- Convulsions
  - 16 Local
  - 17 Generalized
- 18 Other (Specify)

47. TONE. Use the following code which will indicate a gradation from flaccid to rigid. Describe any asymmetry in right hand column.

1. Hypotonic
2. Questionable hypotonicity
3. Normal
4. Questionable hypertonicity
5. Hypertonic

	Both	Right	Left
48. Upper Extremity			
49. Lower Extremity			
50. Neck Flexor			
51. Neck Extensor			
52. Trunk			

DIAGNOSIS BY

53. WEIGHT

- 0 Term Infant (Birth weight over 2500 gms.)
- 1 Premature (Birth weight over 2500 gms. or Less)

54. DYSMATURITY, STAGE OF

- 0 – No sign of dysmaturity
- 7 – Equivocal signs of dysmaturity
- 1 – Stage 1 dysmaturity
- 2 – Stage 2 dysmaturity
- 3 – Stage 3 dysmaturity

55. CLINICAL IMPRESSION

- 0 Normal
- 1 Central Nervous System Defect or Injury
- 2 Congenital Malformations Other Than Central Nervous System
- 3 Other (Specify)

56. UNSATISFACTORY EXAM CONDITIONS — 0 Absent, 1 Present

57. COMMENTS

NEONATAL EXAMINATION

1. Every numbered item should be checked (√). If not normal, findings should be checked (√) and described in margin at right.
2. Bold face items used only in [illegible].

Superseded by COLR-5001-2 rev. 5-60

IDENTIFY REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY WHICH IS CHECKED (√) SHOULD HAVE SOME DESCRIPTION. GIVE REASON FOR NOT EVALUATING ANY ITEM.

EXAMINER'S INITIALS				
STATUS				
DATE				
TIME				
1. CYANOSIS – ABSENT				
PRESENT				
2. JAUNDICE – ABSENT				
PRESENT				
3. SKIN – NORMAL *(Appearance and color)*				
ABNORMAL Pallor				
Rash				
Petechiae				
Inflammation				
Sclerema				
[illegible]				
Other				
4. SUBCUTANEOUS TISSUE – NORMAL				
ABNORMAL Edema				
Dehydration				
Other				
5. RESPIRATORY RATE *(Baby in resting state)*				
6. RESPIRATIONS – NORMAL				
ABNORMAL Irregular				
Shallow				
Grunting				
Labored				
Retractions				
Other				
7. HEART RATE *(Baby in resting state)*				
8. HEART – NORMAL				
ABNORMAL Irregular Rhythm				
Murmur				
Thrill				
Other				

Department of Health, Education and Welfare
Public Health Service

(PED-2) PAGE 1 OF 4

NEONATAL EXAMINATION

1. Every numbered item should be checked (√). If not normal, findings should be checked (√) and described on margin at right.
2. Solid face items need only be recorded once.

9. ABDOMEN – NORMAL					IDENTIFY REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY WHICH IS CHECKED (√) SHOULD HAVE SOME DESCRIPTION. GIVE REASON FOR NOT EVALUATING ANY ITEM.
ABNORMAL					
Distension					
Abnormal Liver					
Abnormal Spleen					
Abnormal Kidneys					
Other					
10. GENITALIA – NORMAL					
ABNORMAL – Male					
ABNORMAL – Female					
Other					
11. HEAD – NORMAL					
ABNORMAL					
Over-Riding Sutures					
Separated Sutures					
Severe Molding					
Cephalhematoma					
Other					
12. EARS – NORMAL					
ABNORMAL					
13. NOSE – NORMAL					
ABNORMAL					
14. MOUTH AND PHARYNX – NORMAL					
ABNORMAL					
15. SUCK (Evaluate with finger)					
STRONG					
WEAK					
ABSENT					
16. PALMAR GRASP (Stimulate – finger applied to ulnar side of palm)					
PRESENT – Right					
PRESENT – Left					
ABSENT – Right					
ABSENT – Left					
ASYMMETRICAL					

1-69

NEONATAL EXAMINATION

1. Every numbered item should be checked (✓). If not normal, findings should be checked (✓) and described in margin at right.
2. Bold face items need only be recorded once.

IDENTIFY REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY WHICH IS CHECKED (✓) SHOULD HAVE SOME DESCRIPTION. GIVE REASON FOR NOT EVALUATING ANY ITEM.

17. PLANTAR GRASP *(Examiner – finger applied to medial side of sole)*					
PRESENT	Right				
	Left				
ABSENT	Right				
	Left				
ASYMMETRICAL					
18. BODY MOVEMENTS – NORMAL					
ABNORMAL					
Tremulous					
Rapid, Jerky Movements					
Writhing Movements					
Convulsions					
Local					
Generalized					
Other					
19. MORO *(Support child under back and head – Let child's head drop back ____ cm)*					
RESPONSE OF ARMS – NORMAL *(Flexor and extensor components symmetrically present)*					
FLEXOR COMPONENT ABSENT					
ASYMMETRICAL					
OTHER					
RESPONSE OF LEGS – Flexor					
Other					
RESPONSE – Obtained with ease					
Obtained with Difficulty					
No Consistent Pattern					
20. TONE – NECK – NORMAL					
Flaccid (Limp)					
Hypertonic (Rigid)					
TRUNK – NORMAL					
Flaccid (Limp)					
Hypertonic (Rigid)					
UPPER EXTREMITY – NORMAL					
Flaccid (Limp)					
Hypertonic (Rigid)					
LOWER EXTREMITY – NORMAL					
Flaccid (Limp)					
Hypertonic (Rigid)					

NEONATAL EXAMINATION

1. Every numbered item should be checked (✓). If not normal, findings should be checked (✓) and described in margin at right.
2. Bold face items need only be recorded once.

21. **NECK** – NORMAL					IDENTIFY REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY WHICH IS CHECKED (✓) SHOULD HAVE SOME DESCRIPTION. GIVE REASON FOR NOT EVALUATING ANY ITEM.
ABNORMAL Restricted Range of Motion					
Masses					
Other					
22. **SPINE** – NORMAL					
ABNORMAL					
23. **MATURITY** – NORMAL					
PREMATURE					
POSTMATURE					
24. **BODY LENGTH**					
25. **HEAD CIRCUMFERENCE**					
26. **CHEST CIRCUMFERENCE**					
27. **OBVIOUS CONGENITAL MALFORMATIONS**					
28. **OBVIOUS SIGNS OF INJURY**					
29. CONDITIONS DURING EXAMINATION					
SATISFACTORY					
OTHER					

Department of Health, Education and Welfare
Public Health Service

(PED-2) PAGE 4 OF 4

PED-3 Nursery History

Form PED-3 was used to record events in the newborn nursery that might signify effects of stress, injury, or diseases not observed in an examination. First implemented in January 1959, the form was revised in May of 1960. Items were altered in revision and some wording was changed, though the information requested remained essentially the same. The title of the form changed from Interval History to Nursery History. Data from PED-3 were recorded on three cards in the master file (Table PED-3.1).

TABLE PED-3.1 Cards and Data Records by Revision for Form PED-3

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-3: Conditions, Weight, Temperature and Activity	1403		
		0	5,885
		1	47,060
			52,945
PED-3: Medications and Procedures	2403		
		0	2,103
		1	22,937
			25,040
PED-3: Medications and Procedures	3403		
		1	1
			1
	total for form		77,986

Data Items Referencing Form PED-3, Nursery History

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4047.....		1403	1	5	Card number (sequence, form type, form number, revision number)
4048..		1403	6	14	NINDB case number
4049..PED-3	1	1403	15	16	Birth date (mo)
4050..PED-3	1	1403	17	18	Birth date (day)
4051..PED-3	1	1403	19	20	Birth date (yr)
4052..PED-3		1403	21	22	Nursery histories, number
4053..PED-3		1403	23	23	Nursery histories in first week
4054..PED-3	5	1403	24	24	Incubator used
4055..PED-3	5	1403	25	25	Incubator; humidity
4056..PED-3	5	1403	26	26	Incubator; mist administered
4057..PED-3	5	1403	27	27	Oxygen administered; nursery
4058..PED-3	5	1403	28	29	Oxygen administered; nursery, maximum concentration
4059..PED-3	5	1403	30	30	Conditions, nursery (lbs), other special treatment/procedures
4060..PED-3	6	1403	31	32	Weight, nursery, maximum (lbs)
4061..PED-3	6	1403	33	34	Weight, nursery, maximum (oz)
4062..PED-3	6	1403	35	36	Weight, nursery, minimum (lbs)
4063..PED-3	6	1403	37	38	Weight, nursery, minimum (oz)
4064..PED-3	7	1403	39	39	Temperature; nursery, within normal range, number
4065..PED-3	7	1403	40	40	Temperature; nursery, below 95 axillary, 96 rectal, number
4066..PED-3	7	1403	41	42	Temperature; nursery, minimum
4067..PED-3	7	1403	43	43	Temperature; nursery, minimum zone
4068..PED-3	7	1403	44	44	Temperature; nursery, above 98.9 axillary, 99.9 rectal, number
4069..PED-.	7	1403	45	47	Temperature; nursery, maximum
4070..PED-3	7	1403	48	48	Temperature; nursery, maximum zone
4071..PED-3	8	1403	49	49	Feeding method; nursery, bottle (days)
4072..PED-3	8	1403	50	50	Feeding method; nursery, breast (days)
4073..PED-3	8	1403	51	51	Feeding method; nursery, gavage (days)
4074..PED-3	8	1403	52	52	Feeding method; nursery, tube (days)
4075..PED-3	8	1403	53	53	Feeding method; nursery, other (days)
4076..PED-3	9	1403	54	54	Activity, nursery, excessive (days)
4077..PED-3	9	1403	55	55	Activity, nursery, diminished (days)
4078..PED-3	10	1403	56	56	Cry, nursery, excessive (days)
4079..PED-3	10	1403	57	57	Cry, nursery, diminished (days)
4080..PED-3	11	1403	58	58	Respiratory abnormalities; nursery, apnea (days)
4081..PED-3	11	1403	59	59	Respiratory abnormalities; nursery, grunting (days)
4082..PED-3	11	1403	60	60	Respiratory abnormalities; nursery, retractions (days)
4083..PED-3	11	1403	61	61	Respiratory abnormalities; nursery, other (days)
4084..PED-3	15	1403	62	62	Cyanosis, nursery, peripheral (days)
4085..PED-3	15	1403	63	63	Cyanosis, nursery, generalized (days)
4086..PED-3	16	1403	64	64	Skin; nursery, pallor (days)
4087..PED-3	17	1403	65	65	Bleeding; nursery, [hemorrhage] (days)
4088..PED-3	18	1403	66	66	Seizures; nursery (days)

Data [illegible], Referencing Form PED-3, Nursery History

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4089..PED-3	19	1403	67	67	Twitching: nursery (days)
4090..PED-3	20	1403	68	68	Vomiting: nursery (days)
4091..PED-3	21	1403	69	69	Feeding problems: nursery (days)
4092..PED-3	23	1403	70	70	Vitamin K: nursery
4093..PED-3	24	1403	71	71	Antibiotics: nursery
4094..PED-3	25	1403	72	72	Medication, nursery, other
4095..PED-3	26	1403	73	73	Procedures, nursery
4096..PED-3	27	1403	74	74	Nursery history, other
4097.....		1403	75	80	Blank
4098.....		2403	1	5	Card number (sequence, form type, form number, revision number)
4099.....		2403	6	14	NINDB case number
4100..PED-3	1	2403	15	16	Birth date (mo)
4101..PED-3	1	2403	17	18	Birth date (day)
4102..PED-3	1	2403	19	20	Birth date (yr)
4103..PED-3		2403	21	24	Medications; procedures; nursery; specific, nth (where max n = 30)
4104..PED-3		2403	25	80	Medications; procedures; nursery; specific, repeat of colums 2 1-24 for possible medications 2 - 15
4105..PED-3		3403	1	80	Medications; procedures; nursery; specific, repeat of card 2403 for possible medications 16 - 30
5407....VAR			577	577	Nursery exam, PED-3, present (yes, no)
5409....VAR	24		579	579	Antibiotics; nursery
5410....VAR	8		580	580	Feeding method; nursery, bottle (days)
5411....VAR	8		581	581	Feeding method; nursery, breast (days)
5412....VAR	8		582	582	Feeding method; nursery, gavage (days)
5413....VAR	8		583	583	Feeding method; nursery, tube (days)
5414....VAR	8		584	584	Feeding method; nursery, other (days)
5415....VAR	23		585	585	Vitamin ; nursery
5[illegible]....VAR	6		1173	1178	Weight; nursery; maximum (gms)

COLLABORATIVE PERINATAL RESEARCH BRANCH, NINDS, NIH
BETHESDA 4, MARYLAND

1. PATIENT'S IDENTIFICATION

NURSERY HISTORY

This history is to be a summary of all available information about the infant's course and condition (except urine studies) since the previous NURSERY HISTORY was completed.

Every item should have an entry. Unusual or abnormal conditions should be reported in detail.

2. EXAMINER'S NAME AND STATUS	DO NOT USE THIS SPACE	(1)	(2)	(3)	(4)	(5)	(6)	12. COMMENTS
3. DATE (Month, day)								
4. TIME (Use 24-hour clock)								
5. SPECIAL CONDITIONS – None								
Incubator								
Humidity								
Mist								
Oxygen (Give max. conc.)								
Other (Describe)								
6. WEIGHT								
7. TEMPERATURE								
ALL (95.0 to 98.9 Axillary; 95.0 to 99.9 Rectal)								
ANY OF LOW (95.0 Axillary; 96.0 Rectal)								
ANY ABOVE (99.0 Axillary; 100.0 Rectal)								
8. FEEDING METHOD – Bottle								
Breast								
Other (Specify)								
9. ACTIVITY – Normal Amount								
Excessive								
Diminished								
10. CRY – Normal Amount								
Excessive								
Diminished								
11. RESPIRATORY ABNORMALITIES –								
None								
Apnea								
Grunting Respirations								
Retractions								
Other (Specify)								

REV. 5-63

(PED-3) PAGE 1 OF 1

COLR-3056-3
REV. 9-60 3)

NURSERY HISTORY
(Continued)

13. PATIENT'S IDENTIFICATION

		(1)	(2)	(3)	(4)	(5)	(6)	28. COMMENTS
14. DATE (Month, day)								
15. CYANOSIS – Absent								
	Present, Peripheral							
	Present, Generalized							
16. PALLOR – Absent								
	Present							
17. BLEEDING – Absent								
	Present							
18. SEIZURES – Absent								
	Present							
19. TWITCHING – Absent								
	Present							
20. VOMITING – Absent								
	Present							
21. FEEDING PROBLEMS – None								
	Yes (Describe)							
22. MEDICATIONS – None								
23.	VITAMIN K							
24.	ANTIBIOTICS (Specify)							
25.	OTHER MED. (Specify)							
26. PROCEDURES – None								
	Yes (Describe)							
27. OTHER (Describe)								

Form Item Numbers linked to Data Items on PED-3, Nursery History

ITEM ON FORM	DATA ITEM ID		CARD NUM	FROM	TO	DATA ITEM NAME
	4103	PED-3	2403	21	24	Medications; procedures; nursery; specific, nth (where max n = 30)
	4105	PED-3	2403	1	90	Medications; procedures; nursery; specific, repeat of card 2403 for possible medications 16 - 30
	4104	PED-3	2403	25	90	Medications; procedures; nursery; specific, repeat of columns 2 1-24 for possible medications 2 - 15
	5467	VAR		577	577	Nursery exam, PED-3, present (yes, no)
	4053	PED-3	1403	23	23	Nursery histories in first week
	4052	PED-3	1403	21	22	Nursery histories, number
1	4101	PED-3	2403	17	18	Birth date (day)
1	4050	PED-3	1403	17	18	Birth date (day)
1	4049	PED-3	1403	15	16	Birth date (mo)
1	4100	PED-3	2403	15	16	Birth date (mo)
1	4102	PED-3	2403	19	20	Birth date (yr)
1	4051	PED-3	1403	19	20	Birth date (yr)
5	4059	PED-3	1403	30	30	Conditions, nursery (ibs), other special treatment/procedures
5	4054	PED-3	1403	24	24	Incubator used
5	4055	PED-3	1403	25	25	Incubator; humidity
5	4056	PED-3	1403	26	26	Incubator; mist administered
5	4057	PED-3	1403	27	27	Oxygen administered; nursery
5	4058	PED-3	1403	28	29	Oxygen administered; nursery, maximum concentration
6	4060	PED-3	1403	31	32	Weight, nursery, maximum (lbs)
6	4061	PED-3	1403	33	34	Weight, nursery, maximum (oz)
6	4062	PED-3	1403	35	36	Weight, nursery, minimum (lbs)
6	4063	PED-3	1403	37	38	Weight, nursery, minimum (oz)
6	5969	VAR		1173	1176	Weight; nursery; maximum (gms)
7	4068	PED-3	1403	44	44	Temperature; nursery, above 98.9 axillary, 99.9 rectal, number
7	4065	PED-3	1403	40	40	Temperature; nursery, below 95 axillary, 96 rectal, number
7	4069	PED-3	1403	45	47	Temperature; nursery, maximum
7	4070	PED-3	1403	48	48	Temperature; nursery, maximum zone
7	4066	PED-3	1403	41	42	Temperature; nursery, minimum
7	4067	PED-3	1403	43	43	Temperature; nursery, minimum zone
7	4064	PED-3	1403	39	39	Temperature; nursery, within normal range, number
8	4071	PED-3	1403	49	49	Feeding method; nursery, bottle (days)
8	5410	VAR		580	580	Feeding method; nursery, bottle (days)
8	5411	VAR		581	581	Feeding method; nursery, breast (days)
8	4072	PED-3	1403	50	50	Feeding method; nursery, breast (days)
8	4073	PED-3	1403	51	51	Feeding method; nursery, gavage (days)
8	5412	VAR		582	582	Feeding method; nursery, gavage (days)
8	5414	VAR		584	584	Feeding method; nursery, other (days)
8	4075	PED-3	1403	53	53	Feeding method; nursery, other (days)
8	4074	PED-3	1403	52	52	Feeding method; nursery, tube (days)
8	5413	VAR		583	583	Feeding method; nursery, tube (days)

Form Item Numbers linked to Data Items on PED-3, Nursery History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
9	4077..PED-3	1403	55	55	Activity, nursery, diminished (days)
9	4076..PED-3	1403	54	54	Activity, nursery, excessive (days)
10	4079..PED-3	1403	57	57	Cry, nursery, diminished (days)
10	4078..PED-3	1403	56	56	Cry, nursery, excessive (days)
11	4080..PED-3	1403	58	58	Respiratory abnormalities; nursery, apnea (days)
11	4081..PED-3	1403	59	59	Respiratory abnormalities; nursery, grunting (days)
11	4083..PED-3	1403	61	61	Respiratory abnormalities; nursery, other (days)
11	4082..PED-3	1403	60	60	Respiratory abnormalities; nursery, retractions (days)
15	4085..PED-3	1403	63	63	Cyanosis, nursery, generalized (days)
15	4084..PED-3	1403	62	62	Cyanosis, nursery, peripheral (days)
16	4086..PED-3	1403	64	64	Skin; nursery, pallor (days)
17	4087..PED-3	1403	65	65	Bleeding; nursery, (hemorrhage) (days)
18	4088..PED-3	1403	66	66	Seizures; nursery (days)
19	4089..PED-3	1403	67	67	Twitching; nursery (days)
20	4090..PED-3	1403	68	68	Vomiting; nursery (days)
21	4091..PED-3	1403	69	69	Feeding problems; nursery (days)
23	5415....VAR		585	585	Vitamin ; nursery
23	4092..PED-3	1403	70	70	Vitamin K; nursery
24	4093..PED-3	1403	71	71	Antibiotics; nursery
24	5409....VAR		579	579	Antibiotics; nursery
25	4094..PED-3	1403	72	72	Medication, nursery, other
26	4095..PED-3	1403	73	73	Procedures, nursery
27	4096..PED-3	1403	74	74	Nursery history, other

DEFINITION OF CODES
NURSERY HISTORY
PED-3 CARD 1403

FIELD		CARD COLUMN
1.	**Card Number** Code: 1	1
2.	**Form Number** Code: 403	2-4
3.	**Revision Number** * Code: 0 - Form Dated: 1/59 1 - Form Dated: 5/60	5
4.	**NIHDB Number** Item 1 Nine digit number for Patient Identification Code: As given	6-14
5.	**Date of Birth** Item 1 Six digit number for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20). Code: As given	15-20
6.	**Number of Histories Recorded** Code: As given	21-22
7.	**Number of Histories in First Week** Code: 1-7 - As given 8 - 8 or more 0 - None	23
8.	**Incubator** Item 5 Code: 0 - Not used 1-7 - Days as given 8 - 8 or more days 9 - Unknown	24
9.	**Humidity** Item 5 Code: Same as in Field 8	25
10.	**Mist** Item 5 Code: Same as in Field 8	26

* Unless specified, Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: 5/60.

FIELD		CARD COLUMN
11.	Oxygen Item 5 Code: Same as in Field 8	27
12.	Oxygen: Maximum Concentration Item 5 Code: 00 - Not used 01-97 - As given in percent 98 - 98% or more 99 - Unknown	28-29
13.	Other (Revision "1" only) Item 5 Code: Same as in Field 8 except 9 - Unknown, not on Rev. "0"	30
14.	Maximum Weight Item 6 Four digit code for pounds (cols. 31-32) and ounces (cols. 33-34) Code: As given 9999 - Unknown	31-34
15.	Minimum Weight Item 6 Four digit code for pounds (cols. 35-36) and ounces (cols. 37-38) Code: Same as in Field 14	35-38
16.	Temperature: Between 95.0-98.9 Axillary or 96.0-99.9 Rectal Item 7 Code: 0 - None 1-7 - Number of times as given 8 - 8 or more 9 - Unknown	39
17.	Temperature: Any below 95.0 Axillary or 96.0 Rectal Item 7 Code: Same as Field 16	40

FIELD		CARD COLUMN
18.	Temperature: Minimum Item 7 Three digit code for: Temperature (cols. 41-42) Code: As given 00 - No temperature below 95° Axillary or 96.0 Rectal 99 - Unknown Zone (col. 43) Code: 0 - Not applicable 1 - Axillary 2 - Rectal 9 - Unknown	41-43
19.	Temperature: Any above 98.9 Axillary or 99.9 Rectal Item 7 Code: Same as in Field 16	44
20.	Temperature: Maximum Item 7 Four digit code for: Temperature (cols. 45-47) Code: 000 - No temperature above 98.9 Axillary or 99.9 Rectal 099-108 - As given in degrees 999 - Unknown Zone (col. 48) Code: 0 - Not applicable 1 - Axillary 2 - Rectal 9 - Unknown	45-48

FIELD		CARD COLUMN
21.	Feeding Method (Revision "1" only) Item 8 Five-digit code for: Bottle (col. 49) Breast (col. 50) Gavage (col. 51) Tube (col. 52) Other (col. 53) Code for each column: 0 - None reported 1-7 - Days as given 8 - 8 or more 9 - Unknown, not on Rev. "0"	49-53
22.	Activity Item 9 Two-digit code for: Excessive (col. 54) Diminished (col. 55) Code for each column: 0 - None reported 1-7 - Days as given 8 - 8 or more 9 - Unknown	54-55
23.	Cry (Revision "1" only) Item 10 Two-digit code for: Excessive (col. 56) Diminished (col. 57) Code for each column: Same as in Field 21	56-57
24.	Respiratory Abnormalities Item 11 Four-digit code for: Apnea (col. 58) Grunting (col. 59) Code for each column: Same as in Field 22 Retractions (Rev. "1" only) (col. 60) Code: Same as in Field 21 Other (col. 61) Code: Same as in Field 22	58-61

FIELD		CARD COLUMN
25.	Cyanosis Item 15 Two-digit code for: Peripheral (col. 62) Generalized (col. 63) Code for each column: Same as in Field 22	62-63

DEFINITION OF CODES (Continued)

FORM PED-3
Card 1403

FIELD		CARD COLUMN
26.	**Pallor** Item 16 Code: Same as in Field 22	64
27.	**Bleeding** Item 17 Code: Same as in Field 22	65
28.	**Seizures** Item 18 Code: Same as in Field 22	66
29.	**Twitching** (Revision "1" only) Item 19 Code: Same as in Field 21	67
30.	**Vomiting** (Revision "1" only) Item 20 Code: Same as in Field 21	68
31.	**Feeding Problems** Item 21 Code: Same as in Field 22	69
32.	**Vitamin K** Item 23 Code: 0 - None reported 1 - Yes (one or more times) 9 - Unknown	70
33.	**Antibiotics** Item 24 Code: Same as in Field 32	71
34.	**Other Medication** Item 25 Code: Same as in Field 32	72
35.	**Procedures** Item 26 Code: Same as in Field 32	73
36.	**Other** Item 27 Code: Same as in Field 32	74

DEFINITION OF CODES (Continued)

FORM PED-3
Card 2403

FIELD		CARD COLUMN
1.	Card Number Code: 2	1
2.	Basic Data Code: Same as in cols. 2-20 of Card 1	2-20
3.	First Medication or Procedure Reported Code: See "Drugs in Pregnancy" 0315 card, pages 4-17 and Attachment "Additional Codes and Medications or Procedures", page PED-3 - 8.	21-24
4.	Two Through Fifteen Medications and/or Procedures Code: Same as in Field 3 if needed.	25-80

Note: Card 3 is required if 16-30 Medications and/or Procedures reported. Codes same as Card 2 except card col. 1 is "3".

ATTACHMENT

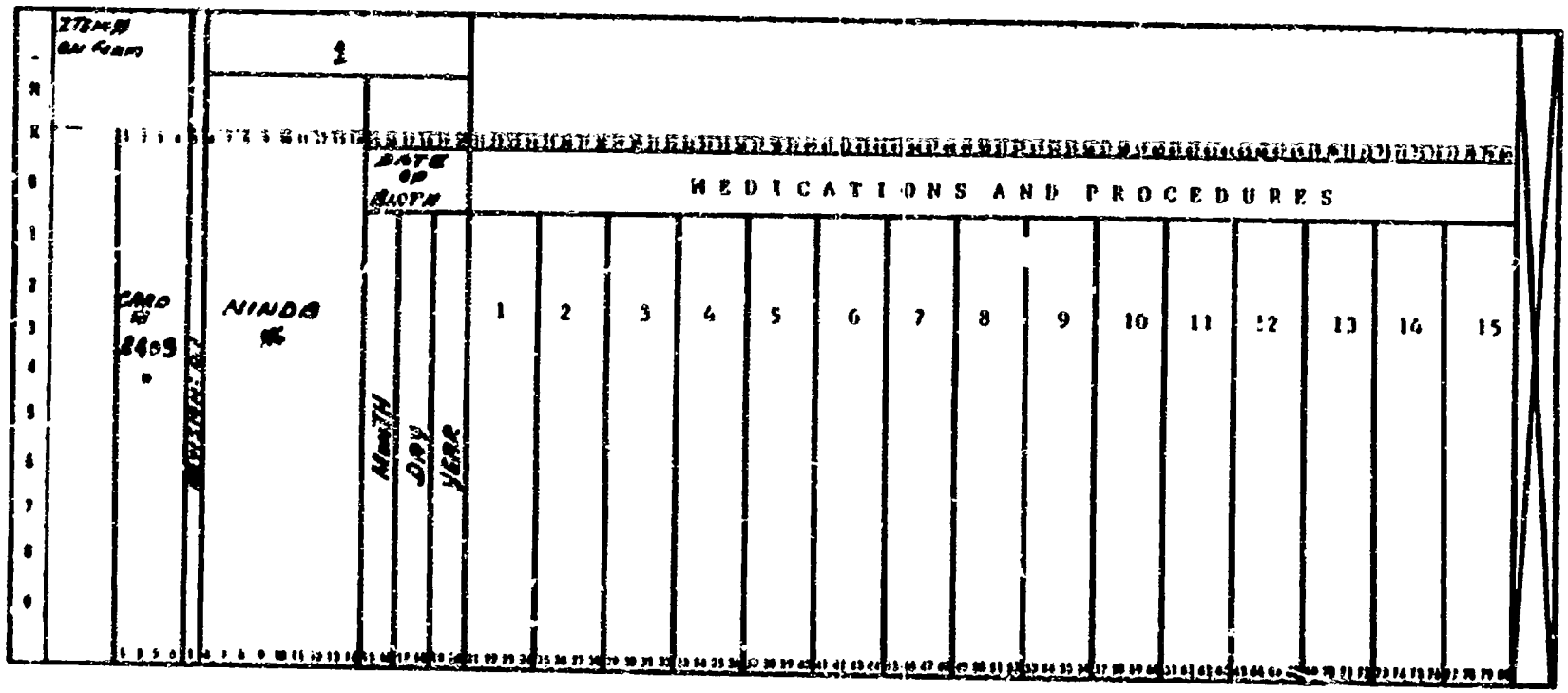
Additional Codes and Medications or Procedures

0700 - Calcium
0710 - Whiskey
0711 - Lactose
0712 - Charcoal
0715 - Growth Hormone
0730 - Plasmanate
0741 - Lyuren
0742 - Ringers Lactate
0751 - Phenylalanine
0752 - Trytophan
0771 - Maltsupex
0772 - Colace
0791 - Aluminum Hydroxide
0792 - Citralka
0800 - Aquamephyton
0801 - Aquanephyton
0802 - Hykinone
0803 - Synkovite
0804 - [illegible]
0805 - Kanokion
0806 - Vitamin K
0807 - Vitamin K_1
0808 - Mephyton
0811 - Cecon
0821 - Nicotinamide
0822 - Pyridoxine
0831 - Folic Acid
0850 - Simple blood transfusion
0851 - Exchange transfusion
0852 - Paenteral fluids
0853 - Spinal puncture
0854 - Subdural puncture
0855 - Ventricular puncture
0856 - General anesthesia
0857 - Surgery
0858 - Chromosome studies
0859 - X-rays
0860 - EEG
0861 - EKG
0862 - Resuscitation
0863 - Umbilical catheterization
0891 - Albumin in saline

NURSERY HISTORY
FORM PED-3

PED-1 - 9

NURSERY HISTORY
FORM PED-3



* Additional card(s) required for more than 15 medications and procedures.

11.E.11B

PED-3

PHS-3004-3: Nursery History

The purpose of the nursery history is to record events occurring during the neonate's nursery stay which may signify or effect stress, injury, or disease and which are not obtainable by examination.

The form PED-3 is a transmittal sheet on which all available information (except other Study records) about the infant course and condition is to be summarized. This manual has been prepared as a guide for extracting information from the hospital records and recording it on the transmittal sheet PED-3.

GENERAL INSTRUCTIONS

A. Source of information to be summarized on PED-3. All information about the infant's course and condition which is recorded on the hospital records or nurses' notes, and any information obtained by word of mouth from physicians or nurses regarding the infant should be reported on this form. Other pediatric study records (PED-1, PED-2, and PED-6) should not be used as sources of information for this summary. Information about the mother is not to be considered in this summary of the infant's course and condition.

B. The Examiner Until further notice, local policy shall determine what type of person does the summary PED-3. It is desirable that a standard procedure for doing the summaries be used within each institution.

C. Timing of the Examination. It is recommended that a summary of the infant's course and condition be done at approximately the same intervals as the pediatrician's examination (PED-2). A daily summary is acceptable, but in many cases will exceed the minimum requirements. The minimum requirements for frequency and timing of the summary (PED-3) are the same as for the pediatrician's examination, and are:

   a. Sometime during the first 24 hours of life.
   b. Sometime between 36 and 60 hours of age centering about 48 hours of age.
   c. Prior to discharge if the infant remains more than 24 hours after the previous summary.
   d. Weekly for infants who have a prolonged hospital stay.
   e. In case the infant died in the nursery, a summary should be made covering the time from the previous summary up to the time of death.

D. Elimination of bias. Ideally, the person who completes the summary should be unaware of the events of pregnancy, including labor and delivery, and of the subsequent course of the mother. In no case shall any records or information concerning these events be considered in completing the summary PED-3. Since several summaries will be recorded on the same form, it is important that the examiner avoid as much as possible reference to previous recordings when completing the summary.

PHS-3004-3: Nursery History

E. Completeness of Recording. Every item should contain an entry each time the summary is completed. If there is no information available about a particular item, the letters N.A. (not applicable) or UNK (unknown) should be put in the appropriate box and an explanation recorded on the right hand side of the page. Every item which is recorded as unusual or abnormal should have an explanation written on the right hand side of the page unless the manual specifically states "no comment necessary." Every comment should be clearly identified by the number of the item to which it relates. Comments need not be written directly opposite the item to which they apply, but rather should be grouped together each day, starting at the top of the space provided. Thus, comments made on different days will be clearly separated. If more space is needed for comments, use form CP-5, Continuation Sheet.

SPECIFIC INSTRUCTIONS AND DEFINITIONS

Item 1. Patient Identification. This item is to be completed using the patient's name plate.

Item 2. Name and Status. Here the person completing the form will record his name and status (pediatrician, nurse, etc.).

Item 3. Date. Record the month and day for the first summary. The day of the month is adequate for subsequent summaries on the same sheet.

Item 4. Time. Record the time of day (24 hour clock) which ends the period covered by the summary.

Item 5. Special Conditions. Record any special environmental situations the child has been subject to during the period since the last summary. Three conditions of importance are listed, and a space is provided for "other." If the infant was in an incubator for any reason, simply check the box "incubator," and no comment is necessary. (Other portions of the History and Physical Examination will identify the indications for its use.) Record the humidity percentage if it is used. If the infant was given added humidity in the form of mist, check the box "Mist." No comment is necessary unless a drug or chemical was added to the mist. If the infant was given added oxygen at any time since the previous summary, indicate how, the approximate time, and the approximate concentration used. Other special conditions might be such things as "rocking bed," or "isolation for infectious disease."

Item 6. Weight. If the infant was weighed since the previous summary, record the weight in the appropriate space (no comment necessary). The value reported on the first summary may be either birth weight or the nursery admission weight. If the weight was taken since the last summary but on a day previous to the day on which the summary is being done, record this value in the same column as the rest of the summary but under "comments" indicate the date on which this weight value was obtained. If

PHS-3004-3: Nursery History

the child has not been weighed since the previous summary write "N.A." in the appropriate box and comment "not weighed."

It is desirable that a metric system scale be used and the weight be recorded in grams. However, if an English system scale is used, report the weight in pounds and ounces rather than converting to grams. There is no need to specify "pounds" and "ounces" in the box, simply express ounces as fractions (-/16) of a pound (7 pounds 6 ounces record as 7 6/16).

Item 7. Temperature. It is assumed that local policy will establish whether routine temperatures are axillary or rectal. Since there is a difference in the normal range as recorded in these two sites, the spaces on the form are labeled with the values for both sites. If all of the temperatures taken during the period since the previous summary fall within the limits of 95.0° - 98.9° F. axillary or 96.0° - 99.9° F. rectal, the first box should be checked, and no comment is necessary. If any of the temperatures recorded during the period are below 95.0° F. axillary or 96.0° F. rectal, check the second box and list the time, value, and site ("A" [Axillary] or "R" [Rectal]) of all temperature recordings taken during the period. If any of the temperatures recorded during the period are above 98.9° F. axillary or 99.9° F. rectal, check the third box and list the time, value, and site of all temperatures taken during the period. A comment is requested only if there is some clear environmental reason for the temperature being above or below the range for box 1.

Item 8. Feeding Method. If the infant is being fed by breast or bottle exclusively, check the appropriate box. If the infant is being breast fed and is also given a supplemental bottle, check both boxes. If the infant is being fed by nasogastric tube, medicine dropper, or other device, check "other" and identify the device. No other comment is necessary.

Item 9. Activity. This item is intended to classify the infant's activity only as to amount. It is difficult to define what a normal amount of activity is, so the decision on this must be left to the judgment of the individuals who see the infants and make the initial records. Only extremes of excessive or diminished activity are desired here. "Excessive" shall include the hyper-active, jittery baby and the baby who seems to be never still. "Diminished" shall include the very quiet baby who moves very little. If the activity is described as abnormal in quality, report this under Item 27.

Item 10. Cry. This item is intended to classify the child's cry only as to amount. It is difficult to define what a normal amount of crying is, so the decision on this must be left to the judgment of the individuals who see the infants and make the initial records. It is only the extremes of excessive or diminished amount of cry that are desired here, such as an infant who seems to cry incessantly without apparent reason, or an infant who cries unusually little or none at all. If the infant's cry is described

PHS-3004-3: Nursery History

as abnormal in character, such as being high pitched, whining, or grunting, report this under Item 27.

Item 11, Respiratory Abnormalities. If the infant had apneic spells (ceased breathing for a notable period--approximately 20 seconds or more), grunting respiration, retraction, or other difficulty in breathing, check and describe. Other unusual respiratory activity including excessively fast or slow, the cyclic (Cheyne-Stokes) breathing should be noted as "other" and described. Include upper-airway problems such as excessive mucus or "runny nose."

Item 12, Comments. Record comments concerning numbered items.

Item 13, Patient Identification. This item is to be completed using the patient's name plate.

Item 14, Date. Record the month and day, for the first summary. The day of the month is adequate for subsequent summaries on the same sheet.

Item 15, Cyanosis. It is important to make a careful distinction between "generalized cyanosis" and "peripheral cyanosis." "Generalized cyanosis" is cyanosis (dusky gray or blue color) over the entire body or major portion of the body. (The entire head, an upper or lower quarter, or one side should be considered as "major portion of the body.") If "generalized" is checked, a description of the distribution and duration is desired. "Peripheral cyanosis" is cyanosis of the hands, feet or perioral region. If this box is checked, indicate the extent and duration of the cyanosis.

Item 16, Pallor. The box "present" should be checked if any of the observers thought the baby was unusually pale. Describe the extent and duration.

Item 17, Bleeding. "Present" shall include bleeding from the cord, from the nose, mouth or other orifice, and unusually prolonged oozing from forceps marks, needle punctures or laceration.

Item 18, Seizures. "Present" shall include what may be described as recurrent tonic or clonic movements, and unconscious or atonic spells as well as "convulsions" or "fits." Spells described as simply hyperactivity or jitteryness should be recorded under Item 9 rather than Item 18.

Item 19, Twitching. "Present" shall be sudden non-rhythmic movements which are usually confined to one extremity or one muscle group and not associated with evidence of unconsciousness.

Item 20, Vomiting. "Present" shall include forceful, excessive or prolonged vomiting, but not the common spitting up with a burp after each feeding. If the infant regurgitates ("drools" or "spits up") to such an extent that remedial measures (propping up, smaller and more frequent feeding,

etc.) are employed, report this under Item 21. Do not report regurgitation which is neither dynamic enough to be called vomiting, nor copious enough to be considered a feeding problem.

Item 21, Feeding Problems. Only problems arising with the present method of feeding as reported in Item 8 are to be recorded here. If a nasogastric tube, medicine dropper, or other device is being used successfully, this information will be reported in Item 8, and need not be repeated here. However, if any difficulty is encountered with the use of such a device, or if the infant who is being breast or bottle fed has unusual difficulty sucking, swallowing, or retaining feedings, this should be reported. If "yes" is checked, describe the type and severity of the problem.

Item 22, Medications. "None" should be checked if there is nothing to record in the following three categories 23 through 25. For the purpose of this study intravenous fluids and subcutaneous (clysis) fluids, whether or not they contain additional drugs, are to be considered medications, and reported under Item 25, "Other Medications." Silver Nitrate prophylactic eye treatment should not be reported.

Item 23, Vitamin K. If Vitamin K was given, specify the trade name of the drug and the amount given. Do not report here Vitamin K given in the delivery room.

Item 24, Antibiotics. If any antibiotics have been given, indicate trade name, dose schedule, and method of administration.

Item 25, Other Medications. If any other drugs or parenteral fluids have been given, list these by trade name or pharmacologic name whichever is in common use, and give dose schedule and method of administration.

Item 26, Procedures. Procedures to be recorded are such things as exchange transfusion, lumbar puncture, cut-down for intravenous infusion, X-ray, operation, etc. Also record blood or other specimens taken for special tests which are done in a research laboratory and probably will not be recorded on the child's laboratory sheet. Do not include under this item circumcision, blood drawn for tests which will be reported from the regular laboratory, or any specimens taken for culture which will be reported from the regular laboratory. Comments should include time of day and brief description of the procedure.

Item 27, Other. Indicate and describe anything unusual about the child which had not been recorded elsewhere, such as abnormal quality of cry, paralysis of arm, unusual bowel movements, etc. No notation for "none" is necessary for this item.

Item 28.—Same as Item 12.

Revision
1-66

INTERVAL HISTORY

Superseded by
C.O.R - 3004 - 3
Rev - 5-66

INSTRUCTIONS:

1. *Every numbered item should be checked (√). If not normal, findings should be checked (√) and described in margin at right.*

OBSERVER'S INITIALS						IDEN... F REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY SHOULD HAVE SOME DESCRIPTION. Give reason for not evaluating any item.
STATUS						
DATE						
TIME						
CONDITION						
1. INCUBATOR – Not Used						
Used						
2. HUMIDITY – Not Used						
Used – 60% to Saturated						
Supersaturated (Mist)						
3. OXYGEN – Not Used						
20% – 39%						
40% – 79%						
80% plus						
INFANT						
4. WEIGHT						
5. TEMPERATURE (Circle one) A or R						
Normal (98.0 – 101.0)						
101.1 – 104.0						
Over 104+						
Under 96+						
6. RESPIRATORY ABNORMALITIES – None						
APNEA (Cessation of breath for more than 20 sec.)						
Grunting Respirations						
Labored Breathing						
Other						
7. FEEDING PROBLEMS – None						
Other						
8. CYANOSIS – Absent						
Present						
9. JAUNDICE – Absent						
Present						
10. PALLOR – Absent						
Present						

Department of Health, Education and Welfare
Public Health Service

(PED-3) PAGE 1 OF 2

Form Approved
1-60

INTERVAL HISTORY
(Continued)

superseded by
CDER-3004-3
apr. 5-60

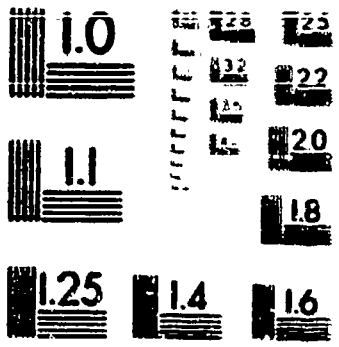
INSTRUCTIONS:

1. *Every numbered item should be checked (✓). If not normal, findings should be checked (✓) and described in margin at right.*

							IDENTIFY REMARKS BY DATE AND NUMBER OF ITEM. EVERY ABNORMALITY SHOULD HAVE SOME DESCRIPTION. Give reasons for not evaluating any item.
11. BLEEDING – Absent							
Present							
12. BODY MOVEMENTS – Normal							
Convulsions							
Other							
13. SENSORIUM – Normal							
Abnormally Drowsy							
Abnormally Wakeful							
14. MEDICATIONS – None							
Antibiotics (List if given)							
Stimulants (List if given)							
Depressants (List if given)							
Other (List)							
15. PROCEDURES – None							
(List)							
16. OTHER (List)							

Department of Health, Education and Welfare
Public Health Service

(PED-3) PAGE 2 OF 2



CONTINUED ON NEXT FICHE


THE NATIONAL ARCHIVES OF THE UNITED STATES
LITTERA
SCRIPTA
MANET
★ 1934 ★

PED-7 Summary of the Hospital Course of the Neonate

Form PED-7 provided a summary of all that was known about the infant from birth to the time of discharge from the nursery. Implemented into the study in January 1959, the form was revised once in May 1960. Revision resulted in a new title and altered the form substantially. "Record of Examination" was eliminated from the form and expanded into PED-5 "Results of Tests and Procedures Done on the Neonate." Course and diagnoses remained but were more detailed. Usage of the form was discontinued on March 3 1963, when PED-7 was replaced by PED-8. Data from PED-7 were recorded on card 0407 of the master file (Table PED-7.1).

TABLE PED-7.1 Cards and Data Records by Revision for Form PED-7

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-7: Date of Birth, Discharge and Observations	0407		
		0	6,094
		1	20,505
			26,599
	total for form		26,599

Data Items Referencing Form (PEDm7), Summary of Hospital Course of Neonate

DATA ITEM ID	ITEM IN FORM	CARD NUM	LOCN	LN	DATA ITEM NAME
4237.....		0407	1	5	Card number (sequence, form type, form number, revision number)
423H.....		0407	6	14	NINDB case number
4239..PED=7	1	0407	15	16	birth date (mo)
4240..PED=7	1	0407	17	18	birth date (day)
4241..PED=7	1	0407	19	20	birth date (yr)
4242..PED=7	2	0407	21	22	discharge date (mo)
4243..PED=7	2	0407	23	24	discharge date (day)
4244..PED=7	2	0407	25	26	discharge date (yr)
4245..PED=7	3	0407	27	28	Hospital days, number
4246..PED=7	4	0407	29	29	Hospital course, event
4247..PED=7	4	0407	30	30	Apgar, group code
4248..PED=7	4	0407	31	31	Bilirubin, serum, total group code
4249..PED=7	4	0407	32	32	Neuromuscular disturbance
4250..PED=7	4	0407	33	33	Hospital course, events, other
4251..PED=7	5	0407	34	34	Dysmaturity, stage
4252..PED=7	7	0407	35	35	Clinical impression, normal or abnormal
4253..PED=7	7	0407	36	36	CNS defect or injury: clinical impression
4254..PED=7	7	0407	37	37	Malformation: congenital: clinical impression
4255..PED=7	7	0407	38	38	Clinical impression, other
4256..PED=7		0407	39	39	Hospital stay, completion
4257.....		0407	40	80	Blank

PATIENT'S IDENTIFICATION

SUMMARY OF HOSPITAL COURSE OF THE NEONATE

EVERY NUMBERED ITEM SHOULD HAVE AN ENTRY

2. DATE OF DISCHARGE
MO. | DAY | YEAR

3. TIME OF DISCHARGE

4. COURSE

- Uneventful
- Significant events and observations
  - Apgar Score of 6 or Less
  - Bilirubin (Total) 10 Mg. or More [illegible] or 15 Mg. or More [illegible]
  - Neuromuscular Disturbance
  - Other (Specify)

DIAGNOSIS BY

5. BIRTH WEIGHT

- Term Infant (Birth weight over 2500 gms.)
- Premature (Birth weight 2500 gms. or less)

6. STAGE OF DYSMATURITY:

- 0 – No Signs of Dysmaturity
- ? – Equivocal Signs of Dysmaturity
- 1 – Stage 1 Dysmaturity
- 2 – Stage 2 Dysmaturity
- 3 – Stage 3 Dysmaturity

7. CLINICAL IMPRESSION

- Normal
- Other (For the items checked below describe and specify DEFINITE or SUSPECTED)
  - Central Nervous System Defect or Injury
  - Congenital Malformations Other Than Central Nervous System
  - Other (Specify)

8. EXAMINER'S NAME

9. DATE OF SUMMARY

10. STATUS OF EXAMINER

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Public Health Service

PED-7

Form item numbers linked to data items on PFD=7, Summary of Hospital Course of Neonate

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4256..PFD=7	0407	39	39	Hospital stay, completion
1	4240..PFD=7	0407	17	18	Birth date (day)
1	4239..PFD=7	0407	15	16	Birth date (mo)
1	4241..PFD=7	0407	19	20	Birth date (yr)
2	4243..PFD=7	0407	23	24	Discharge date (day)
2	4242..PFD=7	0407	21	22	Discharge date (mo)
2	4244..PFD=7	0407	25	26	Discharge date (yr)
3	4245..PFD=7	0407	27	28	Hospital days, number
4	4247..PFD=7	0407	30	30	Apgar, group code
4	4248..PFD=7	0407	31	31	Bilirubin, serum, total group code
4	4246..PFD=7	0407	29	29	Hospital course, event
4	4250..PFD=7	0407	33	33	Hospital course, events, other
4	4249..PFD=7	0407	32	32	Neuromuscular disturbance
6	4251..PFD=7	0407	34	34	Dysmaturity, stage
7	4252..PFD=7	0407	35	35	Clinical impression, normal or abnormal
7	4255..PFD=7	0407	38	38	Clinical impression, other
7	4253..PFD=7	0407	36	36	CNS defect or injury; clinical impression
7	4254..PFD=7	0407	37	37	Malformation; congenital; clinical impression

DEFINITION OF CODES
SUMMARY OF HOSPITAL COURSE OF THE NEONATE
FORM PSD-7 CARD C407

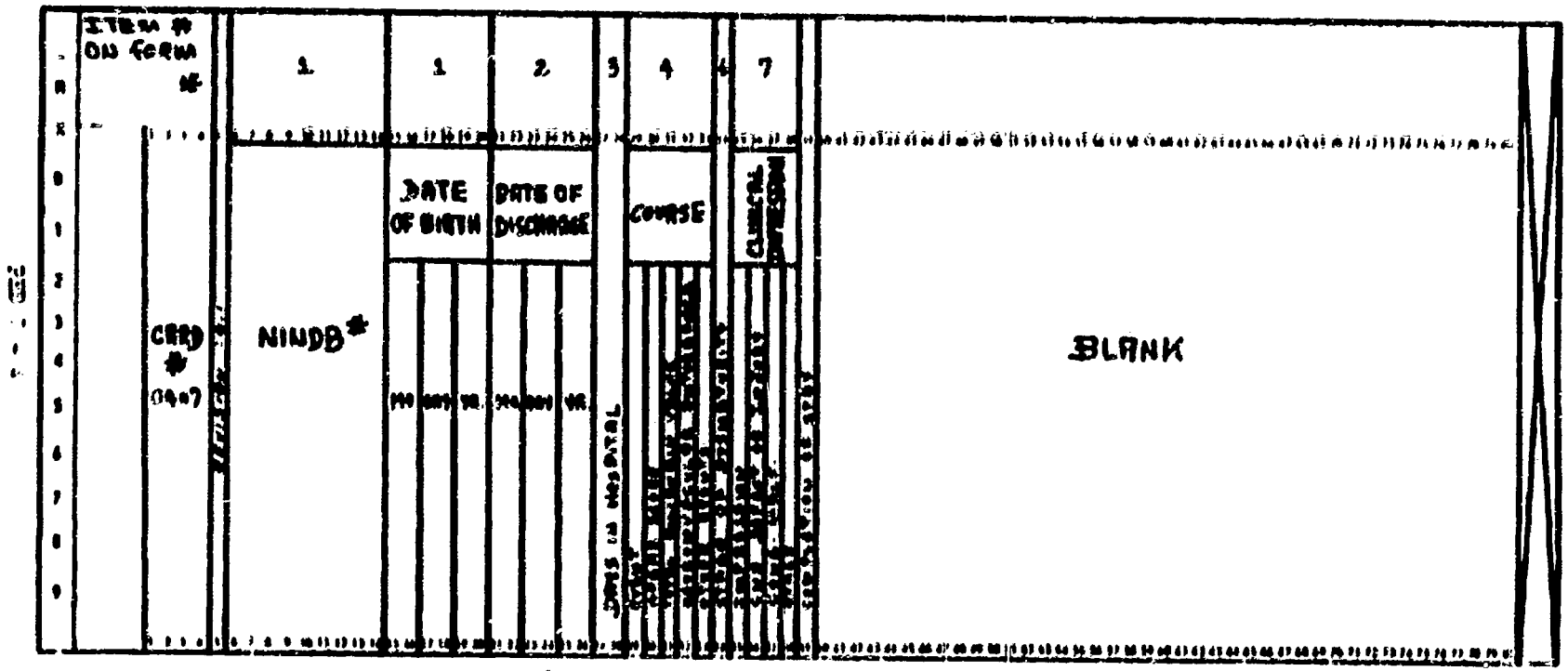
FIELD		CARD COLUMNS
1.	Card Number Code: 0	1
2.	Form Number Code: 407	2-4
3.	Revision Number * Code: 0 - Form Dated: 1/59 1 - Form Dated: Rev. 5/60	5
4.	NNDB Number Item 1 Nine-digit number for Patient Identification Code: As given	6-14
5.	Date of Birth Item 1 Six digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given	15-20
6.	Date of Discharge (Revision "1" only) Item 2 Six-digit code for month (cols. 21-22), day (cols. 23-24) and year (cols. 25-26). Code: As given Blank - Not on Revision "0" 99 - Month, day and/or year unknown	21-26
7.	Days in Hospital (Revision "1" only) Item 3 Code: Blank - Not on Rev. "0" 00 - Less than one day 01-97 - As given 98 - 98 days or more 99 - Not reported	27-28

* Unless specified, Fields, Codes and Card Columns refer to Revisions "0" and "1". Item numbers refer to Form Dated: 5/60

FIELD		CARD COLUMNS
8.	**Course** Item 4 Five-digit code for: **Event** (col. 29) Code: 0 - Uneventful 1 - Eventful 9 - Not reported **Apgar Score** (col. 30) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - 7 or more 1 - 6 or less 9 - Not reported **Total Billirubin Value** (col. 31) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - None over 10 at 0-47 hours or over 15 at 48 and over hours 1 - 10 or more at 0-47 hours or 15 or more at 48 and over hours 9 - Not reported **Neuromuscular Disturbance** (col. 32) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - Normal 1 - Abnormal 9 - Not reported **Other Events** (col. 33) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - No 1 - Yes 9 - Not reported	29-33
9.	**Stage of Dysmaturity** (Rev. "1" only) Item 6 Code: Blank - Not on Rev. "0" 0 - No signs 1 - Stage 1 2 - Stage 2 3 - Stage 3 4 - Equivocal signs 9 - Not reported	34

FIELD		CARD COLUMN
10.	**Clinical Impression** Item 7 Four-digit code for: **Impression** (col. 35) Code: 0 - Normal 1 - Abnormal or other 9 - Not reported **CNS Defect or Injury** (col. 36) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - No CNS defect or injury 1 - CNS defect or injury 9 - Not reported **Congenital Malformations other than CNS** (col. 37) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - No congenital malformations (other than CNS) 1 - Congenital malformations (other than CNS) 9 - Not reported **Other** (col. 38) (Rev. "1" only) Code: Blank - Not on Rev. "0" 0 - No other impressions 1 - Other impressions 9 - Not reported Note (Rev. 1): If col. 35 is "0" then cols. 36-38 are "0". If col. 35 is "9" then cols. 36-38 are "9".	35-38
11.	**Completion of Stay** (Rev. "1" only) Code: Blank - Days in hospital represent complete stay in hospital, not on Rev. "0" 1 - Date of discharge and days in hospital do not represent the complete stay in hospital	39

SUMMARY OF THE HOSPITAL COURSE OF THE PATIENT
WORM PED-7



* Item numbers refer to form dated: 9/60

11.E.223

PED-7

NE: PED-7 Manual of 7-61 discontinued.
as per. #53 of 5-9-63.
New Manual replaced by PED-7

PEDIATRICS MANUAL

PED-7

SUMMARY OF HOSPITAL COURSE OF THE NEONATE

(For Form PED-7, Revised 5-60)

SECOND EDITION

THE COLLABORATIVE STUDY OF CEREBRAL PALSY AND
OTHER NEUROLOGICAL AND SENSORY DISORDERS OF
INFANCY AND CHILDHOOD

JULY 1961

SUMMARY OF HOSPITAL COURSE OF THE NEONATE
(For Form PED-7, Revised 5-60)

I Introduction

The purpose of the PED-7 record is to provide a brief summary of the significant neonatal events and findings from birth to discharge from the hospital, together with a synthesis and interpretation of all that is known about the infant during the hospital stay. This manual supersedes the first edition issued May 1960 and the addendum of December 1960.

II General Instructions

A. **The Reviewer.** Form PED-7 is to be completed by a senior Study pediatrician after a complete review of all applicable records.

B. **Records To Be Reviewed.** The records to be reviewed prior to completing Form PED-7 are the completed and edited PED-1, 2, 3, 5, and 6, PED-4 on deaths in the hospital, and applicable CP-5's; also all hospital records including records of hospital care when the infant is transferred from the nursery to another in-patient service.

C. **The Report.** In general, unusual events and findings during the hospital stay are to be reported under "Course". The interpretation of the events and findings in terms of diagnostic and descriptive statements is to be recorded under "Clinical Impression".

D. **Time of Transmittal.** Completed and edited PED-1, 2, 3, 5, 6, and 7, applicable CP-5's, and PED-4 on infant death in the hospital are to be transmitted as a unit to PRB within three weeks of the infant's discharge from the hospital. These records are not to be delayed in anticipation of a complete autopsy report or the report of a requested laboratory study.

III Specific Instructions

Item 1, Patient Identification. This must include the infant's name, NNDB number, date of birth, time of birth (24 hour clock), birth weight, race, and sex.

Item 2, Date of Discharge. Record the month, day, and year when the infant is discharged from the hospital. This does not refer to the date the infant is transferred from the nursery to another service in the same hospital or to another short hospital on the same day.

Item 3, Time of Discharge. If the infant is under 48 hours of age when discharged, record time of discharge in 24 hour clock time. If the infant is 48 hours of age or more when discharged, simply write N.A. (not applicable) in this space, but do not leave it blank as this will be interpreted as an omission.

Items 4, 5, and 6. These items in the main call for a summary of certain factual observations and findings, regardless of the reviewer's evaluation of their significance or lack of significance. They are to be recorded as reported in the records. A judgment is desired only if the reviewer has reason to believe that any of these facts have been inaccurately reported. In that event the reviewer is to state his reservations and the reasons therefor in the comment column.

Item 4, Course. Category 1 (Convulsions) is to be checked when the infant's course, as reported in the nursery records, is devoid of any unusual or significant events or findings such as are listed in other categories under this item.

Category 2 (Apgar of 6 or less) is to be checked when any Apgar score of 6 or less is recorded on Form PED-1.

Category 3 (Bilirubin over ...) is to be checked when a bilirubin value in the specified concentration level is recorded on Form PED-5.

Category 4 (Neuromuscular disturbance) is to be checked when the nursery records report behavior which, in the reviewer's judgment, may be indicative or suggestive of neuromuscular involvement, regardless of the duration of such behavior. A comment on the location and manifestations of such behavior will be asked.

Category 5 (Other) is to be checked when the nursery records report other unusual or significant events or findings not to cardiovascular difficulty (not in any instance diagnostic and therapeutic procedures) and the like. A comment is to be asked on the type, duration and significance of Item 5 under or event.

Item 5, Birth Weight. The infant is to be classified as full-term or premature in accordance with the criterion given and solely on the basis of the recorded birth weight.

Item 6, Dysmaturity. The infant is to be classified as to stage of dysmaturity in accordance with the criteria given below:

"0" – No signs of dysmaturity.

"1" – Equivocal signs of dysmaturity.

"Stage 1"–The infant's appearance suggests malnutrition and loss of weight, and the infant may appear much older than the usual newborn and be open-eyed and alert. There is no evidence of meconium having been passed prior to birth. The skin is unstained but generally is cracked, parchment-like and peeling.

"Stage 2"–In addition to the characteristics described for Stage 1 the infant has liberated quantities of meconium prior to birth sufficient to stain the skin, cord, and nails.

"Stage 3"–The infant is presumed to have passed through the earlier stages in utero. At birth the desquamating skin is stained golden yellow and the infant exhibits to a more marked degree the characteristics described for earlier stages.

Item 7, Clinical Impression. This item calls for the reviewer's judgment of the presence or absence of pathologic conditions, proved or suspected and not disproved, during the infant's hospital course, regardless of the infant's condition at the time of discharge. For certain conditions an additional note that the infant was or was not normal at the time of discharge may be of importance when later information is related to the current period.

Not to be regarded as pathologic conditions are trivial findings such as minor erythema, chemical preparations, circumcision, Mongol spots, uncomplicated umbilical hernia, etc.

Not to be included as such under pathologic conditions are factual items such as elevated serum bilirubin, low Apgar score, prematurity, and dysmaturity. These items are specifically designated for reporting elsewhere.

Category 0 (Normal) is to be checked when in the reviewer's judgment the infant's hospital course is devoid of pathologic events such as are listed in the subcategories under this item.

Category 1 (CNS defect or injury) is to be checked for CNS defect or injury, nervous system defect or injury other than central, and abnormality in the size and shape of the cranium. This category need not necessarily be checked for all cases classified as "Central-Neuromuscular Disturbance", since it is conceivable that findings suggestive of CNS disturbance at the time they were noted may be considered by the reviewer in retrospect as not suggestive of CNS disturbance. On the other hand this category is to be marked whenever the reviewer feels that the findings were suggestive of CNS disturbance even though the findings were transient and had subsided by the time the infant was discharged from the hospital.

Category 2 (Congenital Malformation other than CNS) is to be checked for anomalies of body systems other than the nervous system and cranium.

Category 3 (Other) is to be checked for other significant pathologic conditions not specified above.

Items 8, 9, and 10. "Examiner's Name", "Status of Examiner", and "Date of Summary" are self-explanatory.

Item 11, Comments. All comments, descriptions, and remarks pertaining to any of the numbered items are to be recorded here. Care must be taken to identify the comment with the number of the item to which it pertains.

Note: The 5-61 PED-7 manual ADD
& 12-60 addendum — superseded
by PED-7 manual of 7-61.

PEDIATRICS MANUAL

PED-7

SUMMARY OF HOSPITAL COURSE OF THE NEONATE

THE COLLABORATIVE STUDY OF CEREBRAL PALSY AND OTHER NEUROLOGICAL AND SENSORY DISORDERS OF INFANCY AND CHILDHOOD

National Institute of Neurological Diseases and Blindness

National Institutes of Health

May 1960

N.I.H. 227 PED-7

PHS-3004-7: Summary--Hospital Course of the Neonate

This form is to provide a summary based on all that is known about the infant from the time of birth to the time of discharge from the nursery. It is not to be merely a recapitulation of data which is recorded elsewhere, but rather an integration of the results of all observations, examinations and tests of the infant by a physician who is able to judge the significance of the particular findings and diagnoses in the light of the total course.

The form should be completed by a Study Pediatrician who reviews the infant's entire hospital and Study record as soon as possible after it is complete.

INSTRUCTIONS AND DEFINITIONS:

Item 1, Patient Identification. This should include the infant's name, hospital number, NINDB number, date of birth, birth weight, race and sex.

Item 2, Date of Discharge. Record as Month, Day, and Year.

Item 3, Time of Discharge. If the infant was discharged before 48 hours of age, record time of discharge to the nearest hour (24 hour clock). If the infant was more than 48 hours of age when discharged, simply draw a line or write N.A. (not applicable) in this space, but do not leave it blank as this will be interpreted as an unknown.

Item 4, Course. The category "uneventful" shall be checked for those infant's whose course is characterized by no significantly unusual symptoms or events such as those listed, including "other."

Categories 2 and 3, "Apgar of 6 or less" and "Bilirubin over. . ." are but reiteration of facts recorded elsewhere. A judgment is desired here only if the physician who summarizes the case may have reason to believe, but cannot prove, that either of these facts may have been erroneously reported. If such is the case, he should check the box according to what has been recorded before and describe the qualifications and reservations he has about these.

Category 4, "Neuromuscular disturbance" shall include but not be limited to seizures, paralysis or flaccidity, drowsiness, myoclorus or twitching, and frank spasticity. The summarizing physician must judge the significance of isolated observations suggestive of neuromuscular disturbance, and need record only those which he considers reliable and significant. A comment on the duration and manifestations of the disturbance is desirable.

Category 8, "Other" shall include but not be limited to such things as symptoms of cardio-vascular or respiratory distress, diagnositc and therapeutic procedures other than routine and consultations. A comment on the type, duration, and manifestations of the disorder or event is desired.

PHS-3004-7: Summary--Hospital Course of the Neonate

Diagnosis. Diagnosis has been divided in three distinct categories: weight, stage of dysmaturity, and clinical impression. The categories are defined and explained as follows:

Item 5, Birth Weight. The first category, weight, asks for the classification of the infant as a term or premature infant based on birth weight only. This is done to separate the classification of "full term" or "premature" from the judgments below.

Item 6, Dysmaturity. The dysmaturity category asks that the child be classified as to the stage of dysmaturity. The stages as defined below:

"O" - No signs of dysmaturity.

"?" - Equivocal signs of dysmaturity.

"Stage 1" - The general appearance of the infants suggest the failure of the placenta to provide for normal growth and development and the infant's condition may suggest some malnutrition and loss of weight. There is no history of the infant having passed meconium. The skin is unstained and generally is cracked, parchment-like and peeling. These signs are also combined with prolonged gestation, the infant may appear much older than the usual newborn and be open eyed and alert.

"Stage 2" - The infant exhibits the characteristics noted for Stage 1, but in addition the infant has liberated quantities of meconium sufficient to stain the skin, umbilical cord, nails, amniotic fluid and the placental membranes. The infant may also give evidence of having aspirated meconium.

"Stage 3" - The infant is assumed to have passed through the earlier stages in utero. At birth the infant's desquamating skin is stained a golden yellow and the child exhibits all of the preceding findings but to a more marked degree.

Item 7, Clinical Impression. The item "clinical impression" is designed to record the examiner's impression of the child independent of the factors of weight and dysmaturity. Thus the baby exhibiting normal findings other than prematurity or dysmaturity can be checked "normal" under clinical impressions. Do not classify an infant as other than normal if prematurity or dysmaturity are the only findings.

Items 8, 9, and 10, "Examiner's Name," "Status of Examiner" and "Date of Summary" are self-explanatory.

Item 11, Comments. All comments, descriptions or remarks pertaining to any of the numbered items of this page should be recorded in this blank column. Care must be taken to identify the comment with the number of the item to which it pertains.

Ref: 12-60 Addendum to PED-7 Manual of 5-60

Both 12-60 addendum and 5-60 Manual superseded by PED-7 Manual of 7-61

Addendum to the Pediatrics Manual

PHS-3004-7 Summary of Hospital Course of the Neonate (PED-7) Rev. 5-60

Several questions have arisen concerning the use of the form PED-7 and interpretation of the manual for this form. The following are offered as clarification of some of these questions.

1. This form is designed to be a brief diagnostic summary code of the child's entire nursery stay. When properly used it should be an adjunct to medical editing and provide a synthesis and interpretation by a mature pediatrician of all that is known about the child from birth to discharge from the nursery.

2. In general, unusual events or findings during the nursery period are recorded under "Course" and the interpretation of the findings and events in terms of diagnostic or descriptive statements are recorded under "Clinical Impression."

3. "Course - (2) Total Serum Bilirubin 10 mg % or more 0-47 hours, or 15 mg % or more 48+ hours." This category is to be checked on all and only those cases in which a bilirubin value above the specified age-intensity level was observed. The data on all bilirubin determinations are available on PED-5 and detailed analysis of various age-intensity levels will be done from these.

Two reasons for a special category for reporting on PED-7 elevated serum bilirubin in certain specified cases are: (1) To keep hyperbilirubinemia as such out of "Course - Other" or "Clinical Impression - Other," and (2) To identify quickly a certain discrete group of cases with a common attribute that most people would agree is abnormal.

The only thing that could be tested if the question were worded "Hyperbilirubinemia" is the inter-examiner variation in definition of the term. Neither is it intended that the criteria for the class to be reported on PED-7 be a definition of "hyperbilirubinemia."

4. "Clinical Impression." Clinical Impression should be a statement of those diagnoses or pathological conditions proven, or suspected but not ruled out, during the infant's nursery stay; and should not be limited to the child's condition at the time of discharge. For certain conditions, an additional note that the child was or was not normal at the time of discharge may be of importance when later information is related to the nursery period.

Not to be reported under "Clinical Impression" are trivial conditions such as erythema toxicum, uncomplicated chemical conjunctivitis, circumcision, Mongolian spots, uncomplicated umbilical hernia, etc.

Not to be reported under "Clinical Impression" are factual items such as elevated serum bilirubin, low Apgar score, prematurity, and dysmaturity. These items are specifically designated for reporting elsewhere, either on PED-7 or on previous records.

It is not necessary that all cases classified as "Course - Neuromuscular Disturbance" also be classified as "Clinical Impression - Central Nervous System Defect or Injury." It is conceivable that an infant who at one time exhibited sufficient unusual neurological findings to be classified as "Neuromuscular Disturbance" could proceed with a course so benign that the reviewer could be confident that an earlier provisional impression of CNS injury had been ruled out.

5. "Clinical Impression - (2) Central Nervous Defect or Injury." Disregard the term "Central" in the caption and report all nervous system disorders under this category. Include size and shape abnormalities of the cranium in this category.

SUMMARY OF CHILD'S COURSE IN THE NURSERY

DATE OF BIRTH | DATE

COURSE

- ☐ Normal
- ☐ Other – Describe

DIAGNOSIS

- ☐ Normal Newborn
- ☐ Other – Describe (include onset suspected and proven abnormalities)

PROGNOSIS

- ☐ Normal
- ☐ Other – Describe

EXAMINER

STATUS

RECORD OF EXAMINATIONS (Check when completed)

DATE								
TIME								
DELIVERY ROOM EXAM								
INTERVAL HISTORY								
NEONATAL EXAM								
FUNDUSCOPIC								
NEUROLOGICAL								
LABORATORY (Record Results)								
HEMOGLOBIN								
BILIRUBIN								
OTHER								
OTHER								

Department of Health, Education and Welfare
Public Health Service

(PED-7)

PED-8 Newborn Diagnostic Summary

Form PED-8 served as a diagnostic "flag sheet" where significant diagnoses and events were recorded in coded form. It was implemented into the study in January 1963 as a replacement for form PED-7; no revisions were made. Data from PED-8 were recorded on six cards of the master file (Table PED-8.1). Code 0 in column 5 (Rev. No.) indicates that the data are for livebirths, code "1" indicates that the data are for stillbirths.

TABLE PED-8.1 Cards and Data Records by Revision for Form PED-8

CARD NAME	CARD NUMBER	REV. NO.	NUMBER RECORDS
PED-8: Summary Data, Diagnoses and Procedures	1408		
		0	53,700
		1	1,116
			54,816
PED-8: Additional Observations >9	2408		
		0	2,061
		1	5
			2,066
PED-8: Additional Observations >18	3408		
		0	344
			344
PED-8: Additional Observations >27	4408		
		0	50
			50
PED-8: Additional Observations >36	5408		
		0	14
			14
PED-8: Additional Observations >45	6408		
		0	2
			2
	total for form		57,292

Data Items Referencing Form PED-R, Newborn Diagnostic Summary

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4258.....		140R	1	5	Card number (sequence, form type, form number, revision number)
4259.....		140R	6	14	NINDB case number
4260..PED-R	1	140R	15	16	Birth date (mo)
4261..PED-R	1	140R	17	18	Birth date (day)
4262..PED-R	1	140R	19	20	Birth date (yr)
4263..PED-R	5	140R	21	22	Discharge date (mo)
4264..PED-R	5	140R	23	24	Discharge date (day)
4265..PED-R	5	140R	25	26	Discharge date (yr)
4266..PED-R	7	140R	27	29	Age at discharge (days)
4267..PED-R	9	140R	30	30	Dysmaturity, stage
4268..PED-R	11	140R	31	31	Procedures, number of
4269..PED-R	13	140R	32	32	Major conditions, other; etiologic impressions, presumptive; summary
4270..PED-R	13	140R	33	33	Information source; summary code
4271.....		140R	34	35	Blank
4272..PED-R	13	140R	36	36	Neurologic abnormality, number of
4273..PED-R	13	140R	37	37	CNS; malformations
4274..PED-R	13	140R	38	38	Musculoskeletal abnormality, number of
4275..PED-R	13	140R	39	39	Eye conditions
4276..PED-R	13	140R	40	40	Ear conditions
4277..PED-R	13	140R	41	41	Mouth conditions; respiratory tract, upper, conditions
4278..PED-R	13	140R	42	42	Thoracic conditions
4279..PED-R	13	140R	43	43	Respiratory abnormality
4280..PED-R	13	140R	44	44	Cardiovascular conditions
4281..PED-R	13	140R	45	45	Alimentary tract; malformation or condition
4282..PED-R	13	140R	46	46	Liver abnormality; bile duct abnormality; spleen abnormality
4283..PED-R	13	140R	47	47	Genitourinary conditions
4284..PED-R	13	140R	48	48	Neoplastic condition
4285..PED-R	13	140R	49	49	Hematologic conditions
4286..PED-R	13	140R	50	50	Skin; malformations or conditions
4287..PED-R	13	140R	51	51	Infection
4288..PED-R	13	140R	52	52	Syndromes
4289..PED-R	13	140R	53	53	Endocrine disease; metabolic disease
4290..PED-R	J.11	140R	54	56	Abdominal adhesions, code: 748
4290..PED-R	I.8	140R	54	56	Abnormal aortic cusp, code: 730
4290..PED-R	C.14	140R	54	56	Abnormal position of; fingers, code: 338
4290..PED-R	M.17	140R	54	56	Absence of corpus callosum, code: 226
4290..PED-R	C.6	140R	54	56	Absence or hypoplasia of; cleft hallux, code: 285
4290..PED-R	C.6	140R	54	56	Absence or hypoplasia of; femoral epiphysis, distal, code: 265
4290..PED-R	C.6	140R	54	56	Absence or hypoplasia of; femur, code: 268
4290..PED-R	C.6	140R	54	56	Absence or hypoplasia of; fibula, code: 272
4290..PED-R	C.6	140R	54	56	Absence or hypoplasia of; fingers, code: 288

Data Items Referencing Form PED-H, Newborn Diagnostic Summary

DATA ITEM TO	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; foot, code: 274
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; forearm, code: 279
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; hand, code: 286
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; humerus, code: 280
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; lower extremity, code: 266
4290..PED-A	H.12	140A	54	56	Absence or hypoplasia of; olfactory nerve and/or bulb, code: 228
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; radius, code: 282
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; ribs and spine, code: 201
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; ribs, anomalies of, code: 287
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; ribs, code: 292
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; tibia, code: 270
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; toes, code: 276
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; ulna, code: 290
4290..PED-A	C.6	140A	54	56	Absence or hypoplasia of; upper extremity, code: 274
4290..PED-A	J.5	140A	54	56	Absence; ductus arteriosis, code: 511
4290..PED-A	J.11	140A	54	56	Absence; ligament of Treitz, code: 643
4290..PED-A	J.2	140A	54	56	Absence; lung, right or left, code: 452
4290..PED-A	F.5	140A	54	56	Absence; meatus, external ear, code: 402
4290..PED-A	C.14	140A	54	56	Absence; pubic fusion, code: 140
4290..PED-A	H.12	140A	54	56	Absence; sacrum, code: 292
4290..PED-A	L.7	140A	54	56	Absent glomerulogenesis with persistence mullerian duct, code: 716
4290..PED-A	F.8	140A	54	56	Absent; antrum, floor of, code: 438
4290..PED-A	L.7	140A	54	56	Absent; bladder, right hemi-trigone, code: 711
4290..PED-A	I.8	140A	54	56	Absent; coronary artery, code: 582
4290..PED-A	I.8	140A	54	56	Absent; coronary sinus, code: 578
4290..PED-A	L.7	140A	54	56	Absent; kidney hilar, code: 745
4290..PED-A	F.8	140A	54	56	Absent; nose, bridge of, code: 136
4290..PED-A	H.12	140A	54	56	Absent; posterior lobe pituitary, aplasia pituitary, code: 249
4290..PED-A	C.6	140A	54	56	Absent; sternocleidomastoid muscle, code: 280
4290..PED-A	I.8	140A	54	56	Absent; umbilical artery, code: 551
4290..PED-A	L.7	140A	54	56	Absent; ureter, code: 714
4290..PED-A	L.7	140A	54	56	Absent; ureters (both), code: 718
4290..PED-A	F.8	140A	54	56	Absent; uvula, code: 440
4290..PED-A	C.11	140A	54	56	Achondroplasia, codes: 301, 302
4290..PED-A	D.6	140A	54	56	Acrocephaly-syndactyly of Apert, code: 901
4290..PED-A	J.11	140A	54	56	Adhesions of cecum to liver, code: 630
4290..PED-A	J.11	140A	54	56	Adhesive bands; duodenal obstruction, secondary, code: 626
4290..PED-A	H.6	140A	54	56	Adrenal atrophy hypoplasia, hemorrhage, necrosis, code: 930
4290..PED-A	H.6	140A	54	56	Adrenal hyperplasia, code: 940
4290..PED-A	D.1	140A	54	56	Adrenogenital syndrome, codes: 891, 892
4290..PED-A	L.7	140A	54	56	Agenesis; bladder, code: 715
4290..PED-A	H.5	140A	54	56	Albinism, code: 928
4290..PED-A	J.11	140A	54	56	Alimentary tract malformations and conditions, other noninfectious, codes: 621, 622

Data Items Referencing Form PEDNB, Newborn Diagnostic Summary

DATA ITEM ID	ITEM SEQ#	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-B	J.11	140B	54	56	Anal fissure, code: 537
4290..PED-B	H.1	140B	54	56	Anencephaly, code: 184
4290..PED-B	I.7	140B	54	56	Anesthesia, general, code: 971
4290..PED-B	I.H	140B	54	56	Aneurism of: pulmonary artery, sinus valsalva, aortic valve, code: 501
4290..PED-B	D.H	140B	54	56	Aniridia, code: 178
4290..PED-B	I.8	140B	54	56	Anomalous: pulmonary venous connection and/or return, code: 559
4290..PED-B	I.8	140B	54	56	Anomalous: subclavian, right, code: 555
4290..PED-B	I.8	140B	54	56	Anomalus muscle band at septum, code: 729
4290..PED-B	G.3	140B	54	56	Anomaly: chest wall: deformed thorax, code: 462
4290..PED-B	G.3	140B	54	56	Anomaly: chest wall: pectus carinatum (Keel) (Pigeon), code: 466
4290..PED-B	G.3	140B	54	56	Anomaly: chest wall: ribs, flarion, code: 4b6
4290..PED-B	G.3	140B	54	56	Anomaly: chest wall: scare shaped, code: 463
4290..PED-B	G.2	140B	54	56	Anomaly: lung: cyst or cysts, code: 456
4290..PED-B	G.2	140B	54	56	Anomaly: lung: hypoplasia or immaturity, code: 458
4290..PED-B	G.2	140B	54	56	Anomaly: lung: lobe or lobes absence or incomplete division, code: 454
4290..PED-B	G.2	140B	54	56	Anomaly: lung: lobes, extra, code: 457
4290..PED-B	G.2	140B	54	56	Anomaly: lung: pneumatocele, code: 455
4290..PED-B	F.H	140B	54	56	Anomaly: lung: pleural defect, congenital, code: 435
4290..PED-B	G.2	140B	54	56	Anomaly: lung: pulmonary encil, code: 453
4290..PED-B	I.H	140B	54	56	Anomaly: vena cava, inferior, with azygous drainage, code: 594
4290..PED-B	D.H	140B	54	56	Anophthalmia, code: 168
4290..PED-B	U.1	140B	54	56	Anoxia, presumed etiology of conditions, code: 987
4290..PED-B	I.11	140B	54	56	Antibiotics, internal administration, code: 984
4290..PED-B	I.H	140B	54	56	Aorta, over-riding, code: 507
4290..PED-B	I.H	140B	54	56	Aorta: hypoplastic, code: 549
4290..PED-B	I.H	140B	54	56	Aortic arch, right, code: 540
4290..PED-B	I.H	140B	54	56	Aortic arch: anomaly, code: 559
4290..PED-B	I.H	140B	54	56	Aortic atresia, code: 547
4290..PED-B	H.14	140B	54	56	Apnea, multiple episodes, code: 526
4290..PED-B	H.12	140B	54	56	Apnea, primary, code: 522
4290..PED-B	H.13	140B	54	56	Apnea, single episode, code: 524
4290..PED-B	H.12	140B	54	56	Arrhinencephaly, code: 214
4290..PED-B	C.10	140B	54	56	Arthrogryposis multiplex, codes: 299, 300
4290..PED-B	H.5	140B	54	56	Aspiration after delivery, codes: 487, 488
4290..PED-B	H.4	140B	54	56	Aspiration before or during delivery, codes: 485, 486
4290..PED-B	G.5	140B	54	56	Atelectasis (comp. collapse lung), code: 477
4290..PED-B	H.2	140B	54	56	Atelectasis, primary, codes: 481, 482
4290..PED-B	J.11	140B	54	56	Atresia: colon or parts thereof, code: 613
4290..PED-B	I.H	140B	54	56	Atresia: mitral valve, code: 563
4290..PED-B	J.11	140B	54	56	Atresia: small bowel or parts thereof, code: 614
4290..PED-B	I.H	140B	54	56	Atrial septal defect, code: 539

Data Items Referencing Form PED-H, Newborn Diagnostic Summary

DATA ITEM TO	ITEM IN FROM	CARD NUM	FROM	PD	DATA ITEM NAME
4290..PED-A	I.H	140A	54	56	Atrioventricular canal (communication), code: 550
4290..PED-A	I.H	140A	54	56	Atrium, common, code: 442
4290..PED-A	I.H	140A	54	56	Atrium: aortic valve, code: 581
4290..PED-A	K.1	140A	54	56	Bile ducts, focal malformation, code: 667
4290..PED-A	K.1	140A	54	56	Biliary atresia, code: 665
4290..PED-A	G.7	140A	54	56	Bladder diverticulum, code: 707
4290..PED-A	G.4	140A	54	56	Bladder outflow: urethral obstruction, codes: 677, 678
4290..PED-A	I.H	140A	54	56	Blalock shunt, Portman, code: 584
4290..PED-A	D.6	140A	54	56	Blindness, codes: 361, 362
4290..PED-A	H.7	140A	54	56	Blood loss, intrauterine, codes: 761, 762
4290..PED-A	I.2	140A	54	56	Blood: transfusions, exchange, code: 966
4290..PED-A	I.1	140A	54	56	Blood: transfusions, simple, code: 965
4290..PED-A	J.11	140A	54	56	Bowel, large, acute serositis of, code: 628
4290..PED-A	A.1	140A	54	56	Brain abnormality, codes: 001, 002
4290..PED-A	A.1.10	140A	54	56	Brain abnormality, other, codes: 065, 066
4290..PED-A	A.1.c	140A	54	56	Brain status, abnormal, one exam or no protocol exam, code: 094
4290..PED-A	A.1.b	140A	54	56	Brain status, abnormal, persistent, code: 092
4290..PED-A	A.1.a	140A	54	56	Brain status, abnormal, transient, code: 090
4290..PED-A	F.3	140A	54	56	Branchial cleft anomaly, codes: 395, 396
4290..PED-A	G.5	140A	54	56	Bronchi, compression of, code: 674
4290..PED-A	D.H	140A	54	56	Bupthalmos, glaucoma, code: 372
4290..PED-A	I.3	140A	54	56	Cafe au lait spots, code: 837
4290..PED-A	C.4	140A	54	56	Calcaneo Varus, codes: 259, 260
4290..PED-A	C.14	140A	54	56	Calcaneo varus (also talipes), code: 344
4290..PED-A	I.6	140A	54	56	Cardiac enlargement, codes: 541, 542
4290..PED-A	I.5	140A	54	56	Cardiac rate disorder, codes: 539, 540
4290..PED-A	I.4	140A	54	56	Cardiac rhythm disorder, codes: 537, 538
4290..PED-A	I.H	140A	54	56	Cardiovascular diagnosis, specific, code: 546
4290..PED-A	I.1	140A	54	56	Cardiovascular disease: congenital: acyanotic, codes: 531, 532
4290..PED-A	I.2	140A	54	56	Cardiovascular disease: congenital: cyanotic, codes: 533, 534
4290..PED-A	I.9	140A	54	56	Cardiovascular diseases and conditions, other, codes: 573, 574
4290..PED-A	I.H	140A	54	56	Carotid, missing (left), code: 575
4290..PED-A	D.3	140A	54	56	Cataract, codes: 355, 356
4290..PED-A	J.11	140A	54	56	Cecum, bowel, duplication, code: 635
4290..PED-A	A.III.2	140A	54	56	Cephalhematoma, codes: 121, 122
4290..PED-A	H.12	140A	54	56	Cerebral hypoplasia-frontal, code: 236
4290..PED-A	C.14	140A	54	56	Cervical ribs, code: 342
4290..PED-A	G.7	140A	54	56	Cervix, double, code: 789
4290..PED-A	J.11	140A	54	56	Chalasia, code: 636
4290..PED-A	G.3	140A	54	56	Chest wall anomaly, codes: 459, 460
4290..PED-A	F.1	140A	54	56	Choanal atresia, codes: 419, 420
4290..PED-A	F.8	140A	54	56	Choanal stenosis with absence nasal cartilage, code: 444
4290..PED-A	J.6	140A	54	56	Chondrodystrophia calcificans congenita, code: 902

Data Items Referencing Form PED-B, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-B	D.2	140B	54	56	Choriae, codes: 050, 060
4290..PED-B	D.1	140B	54	56	Chorioretinitis, codes: 051, 052
4290..PED-B	E.9	140B	54	56	Chromosome studies, code: 082
4290..PED-B	C.12	140B	54	56	Clavicle, fractured, codes: 101, 104
4290..PED-B	F.5	140B	54	56	Cleft gum, code: 423
4290..PED-B	F.4	140B	54	56	Cleft lip, code: 426
4290..PED-B	F.2	140B	54	56	Cleft palate, code: 422
4290..PED-B	F.3	140B	54	56	Cleft uvula, bifid, code: 424
4290..PED-B	J.6	140B	54	56	Cleidocranial dysotosis, code: 904
4290..PED-B	H.12	140B	54	56	CNS malformations and related skeletal conditions, other, codes: 221, 224
4290..PED-B	N.6	140B	54	56	Coagulation defect, specify, codes: 751, 752
4290..PED-B	N.6	140B	54	56	Coagulation defect; factor 7 (VIII) def., code: 751
4290..PED-B	N.6	140B	54	56	Coagulation defect; factor X def., code: 754
4290..PED-B	N.6	140B	54	56	Coagulation defect; hypoprothrombinemia, code: 758
4290..PED-B	N.6	140B	54	56	Coagulation defect; SPCA and/or PTC, code: 755
4290..PED-B	N.6	140B	54	56	Coagulation defect; thrombocytopenia, code: 759
4290..PED-B	N.6	140B	54	56	Coagulation defect; vitamin K def., code: 756
4290..PED-B	I.H	140B	54	56	Coarctation, code: 551
4290..PED-B	D.H	140B	54	56	Coloboma, code: 174
4290..PED-B	I.H	140B	54	56	Common truncus, truncus arteriosis, code: 564
4290..PED-B	C.14	140B	54	56	Congenital dislocation; knees, code: 346
4290..PED-B	C.14	140B	54	56	Congenital dislocation; wrist, code: 348
4290..PED-B	J.5	140B	54	56	Congenital laryngeal stridor, inspiratory stridor, code: 471
4290..PED-B	C.14	140B	54	56	Constriction bands; hand, code: 350
4290..PED-B	I.H	140B	54	56	Cor biloculare, code: 546
4290..PED-B	I.H	140B	54	56	Cor triloculare, code: 565
4290..PED-B	H.12	140B	54	56	Cord abnormality, code: 210
4290..PED-B	D.4	140B	54	56	Corneal opacity, codes: 157, 158
4290..PED-B	B.6	140B	54	56	Cornelia De Lange syndrome, code: 905
4290..PED-B	B.6	140B	54	56	Cranial sutures, abnormal separation, codes: 193, 194
4290..PED-B	J.6	140B	54	56	Cranio carpal tarsal dystrophy syndrome, code: 925
4290..PED-B	H.12	140B	54	56	Craniochisis, code: 252
4290..PED-B	H.5	140B	54	56	Craniosynostosis, codes: 191, 192
4290..PED-B	H.1	140B	54	56	Creftinism hypothyroidism, infantile, codes: 915, 916
4290..PED-B	A.1.17	140B	54	56	Cry abnormal, codes: 061, 062
4290..PED-B	H.12	140B	54	56	Cyst; septum pellucidum, code: 218
4290..PED-B	H.12	140B	54	56	Cystic mass; lumbosacral area, code: 260
4290..PED-B	L.6	140B	54	56	Cystic; kidney, codes: 681, 682
4290..PED-B	H.6	140B	54	56	Cytomegaly adrenal cortex, code: 941
4290..PED-B	J.6	140B	54	56	Dandy-walker syndrome, code: 907
4290..PED-B	E.4	140B	54	56	Deafness, codes: 197, 198
4290..PED-B		140B	54	56	Diagnoses; procedures; specific, oth, (where max n = 56)

Data Items Referencing Form PEDs-B, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-B	C.1	140B	54	56	diaphragm anomaly, codes: 447, 448
4290..PED-B	C.14	140B	54	56	digits, marked deviation of 2 or more, code: 187
4290..PED-B	C.1	140B	54	56	diseases and conditions, other specified, codes: 951, 952
4290..PED-B	C.14	140B	54	56	dislocation: humerous (shoulder), code: 187
4290..PED-B	C.14	140B	54	56	dislocation: toe, 5th, code: 449
4290..PED-B	I.8	140B	54	56	ductus arteriosus, code: 451
4290..PED-B	J.2	140B	54	56	duodenal atresia, codes: 503, 504
4290..PED-B	J.11	140B	54	56	duodenal obstruction, code: 851
4290..PED-B	L.7	140B	54	56	dysgenesis: ovaries, code: 102
4290..PED-B	B.6	140B	54	56	Ehlo's syndrome, code: 908
4290..PED-B	E.5	140B	54	56	ear conditions, other noninfectious, codes: 399, 400
4290..PED-B	E.2	140B	54	56	ear pinna deformed, codes: 193, 194
4290..PED-B	E.1	140B	54	56	ears, low set, codes: 191, 192
4290..PED-B	I.8	140B	54	56	Ebstein's complex, code: 586
4290..PED-B	J.6	140B	54	56	ecchymosis, severe, code: 826
4290..PED-B	I.9	140B	54	56	ectopic cord tip ventricle fused with left eye absent disc, codes: 595
4290..PED-B	E.1	140B	54	56	ectopic spleen in pancreas, code: 632
4290..PED-B	F.12	140B	54	56	electroencephalogramy (EEG), code: 9H5
4290..PED-B	H.10	140B	54	56	emphysema, codes: 499
4290..PED-B	A.8	140B	54	56	encephalocele, codes: 101, 102
4290..PED-B	I.4	140B	54	56	epicardial cushion effect, code: 567
4290..PED-B	I.5	140B	54	56	epicardial scirrhosis, code: 568
4290..PED-B	H.6	140B	54	56	epicrine diseases, other: metabolic diseases, other, codes: 917, 918
4290..PED-B	C.14	140B	54	56	epiphysis: talus and leg, code: 185
4290..PED-B	F.7	140B	54	56	epiplatis malformation: larynx malformation, codes: 431, 432
4290..PED-B	L.7	140B	54	56	epispadias, code: 687
4290..PED-B	N.1	140B	54	56	erythroblastosis, codes: 719, 720
4290..PED-B	N.4	140B	54	56	erythroblastosis, other, specified, codes: 725, 726
4290..PED-B	N.4	140B	54	56	erythroblastosis, other: C incompatability, code: 729
4290..PED-B	N.4	140B	54	56	erythroblastosis, other: Lea factor, code: 727
4290..PED-B	N.3	140B	54	56	erythroblastosis: ABO incompatibility, codes: 723, 724
4290..PED-B	N.2	140B	54	56	erythroblastosis: Rh incompatibility, codes: 721, 722
4290..PED-B	J.11	140B	54	56	esophageal atresia, code: 639
4290..PED-B	D.8	140B	54	56	exophthalmos, proptosis, code: 376
4290..PED-B	L.7	140B	54	56	exstrophy of bladder, code: 698
4290..PED-B	C.6	140B	54	56	extremity or part, specify: absence or hypoplasia of, codes: 263, 264
4290..PED-B	D.8	140B	54	56	eye conditions, other noninfectious, codes: 365, 366
4290..PED-B	D.8	140B	54	56	eye herniation, code: 378
4290..PED-B	G.1	140B	54	56	fever of undetermined etiology, F.U.O., code: 951
4290..PED-B	H.2	140B	54	56	fibrocystic disease of pancreas: cystic fibrosis, codes: 913, 914

Data Items Referencing Form [illegible]-H, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-A	J.1	140A	54	56	Fibroelastosis, codes: 515, 516
4290..PED-A	C.14	140A	54	56	Fibrous dysplasia of bone, code: 141
4290..PED-A	C.14	140A	54	56	Flexion deformity, contractions, code: 301
4290..PED-A	G.7	140A	54	56	Follicular cyst; ovary, code: 609
4290..PED-A	C.11	140A	54	56	Fractures, other, codes: 105, 106
4290..PED-A	D.6	140A	54	56	Frontal and parietal bones, under mineralization of, code: 971
4290..PED-A	K.1	140A	54	56	Gall bladder, absence, code: 557
4290..PED-A	G.7	140A	54	56	Gartner's duct cyst, code: 588
4290..PED-A	G.1	140A	54	56	Genitalia, external abnormalities, other, codes: 661, 662
4290..PED-A	G.1	140A	54	56	Genitalia, external abnormality, other; clitoral hypertrophy, code: 675
4290..PED-A	G.1	140A	54	56	Genitalia, external abnormality, other; ventral foreskin - congenital, absence of, code: 676
4290..PED-A	G.7	140A	54	56	Genitourinary conditions, noninfectious, other, codes: 681, 684
4290..PED-A	C.14	140A	54	56	Genu recurvatum, code: 113
4290..PED-A	G.7	140A	54	56	Glomerular cyst, code: 703
4290..PED-A	K.5	140A	54	56	Glucose-6-phosphate dehydrogenase def., code: 929
4290..PED-A	K.5	140A	54	56	Glycogen storage disease, code: 926
4290..PED-A	K.6	140A	54	56	Goiter, code: 961
4290..PED-A	J.2	140A	54	56	Gonadal dysgenesis, codes: 489, 490
4290..PED-A	C.14	140A	54	56	Hammer toes, code: 119
4290..PED-A	E.4	140A	54	56	Heart, fatty degeneration, code: 596
4290..PED-A	D.2	140A	54	56	Hemangioma; cavernous, codes: 817, 818
4290..PED-A	D.1	140A	54	56	Hemangioma; strawberry/portwine, codes: 815, 816
4290..PED-A	G.5	140A	54	56	Hematuria, code: 826
4290..PED-A	G.9	140A	54	56	Hematologic conditions, other, codes: 781, 784
4290..PED-A	A.1	140A	54	56	Hematoma; liver, subcapsular, code: 671
4290..PED-A	C.14	140A	54	56	Hemihypertrophy (left side body), code: 129
4290..PED-A	H.5	140A	54	56	Hemolytic disease, other, codes: 741, 742
4290..PED-A	J.11	140A	54	56	Hemoperitoneum, code: 743
4290..PED-A	A.8	140A	54	56	Hemorrhage, major, other specified site, codes: 763, 764
4290..PED-A	A.III.1	140A	54	56	Hemorrhage; intracranial, codes: 121, 124
4290..PED-A	K.1	140A	54	56	Hemosiderosis, code: 673
4290..PED-A	K.1	140A	54	56	Hepatitis, giant cell, code: 660
4290..PED-A	K.1	140A	54	56	Hepatitis, herpetic, code: 669
4290..PED-A	K.1	140A	54	56	Hepatoblastoma (primary), code: 989
4290..PED-A	J.9	140A	54	56	Hernia; femoral, codes: 615, 616
4290..PED-A	J.9	140A	54	56	Hernia; inguinal, codes: 613, 614
4290..PED-A	J.10	140A	54	56	Hernia; other, codes: 617, 618
4290..PED-A	J.10	140A	54	56	Hernia; supra umbilical, code: 673
4290..PED-A	J.10	140A	54	56	Hernia; ventral, code: 619
4290..PED-A	C.5	140A	54	56	Hip; dislocation or dysplasia, congenital, codes: 261, 262
4290..PED-A	J.11	140A	54	56	Hirschsprung's disease (aganglionosis of ileum and colon), code: 746

Data Items Referenced: Form PED-8, Newborn Diagnostic Summary

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4200..PED-8	D.6	1408	54	56	Horner's syndrome, code: 300
4200..PED-8	D.7	1408	54	56	Horseshoe kidney, code: 703
4200..PED-8	B.3	1408	54	56	Hydranencephaly, codes: 187, 188
4200..PED-8	B.4	1408	54	56	Hydrocephaly, codes: 189, 190
4200..PED-8	B.12	1408	54	56	Hydromyelia, code: 242
4200..PED-8	G.5	1408	54	56	Hydrothorax, bilateral or unilateral, code: 477
4200..PED-8	H.1	1408	54	56	Hygroma, code: 980
4200..PED-8	L.7	1408	54	56	Hymen cyst, code: 695
4200..PED-8	L.7	1408	54	56	Hymen: imperforate, code: 690
4200..PED-8	A.1.5	1408	54	56	Hyperactivity, codes: 011, 012
4200..PED-8	K.6	1408	54	56	Hyperbilirubinemia ? mother's milk, code: 942
4200..PED-8	C.14	1408	54	56	Hypermobile or extensible: joints, code: 337
4200..PED-8	K.6	1408	54	56	Hypernatremia, code: 943
4200..PED-8	K.6	1408	54	56	Hyperplasia (focal): thyroid, code: 944
4200..PED-8	K.6	1408	54	56	Hyperplasia: islets of Langerhans, code: 945
4200..PED-8	K.6	1408	54	56	Hyperplastic: pituitary, code: 946
4200..PED-8	S.1	1408	54	56	Hyperthermia, code: 954
4200..PED-8	A.1.3	1408	54	56	Hypertonia, codes: 007, 008
4200..PED-8	L.7	1408	54	56	Hypertrophy: bladder, code: 705
4200..PED-8	I.H	1408	54	56	Hypertrophy: ventricle, right, code: 572
4200..PED-8	A.1.12	1408	54	56	Hyperactivity, codes: 051, 052
4200..PED-8	K.6	1408	54	56	Hypoalbuminemia, code: 947
4200..PED-8	K.3	1408	54	56	Hypocalcemia, symptomatic (presumed), codes: 919, 920
4200..PED-8	K.6	1408	54	56	Hypogammaglobulinemia, code: 964
4200..PED-8	S.1	1408	54	56	Hypoglycemia, chemical, code: 950
4200..PED-8	K.4	1408	54	56	Hypoglycemia, symptomatic (presumed), codes: 921, 922
4200..PED-8	O.8	1408	54	56	Hypoplasia of: optic nerve, code: 180
4200..PED-8	I.8	1408	54	56	Hypoplasia: auricle (left), code: 562
4200..PED-8	C.14	1408	54	56	Hypoplasia: jaw, code: 331
4200..PED-8	H.12	1408	54	56	Hypoplasia: skull bones, code: 244
4200..PED-8	I.8	1408	54	56	Hypoplastic: atrium, left, code: 571
4200..PED-8	I.8	1408	54	56	Hypoplastic: heart, left, code: 585
4200..PED-8	L.7	1408	54	56	Hypoplastic: kidney, code: 701
4200..PED-8	J.11	1408	54	56	Hypoplastic: small intestines, code: 631
4200..PED-8	L.7	1408	54	56	Hypoplastic: vagina and vulva, code: 689
4200..PED-8	I.8	1408	54	56	Hypoplastic: ventricle, right, code: 569
4200..PED-8	K.6	1408	54	56	Hypoproteinemia, code: 948
4200..PED-8	H.1	1408	54	56	Hypospadias, code: 658
4200..PED-8	S.1	1408	54	56	Hypothermia, code: 955
4200..PED-8	A.1.11	1408	54	56	Hypotonia, codes: 049, 050
4200..PED-8	J.11	1408	54	56	Ileostomy, prolapse, code: 747
4200..PED-8	J.6	1408	54	56	Imperforate anus: (anal atresia), code: 612
4200..PED-8	K.5	1408	54	56	Inborn errors of: metabolism, codes: 923, 924

Data Items Referenced: Form PED-R, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-R	I.8	140R	54	56	Int. vena cava to anat. left atrium, code: 587
4290..PED-R	P.12	140R	54	56	Infection, other, codes: 885, 886
4290..PED-R	P.5	140R	54	56	Infection: bone and joint, codes: 871, 872
4290..PED-R	P.2	140R	54	56	Infection: central nervous system, codes: 865, 866
4290..PED-R	P.10	140R	54	56	Infection: cutaneous, codes: 881, 882
4290..PED-R	P.9	140R	54	56	Infection: ear, codes: 879, 880
4290..PED-R	P.8	140R	54	56	Infection: eye, codes: 877, 878
4290..PED-R	P.7	140R	54	56	Infection: gastrointestinal, codes: 875, 876
4290..PED-R	P.6	140R	54	56	Infection: heart, codes: 873, 874
4290..PED-R	P.11	140R	54	56	Infection: mucous membrane, codes: 883, 884
4290..PED-R	P.3	140R	54	56	Infection: respiratory, codes: 867, 868
4290..PED-R	P.1	140R	54	56	Infection: septicemia, codes: 863, 864
4290..PED-R	P.4	140R	54	56	Infection: urinary tract, codes: 869, 870
4290..PED-R	H.10	140R	54	56	Interstitial emphysema, code: 500
4290..PED-R	K.1	140R	54	56	Intrahepatic vein thrombosis and hepatic infraction and necrosis, code: 670
4290..PED-R	J.11	140R	54	56	Intussusception, code: 745
4290..PED-R	A.1.4	140R	54	56	Jitteriness: irritableness, codes: 009, 013
4290..PED-R	L.7	140R	54	56	Kidney, decreased function, code: 744
4290..PED-R	L.7	140R	54	56	Kidney, non-functioning, code: 791
4290..PED-R	L.7	140R	54	56	Kidney, single, code: 710
4290..PED-R	J.6	140R	54	56	Koerber Salus Elschnig syndrome, code: 910
4290..PED-R	D.10	140R	54	56	Lack of subcutaneous fat, code: 838
4290..PED-R	A.1.13	140R	54	56	Lethargy, codes: 051, 054
4290..PED-R	M.1	140R	54	56	Leukemia, code: 814
4290..PED-R	K.1	140R	54	56	Liver abnormality; bile duct abnormality; spleen abnormality, codes: 641, 642
4290..PED-R	K.1	140R	54	56	Liver, degeneration, code: 660
4290..PED-R	J.6	140R	54	56	Lowe's syndrome, code: 911
4290..PED-R	G.2	140R	54	56	Lung anomaly, codes: 449, 450
4290..PED-R	M.1	140R	54	56	Lung; tumor of bronchial origin, large (hamartoma?), code: 990
4290..PED-R	D.4	140R	54	56	Lymphangioma, codes: 821, 822
4290..PED-R	B.12	140R	54	56	Macrocephaly, code: 227
4290..PED-R	S.1	140R	54	56	Macrosomia, code: 958
4290..PED-R	H.12	140R	54	56	Malformation, nonspecific: brain, code: 246
4290..PED-R	J.3	140R	54	56	Malrotation, codes: 605, 606
4290..PED-R	D.4	140R	54	56	Marfan's syndrome, codes: 893, 894
4290..PED-R	M.1	140R	54	56	Mass, cystic, abdominal wall-probably lipoma, code: 813
4290..PED-R	M.1	140R	54	56	Mass, intra abdominal calcified, code: 997
4290..PED-R	M.1	140R	54	56	Mass, neck, code: 998
4290..PED-R	C.14	140R	54	56	Maxilla and mandible, abnormally long, code: 327
4290..PED-R	J.11	140R	54	56	Meckel's diverticulum, code: 645
4290..PED-R	J.11	140R	54	56	Meconium ileus, code: 648

Data Items Referencing Form PEDS-R, Newborn Diagnostic Summary

DATA ITEM ID	ITEM TYPE	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PEDS-R	J.11	140R	54	56	Meconium peritonitis, code: 649
4290..PEDS-R	G.5	140R	54	56	Mediastinal emphysema, and/or pneumothorax, code: 475
4290..PEDS-R	J.11	140R	54	56	Meningocele, code: 650
4290..PEDS-R	A.9	140R	54	56	Meningomyelocele; meningocele, codes: 199, 200
4290..PEDS-R	J.11	140R	54	56	Mesenteric infarct, code: 734
4290..PEDS-R	J.11	140R	54	56	Mesentery, common, single mesentery, code: 644
4290..PEDS-R	C.1	140R	54	56	Metatarsus adductus, codes: 257, 258
4290..PEDS-R	B.2	140R	54	56	Microcephaly, codes: 185, 186
4290..PEDS-R	J.11	140R	54	56	Microcolon, code: 647
4290..PEDS-R	F.6	140R	54	56	Micrognathia, codes: 429, 430
4290..PEDS-R	D.5	140R	54	56	Microphthalmia, codes: 154, 360
4290..PEDS-R	I.8	140R	54	56	Mitral valve, cleft ant. leaf or rudiment valve, code: 560
4290..PEDS-R	J.1	140R	54	56	Monocilia; fibro dysplasia, codes: 887, 888
4290..PEDS-R	A.1.16	140R	54	56	Moro; reflex abnormal, codes: 059, 060
4290..PEDS-R	H.10	140R	54	56	Mucous plug in trachea, code: 501
4290..PEDS-R	C.14	140R	54	56	Musculoskeletal abnormality, other noninfectious, codes: 333, 334
4290..PEDS-R	I.8	140R	54	56	Myocardinal necrosis, code: 542
4290..PEDS-R	A.1.2	140R	54	56	Myoclonus, codes: 005, 006
4290..PEDS-R	S.1	140R	54	56	Narcotic withdrawal syndrome, code: 956
4290..PEDS-R	M.1	140R	54	56	Neoplastic disease, tumors, specified, codes: 701, 702
4290..PEDS-R	A.II.4	140R	54	56	Nerve abnormality, peripheral or cranial, other, codes: 101, 102
4290..PEDS-R	A.II.1	140R	54	56	Nerve abnormality, peripheral or cranial; brachial, codes: 095, 096
4290..PEDS-R	A.II.2	140R	54	56	Nerve abnormality, peripheral or cranial; facial, codes: 097, 098
4290..PEDS-R	A.II.3	140R	54	56	Nerve abnormality, peripheral or cranial; ocular, codes: 099, 100
4290..PEDS-R	M.1	140R	54	56	Neuroblastoma, code: 705
4290..PEDS-R	A.III.5	140R	54	56	Neurologic abnormality, other, codes: 153, 154
4290..PEDS-R	D.3	140R	54	56	Nevus, dairy, code: 820
4290..PEDS-R	D.4	140R	54	56	Nipples, supernumerary, codes: 829, 830
4290..PEDS-R	D.7	140R	54	56	Nystagmus, codes: 363, 364
4290..PEDS-R	J.4	140R	54	56	Omphalocele, code: 608
4290..PEDS-R	J.11	140R	54	56	Omphalomesenteric cyst, code: 652
4290..PEDS-R	J.6	140R	54	56	Osteogenesis imperfecta, code: 906
4290..PEDS-R	L.7	140R	54	56	Ovary, multicystic, code: 706
4290..PEDS-R	J.11	140R	54	56	Pancreas, anomalous shape, code: 646
4290..PEDS-R	J.11	140R	54	56	Pancreas, dysplasia, code: 637
4290..PEDS-R	J.11	140R	54	56	Pancreas, ectopic, code: 638
4290..PEDS-R	J.11	140R	54	56	Pancreatitis, acute, code: 627
4290..PEDS-R	D.8	140R	54	56	Papilledema, code: 382
4290..PEDS-R	M.1	140R	54	56	Papilloma - sacrum midline, code: 812
4290..PEDS-R	A.I.7	140R	54	56	Paralysis/paresis, hemi, codes: 013, 014
4290..PEDS-R	A.I.10	140R	54	56	Paralysis/paresis, other, codes: 019, 020
4290..PEDS-R	A.I.8	140R	54	56	Paralysis/paresis, para, codes: 015, 016

Data Items Referencing Form PED-8, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-8	A.I.9	140R	54	56	Paralysis/paresis, tetra, codes: 017, 018
4290..PED-8	F.1	140R	54	56	Parenteral fluid administration, code: 967
4290..PED-8	G.4	140R	54	56	Pectus excavatum, codes: 467, 468
4290..PED-8	L.7	140R	54	56	Penile hypoplasia with hypoplastic testes, code: 691
4290..PED-8	L.7	140R	54	56	Periurethral cyst, code: 692
4290..PED-8	D.7	140R	54	56	Petechiae, significant, code: 828
4290..PED-8	J.5	140R	54	56	Pierre Robin syndrome, codes: 895, 896
4290..PED-8	H.10	140R	54	56	Pilonidal sinus, not dimple, codes: 201, 202
4290..PED-8	H.3	140R	54	56	Pneumonia, codes: 481, 482
4290..PED-8	L.7	140R	54	56	Polycystic testicle, code: 708
4290..PED-8	C.7	140R	54	56	Polydactyly, code: 294
4290..PED-8	F.12	140R	54	56	Porencephaly, code: 248
4290..PED-8	B.6	140R	54	56	Post rubella syndrome, code: 911
4290..PED-8	B.6	140R	54	56	Potter's syndrome, code: 912
4290..PED-8	T.13	140R	54	56	Procedures, other, code: 986
4290..PED-8	L.7	140R	54	56	Pseudohermaphrodite, code: 691
4290..PED-8	I.8	140R	54	56	Pulmonary hemosiderosis, code: 598
4290..PED-8	I.8	140R	54	56	Pulmonary hypertension, code: 590
4290..PED-8	I.8	140R	54	56	Pulmonary thrombosis or emboli, code: 599
4290..PED-8	I.8	140R	54	56	Pulmonary: stenosis or hypoplasia, code: 577
4290..PED-8	J.11	140R	54	56	Pyloric stenosis, code: 680
4290..PED-8	H.12	140R	54	56	Rachischisis, code: 250
4290..PED-8	I.10	140R	54	56	[Radiography: x-ray and or fluoroscopy, code: 983
4290..PED-8	F.8	140R	54	56	Ranula (sublingual cyst), code: 441
4290..PED-8	J.11	140R	54	56	Rectal polyp, code: 651
4290..PED-8	J.11	140R	54	56	Rectal prolapse, code: 656
4290..PED-8	L.7	140R	54	56	Rectourethral fistula, code: 709
4290..PED-8	L.7	140R	54	56	Rectovaginal fistula, code: 790
4290..PED-8	A.I.14	140R	54	56	Reflexes: asymmetric, activity or tone, codes: 055, 056
4290..PED-8	A.I.15	140R	54	56	Reflexes: symmetrical but abnormal, codes: 057, 058
4290..PED-8	L.7	140R	54	56	Renal interact, code: 741
4290..PED-8	L.7	140R	54	56	Renal tubular dysfunction, transient, code: 795
4290..PED-8	H.7	140R	54	56	Respiratory abnormality, cardiac conditions, codes: 491, 492
4290..PED-8	H.8	140R	54	56	Respiratory abnormality, CNS abnormality, codes: 493, 494
4290..PED-8	H.9	140R	54	56	Respiratory abnormality, metabolic abnormality, codes: 495, 496
4290..PED-8	H.10	140R	54	56	Respiratory abnormality, other, codes: 497, 498
4290..PED-8	H.6	140R	54	56	Respiratory abnormality, pulmonary hemorrhage, codes: 489, 490
4290..PED-8	H.11	140R	54	56	Respiratory abnormality, unknown condition, codes: 511, 512
4290..PED-8	H.1	140R	54	56	Respiratory distress syndrome: hyaline membrane disease, codes: 479, 480
4290..PED-8	H.4	140R	54	56	Respiratory distress, degree, marked, code: 520
4290..PED-8	H.C	140R	54	56	Respiratory distress, degree, moderate, code: 518
4290..PED-8	H.A	140R	54	56	Respirator distress, degree, none, code: 516

Data Items Referencing Form PED-R, Newborn Diagnostic Summary

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-R	H.6	140R	54	56	Respiratory distress, severe, slight, code: 516
4290..PED-R	F.R	140R	54	56	Respiratory tract, upper, with conditions, other, codes: 433, 434
4290..PED-R	H.16	140R	54	56	Resuscitation after first 5 minutes of life, code: 530
4290..PED-R	H.15	140R	54	56	Resuscitation during first 5 minutes of life, code: 528
4290..PED-R	D.2	140R	54	56	Retrolental fibroplasia, codes: 351, 354
4290..PED-R	H.6	140R	54	56	Rickets and scurvy, code: 910
4290..PED-R	E.5	140R	54	56	Ruptured: tympanic membrane, code: 404
4290..PED-R	F.R	140F	54	56	Salivary gland, ectopic, code: 445
4290..PED-R	J.5	140R	54	56	Scleroma, codes: 823, 824
4290..PED-R	G.2	140R	54	56	Scrotus fixed to half length of penis with chordee, code: 694
4290..PED-R	A.I.1	14 R	54	56	Seizures, codes: 003, 004
4290..PED-R	H.5	140R	54	56	Sex linked recessive, cataract, dental retardation, renal function abnormality, code: 930
4290..PED-R	C.1	140R	54	56	Silicone embolization, massive, code: 957
4290..PED-R	I.H	140R	54	56	Single pulmonary vein and artery, code: 580
4290..PED-R	H.11	140R	54	56	Sinuses, milium, other, codes: 203, 204
4290..PED-R	I.H	140R	54	56	Situs inversus, dextroversion, dextrorotation, dextroposition, code: 957
4290..PED-R	J.6	140R	54	56	Situs inversus, code: 914
4290..PED-R	J.10	140R	54	56	Skin conditions and malformations, other noninfectious, codes: 811, 814
4290..PED-R	H.7	140R	54	56	Skull shape abnormal, codes: 105, 106
4290..PED-R	A.III.1	140R	54	56	Skull: fractured, codes: 119, 120
4290..PED-R	A.III.4	140R	54	56	Spinal cord abnormality, codes: 131, 134
4290..PED-R	F.4	140R	54	56	Spinal puncture, code: 958
4290..PED-R	A.1	140R	54	56	Spleen or liver capsule, tear, code: 674
4290..PED-R	A.1	140R	54	56	Spleen, absent, code: 661
4290..PED-R	A.1	140R	54	56	Spleen, accessory, code: 664
4290..PED-R	J.11	140R	54	56	Stomach ulcer (gastric), code: 629
4290..PED-R	J.10	140R	54	56	Subcutaneous emphysema, code: 839
4290..PED-R	I.5	140R	54	56	Subdural puncture, code: 959
4290..PED-R	B.12	140R	54	56	Suboccipital cyst, code: 229
4290..PED-R	B.12	140R	54	56	Suboccipital sinus tract, code: 251
4290..PED-R	A.I.1R	140R	54	56	Suck abnormal, codes: 063, 064
4290..PED-R	I.H	140R	54	56	Surgery, code: 912
4290..PED-R	C.R	140R	54	56	Syndactyly, code: 296
4290..PED-R	D.6	140R	54	56	Syndromes, other, codes: 807, 808
4290..PED-R	C.2	140R	54	56	Talipes equinovarus, codes: 255, 256
4290..PED-R	I.H	140R	54	56	Tamponade, hemopericardium, hydropericardium, code: 556
4290..PED-R	H.1	140R	54	56	Teratoma: sacrococcygeal area, code: 992
4290..PED-R	G.5	140R	54	56	Thoracic abnormality, other, codes: 469, 470
4290..PED-R	I.H	140R	54	56	Thrombophlebitis, code: 600
4290..PED-R	C.14	140R	54	56	Toes: abnormal placement, position, or deviation, code: 336

Data Items Referencing Form PED-R, Newborn Diagnostic Summary

DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
4290..PED-R	C.9	140R	54	56	Torticollis, codes: 797, 798
4290..PED-R	J.1	140R	54	56	Tracheo-esophageal fistula, codes: 601, 602
4290..PED-R	I.H	140R	54	56	Transposition, code: 570
4290..PED-R	U.2	140R	54	56	Trauma, presumed etiology of conditions, code: 988
4290..PED-R	I.H	140R	54	56	Tricuspid atresia, code: 588
4290..PED-R	H.6	140R	54	56	Trisomy, code: 993
4290..PED-R	H.1	140R	54	56	Tumor (carcinoid) of lung, code: 931
4290..PED-R	C.14	140R	54	56	Ulnar deviation: hands or digits, code: 135
4290..PED-R	L.7	140R	54	56	Ureter, ureters, double, code: 788
4290..PED-R	L.7	140R	54	56	Ureters, tortuosity, stenosis, kink, code: 711
4290..PED-R	L.7	140R	54	56	Urethral meatus: ectopic, code: 606
4290..PED-R	L.7	140R	54	56	Uric acid deposits tubules, code: 757
4290..PED-R	L.5	140R	54	56	Urinary tract obstruction, upper, codes: 679, 680
4290..PED-R	L.7	140R	54	56	Uterus, bicornuate, code: 745
4290..PED-R	L.7	140R	54	56	Vagina, cystic walls protruding from, code: 787
4290..PED-R	L.7	140R	54	56	Vagina, double, code: 711
4290..PED-R	L.7	140R	54	56	Vaginal cyst, code: 697
4290..PED-R	I.H	140R	54	56	Vaginal mucosa: prolapse, code: 696
4290..PED-R	I.H	140R	54	56	Vascular ring, code: 581
4290..PED-R	I.H	140R	54	56	Vena cava, superior, left, code: 579
4290..PED-R	I.H	140R	54	56	Ventricular septal defect, code: 552
4290..PED-R	I.H	140R	54	56	Ventricle, single (absent ventricle), code: 561
4290..PED-R	I.6	140R	54	56	Ventricular puncture, code: 920
4290..PED-R	C.1	140R	54	56	Vertebral: abnormality, codes: 751, 754
4290..PED-R	J.5	140R	54	56	Visceral perforation, codes: 604, 610
4290..PED-R	J.10	140R	54	56	Vitiligo, code: 835
4290..PED-R	J.10	140R	54	56	Volvulus of upper jejunum, code: 624
4290..PED-R	J.11	140R	54	56	Volvulus, code: 656
4290..PED-R	D.10	140R	54	56	Webbed neck, code: 836
4290..PED-R	D.10	140R	54	56	White forelock, code: 812
4290..PED-R	H.1	140R	54	56	Wilms' tumor, code: 994
4291..PED-R		140R	57	80	Diagnoses: procedures: specific, repeat of columns 54-56 for possible diagnosis 2 - 9
4292..PED-R		240R	1	80	Diagnoses: procedures: specific, repeat of card 140R for possible diagnoses 10-18
4293..PED-R		340R	1	80	Diagnoses: procedures: specific, repeat of card 140R for possible diagnoses 19-27
4294..PED-R		440R	1	80	Diagnoses: procedures: specific, repeat of card 140R for possible diagnoses 28-36
4295..PED-R		540R	1	80	Diagnoses: procedures: specific, repeat of card 140R for possible diagnoses 37-45
4296..PED-R		640R	1	80	Diagnoses: procedures: specific, repeat of card 140R for possible diagnoses 46-54

Data items referencing form PFD-H, Newborn Diagnostic Summary

DATA ITEM TO	ITEM NO FROM	CARD NUM	FROM	TO	DATA ITEM NAME
5472....VAR	11		596	596	PFD-H diagnoses: Switch, data availability, any info in variable file locations 591-605, 1=no, 2=yes
5473....VAR	A.I		597	597	Brain abnormality
5474....VAR	A.I.1		598	598	Seizures
5475....VAR	A.I.2		599	599	Hypotonus
5476....VAR	A.I.3		600	600	Hypertonia
5477....VAR	A.I.4		601	601	Jitteriness; tremulousness
5478....VAR	A.I.5		602	602	Hyperactivity
5479....VAR	A.I.7		603	603	Paralysis/paresis, hemi
5480....VAR	A.I.8		604	604	Paralysis/paresis, para
5481....VAR	A.I.9		605	605	Paralysis/paresis, tetra
5482....VAR	A.I.10		606	606	Paralysis/paresis, other
5483....VAR	A.I.11		607	607	Hypotonia
5484....VAR	A.I.12		608	608	Hypoactivity
5485....VAR	A.I.13		609	609	Lethargy
5486....VAR	A.I.14		610	610	Reflexes; asymmetric, activity or tone
5487....VAR	A.I.15		611	611	Reflexes; symmetrical but abnormal
5488....VAR	A.I.16		612	612	Moro; reflex abnormal
5489....VAR	A.I.17		613	613	Cry abnormal
5490....VAR	A.I.18		614	614	Suck abnormal
5491....VAR	A.I.19		615	615	Brain abnormality, other
5492....VAR	A.I.a		616	616	Brain status, abnormal, transient
5493....VAR	A.I.b		617	617	Brain status, abnormal, persistent
5494....VAR	A.I.c		618	618	Brain status, abnormal, on exam or no protocol exam
5495....VAR	A.II.1		619	619	Nerve abnormality, peripheral or cranial; brachial
5496....VAR	A.II.2		620	620	Nerve abnormality, peripheral or cranial; facial
5497....VAR	A.II.3		621	621	Nerve abnormality, peripheral or cranial; ocular
5498....VAR	A.II.4		622	622	Nerve abnormality, peripheral or cranial, other
5499....VAR	A.III.1		623	623	Skull; fracture
5500....VAR	A.III.2		624	624	Cephalohematoma
5501....VAR	A.III.3		625	625	Hemorrhage; intracranial
5502....VAR	A.III.4		626	626	Spinal cord abnormality
5503....VAR	A.III.5		627	627	Neurologic abnormality, other
5504....VAR	B.1		628	628	Anencephaly
5505....VAR	B.2		629	629	Microcephaly
5506....VAR	B.3		630	630	Hydranencephaly
5507....VAR	B.4		631	631	Hydrocephaly
5508....VAR	B.5		632	632	Craniosynostosis
5509....VAR	B.6		633	633	Cranial sutures, abnormal separation
5510....VAR	B.7		634	634	Skull shape abnormal
5511....VAR	B.8		635	635	Encephalocele
5512....VAR	B.9		636	636	Meningomyelocele; meningocele
5513....VAR	B.10		637	637	Pilonidal sinus, not simple

Data Items Referencing Form PFD-H, Newborn Diagnostic Summary

DATA ITEM ID	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5464....VAR	H.11		638	638	Sinuses, midline, other
5465....VAR	H.12		639	639	CNS malformations and related skeletal conditions, other
5466....VAR	C.1		640	640	Vertebral abnormality
5467....VAR	C.2		641	641	Talipes equinovarus
5468....VAR	C.3		642	642	Metatarsus adductus
5469....VAR	C.4		643	643	Calcaneo varus
5470....VAR	C.5		644	644	Hip dislocation or dysplasia; congenital
5471....VAR	C.6		645	645	Extremity; hypoplasia or absence
5472....VAR	C.7		646	646	Polydactyly
5473....VAR	C.8		647	647	Syndactyly
5474....VAR	C.9		648	648	Torticollis
5475....VAR	C.10		649	649	Arthrogryposis multiplex
5476....VAR	C.11		650	650	Achondroplasia
5477....VAR	C.12		651	651	Clavicle, fractured
5478....VAR	C.13		652	652	Fractures, other
5479....VAR	C.14		653	653	Musculoskeletal abnormality, other noninfectious
5480....VAR	D.1		654	654	Chorioretinitis
5481....VAR	D.2		655	655	Retrolental fibroplasia
5482....VAR	D.3		656	656	Cataract
5483....VAR	D.4		657	657	Corneal opacity
5484....VAR	D.5		658	658	Microophthalmia
5485....VAR	D.6		659	659	Blindness
5486....VAR	D.7		660	660	Nystagmus
5487....VAR	D.8		661	661	Eye conditions, other noninfectious
5488....VAR	E.1		662	662	Ears, low set
5489....VAR	E.2		663	663	Ear pinna deformed
5490....VAR	E.3		664	664	Branchial cleft anomaly
5491....VAR	E.4		665	665	Deafness
5492....VAR	E.5		666	666	Ear conditions, other noninfectious
5493....VAR	F.1		667	667	Choanal atresia
5494....VAR	F.2		668	668	Cleft palate
5495....VAR	F.3		669	669	Cleft uvula, bifid
5496....VAR	F.4		670	670	Cleft lip
5497....VAR	F.5		671	671	Cleft jaw
5498....VAR	F.6		672	672	Micrognathia
5499....VAR	F.7		673	673	Epiglottis malformation; larynx malformation
5500....VAR	F.8		674	674	Respiratory tract, upper; mouth conditions, other
5501....VAR	G.1		675	675	Diaphragm anomaly
5502....VAR	G.2		676	676	Lung anomaly
5503....VAR	G.3		677	677	Chest wall anomaly
5504....VAR	G.4		678	678	Pectus excavatum
5505....VAR	G.5		679	679	Thoracic abnormality, other
5506....VAR	H.1		680	680	Respiratory distress syndrome; hyaline membrane disease

Data Items Referencing Form PSD-8, Newborn Diagnostic Summary

DATA ITEM ID	ITEM ON FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5507....VAR	H.2		681	681	Atelectasis, primary
5508....VAR	H.3		682	682	Pneumonia
5509....VAR	H.4		683	683	Aspiration before or during delivery
5510....VAR	H.5		684	684	Aspiration after delivery
5511....VAR	H.6		685	685	Pulmonary hemorrhage
5512....VAR	H.7		686	686	Cardiac condition
5513....VAR	H.8		687	687	CNS abnormality
5514....VAR	H.9		688	688	Metabolic imbalance
5515....VAR	H.10		689	689	Respiratory abnormality
5516....VAR	H.11		690	690	Respiratory abnormality, unknown condition
5517....VAR	H.A		691	691	Respiratory distress, degree, none
5518....VAR	H.B		692	692	Respiratory distress, degree, slight
5519....VAR	H.C		693	693	Respiratory distress, degree, moderate
5520....VAR	H.D		694	694	Respiratory distress, degree, marked
5521....VAR	H.12		695	695	Apnea, primary
5522....VAR	H.13		696	696	Apnea, single episode
5523....VAR	H.14		697	697	Apnea, multiple episodes
5524....VAR	H.15		698	698	Resuscitation during first 5 minutes of life
5525....VAR	H.16		699	699	Resuscitation after first 5 minutes of life
5526....VAR	I.1		700	700	Cardiovascular disease; congenital; acyanotic
5527....VAR	I.2		701	701	Cardiovascular disease; congenital; cyanotic
5528....VAR	I.3		702	702	Fibroelastosis
5529....VAR	I.4		703	703	Cardiac rhythm disorder
5530....VAR	I.5		704	704	Cardiac rate disorder
5531....VAR	I.6		705	705	Cardiac enlargement
5532....VAR	I.7		706	706	Cardiac decompensation
5533....VAR	I.8		707	707	Cardiovascular diagnosis, specific
5534....VAR	I.9		708	708	Cardiovascular diseases and conditions, other
5535....VAR	J.1		709	709	Tracheo esophageal fistula
5536....VAR	J.2		710	710	Duodenal atresia
5537....VAR	J.3		711	711	Malrotation
5538....VAR	J.4		712	712	Omphalocele
5539....VAR	J.5		713	713	Visceral perforation
5540....VAR	J.6		714	714	Imperforate anus; anal atresia
5541....VAR	J.8		715	715	Hernia; inguinal
5542....VAR	J.9		716	716	Hernia; femoral
5543....VAR	J.10		717	717	Hernia; other
5544....VAR	J.11		718	718	Alimentary tract obstructions and conditions, other noninfectious
5545....VAR	K.1		719	719	Liver abnormality; bile duct abnormality; spleen abnormality
5546....VAR	L.1		720	720	Hypospadias
5547....VAR	L.2		721	721	Chordee
5548....VAR	L.3		722	722	Genitalia, external abnormalities, other
5549....VAR	L.4		723	723	Bladder outflow urethral obstruction

Data Items Referencing Form NFD-H, Newborn Diagnostic Summary

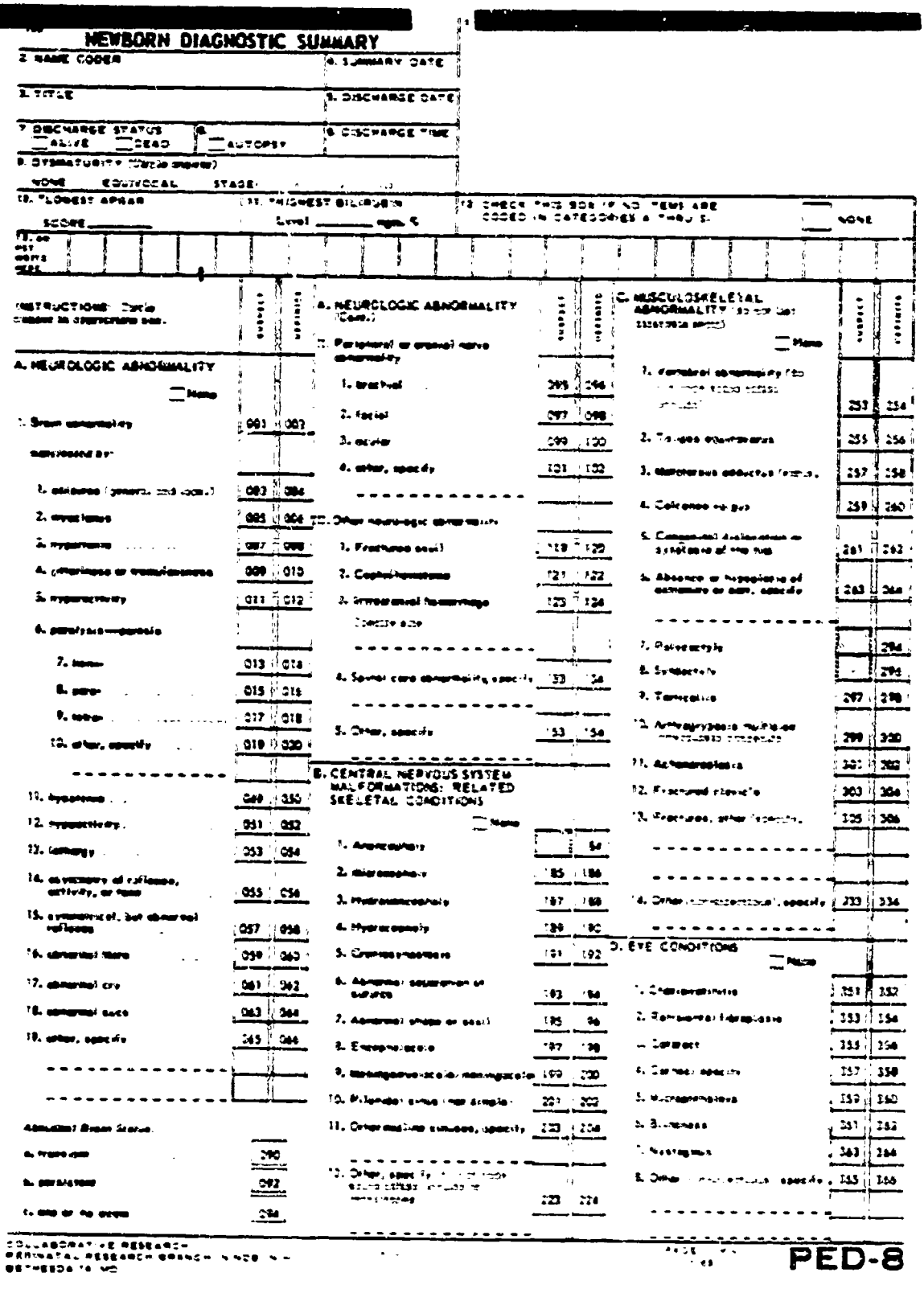
DATA ITEM TO	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
5550....VAR	D.5		724	724	Urinary tract obstruction, other
5551....VAR	D.6		725	725	Cystic kidney
5552....VAR	D.7		726	726	Genitourinary conditions, noninfectious, other
5553....VAR	N.1		727	727	Neoplastic disease, tumors, specified
5554....VAR	N.1		728	728	Erythroblastosis
5555....VAR	N.2		729	729	Erythroblastosis: Rh incompatibility
5556....VAR	N.3		730	730	Erythroblastosis: ABO incompatibility
5557....VAR	N.4		731	731	Erythroblastosis, other specified
5558....VAR	N.5		732	732	Hemolytic disease, other
5559....VAR	N.6		733	733	Coagulation defect
5560....VAR	N.7		734	734	Blood loss, intrauterine
5561....VAR	N.8		735	735	Hemorrhage, major, other specified site
5562....VAR	N.9		736	736	Hematologic conditions, other
5563....VAR	O.1		737	737	Hemangioma: strawberry/portwine
5564....VAR	O.2		738	738	Hemangioma: cavernous
5565....VAR	O.3		739	739	Nevus, hairy
5566....VAR	O.4		740	740	Lymphangioma
5567....VAR	O.5		741	741	Sclerema
5568....VAR	O.6		742	742	Ecchymosis, severe
5569....VAR	O.7		743	743	Petechiae, significant
5570....VAR	O.8		744	744	Nipples, supernumerary
5571....VAR	O.9		745	745	Cafe au lait spots
5572....VAR	O.10		746	746	Skin conditions and malformations, other noninfectious
5573....VAR	P.1		747	747	Infection: septicemia
5574....VAR	P.2		748	748	Infection: central nervous system
5575....VAR	P.3		749	749	Infection: respiratory
5576....VAR	P.4		750	750	Infection: urinary tract
5577....VAR	P.5		751	751	Infection: bone and joint
5578....VAR	P.6		752	752	Infection: heart
5579....VAR	P.7		753	753	Infection: gastrointestinal
5580....VAR	P.8		754	754	Infection: eye
5581....VAR	P.9		755	755	Infection: ear
5582....VAR	P.10		756	756	Infection: cutaneous
5583....VAR	P.11		757	757	Infection: mucous membrane
5584....VAR	P.12		758	758	Infection, other
5585....VAR	J.1		759	759	Neonatal: Down syndrome
5586....VAR	J.2		760	760	Congenital dysgenesis
5587....VAR	J.3		761	761	Adrenogenital syndrome
5588....VAR	J.4		762	762	Marfan syndrome
5589....VAR	J.5		763	763	Pierre Robin syndrome
5590....VAR	J.6		764	764	Syndromes, other
5591....VAR	K.1		765	765	Cretinism: hypothyroidism, infantile
5592....VAR	K.2		766	766	Fibrocystic disease of pancreas: [cystic fibrosis]

Data Items Referencing Form PED-8, Newborn Diagnostic Summary

DATA ITEM TD	ITEM IN FORM	CARD NUM	FROM	TO	DATA ITEM NAME
$593....VAR	H.3		767	767	Hypercalcemia, symptomatic (presumed)
$594....VAR	H.4		768	768	Hypoglycemia, symptomatic (presumed)
$595....VAR	H.5		769	769	Inborn errors of metabolism
$596....VAR	H.6		770	770	Endocrine diseases, other; metabolic diseases, other
$597....VAR	I.1		771	771	Blood: transfusions, simple
$598....VAR	I.2		772	772	Blood: transfusions, exchange
$599....VAR	I.3		773	773	Parenteral: fluids administered
$600....VAR	I.4		774	774	Spinal puncture
$601....VAR	I.5		775	775	Subdural puncture
$602....VAR	I.6		776	776	Ventricular puncture
$603....VAR	I.7		777	777	Anesthesia, general
$604....VAR	I.8		778	778	Surgery
$605....VAR	I.9		779	779	Chromosome studies
$606....VAR	I.10		780	780	[Radiography]: x-ray and or; fluoroscopy
$607....VAR	I.11		781	781	Antibiotics, internal administration
$608....VAR	I.12		782	782	Electroencephalography (EEG)
$609....VAR	I.13		783	783	Procedures, other
$610....VAR	G.1		784	784	Diseases and conditions, other specified
$611....VAR	H.1		785	785	Anoxia, presumed etiology of conditions
$612....VAR	H.2		786	786	Trauma, presumed etiology of conditions
$613....VAR	11.A		787	787	Neurologic abnormality, number of, (PED-8 sect A)
$614....VAR	11.B		788	788	Central nervous system malformation and related skeletal conditions, number of, (PED-8 sect B)
$615....VAR	11.C		789	789	Musculoskeletal abnormality, number of, (PED-8 sect C)
$616....VAR	11.D		790	790	Eye conditions, number of, (PED-8 sect D)
$617....VAR	11.E		791	791	Ear conditions, number of, (PED-8 sect E)
$618....VAR	11.F		792	792	Oral conditions; respiratory tract, upper, conditions, number of, (PED-8 sect F)
$619....VAR	11.G		793	793	Thoracic abnormality, number of, (PED-8 sect G)
$620....VAR	11.H		794	794	Respiratory abnormality
$621....VAR	11.I		795	795	Cardiovascular conditions, number of, (PED-8 sect I)
$622....VAR	11.J		796	796	Alimentary tract malformations and conditions, number of, (PED-8 sect J)
$623....VAR	11.K		797	797	Liver abnormality; bile duct abnormality; spleen abnormality, number of, (PED-8 sect K)
$624....VAR	11.L		798	798	Genitourinary conditions, number of, (PED-8 sect L)
$625....VAR	11.M		799	799	Neoplastic disease; tumors, number of, (PED-8 sect M)
$626....VAR	11.N		800	800	Hematologic conditions, number of, (PED-8 sect N)
$627....VAR	11.O		801	801	Skin conditions and malformations, number of, (PED-8 sect O)
$628....VAR	11.P		802	802	Infection, number of, (PED-8 sect P)
$629....VAR	11.Q		803	803	Syndromes, number of, (PED-8 sect Q)
$630....VAR	11.R		804	804	Endocrine diseases; metabolic diseases, number of, (PED-8 sect R)
$631....VAR	11.T		805	805	Procedures, number of, (PED-8 sect T)

Data Items Referencing Form PED-H, Newborn Diagnostic Summary

DATA ITEM ID	ITEM ON FORM	CARD NUM	PROG ID	DATA ITEM NAME
%692....VAU	11.5,13.U		R06	R06 diseases, conditions and presumptive etiologic impressions not elsewhere specified, number of, (PED-H sect 3 & U)
6246....M-5			10	10 malformations congenital, nfn, 1 year, source of information, PED-8



NEWBORN DIAGNOSTIC SUMMARY

PED-8

NEWBORN DIAGNOSTIC SUMMARY

E. EAR CONDITIONS

☐ None

	Suspected	Definite
1. Low set ears	391	392
2. Deformed ear pinna	393	394
3. Branchial cleft anomaly (preauricular sinus, etc.)	395	396
4. Deafness	397	398
5. Other [illegible], specify	399	400

F. UPPER RESPIRATORY TRACT AND MOUTH CONDITIONS

☐ None

	Suspected	Definite
1. Choanal atresia	419	420
2. Cleft palate		422
3. Cleft uvula (only)		424
4. Cleft lip		426
5. Cleft gum		428
6. Micrognathia	429	430
7. Malformation of epiglottis and larynx	431	432
8. Other [illegible], specify [illegible]	433	434

G. THORACIC ABNORMALITY except respiratory and cardiovascular conditions

☐ None

	Suspected	Definite
1. Anomaly of diaphragm	447	448
2. Anomaly of lung, specify	449	450
3. Anomaly of chest wall, specify	459	460
4. Pectus excavatum	467	468
5. Other, specify	469	470

H. RESPIRATORY ABNORMALITY

☐ None

Respiratory abnormality associated with:

	Suspected	Definite
1. Respiratory distress syndrome (Hyaline membrane disease)	479	480
2. Primary atelectasis	481	482
3. Pneumonia	483	484
4. Aspiration before or during delivery	485	486
5. Aspiration after delivery	487	488
6. Pulmonary hemorrhage	489	490
7. Cardiac conditions	491	492
8. C.N.S. abnormality	493	494
9. Metabolic imbalance	495	496
10. Other, specify	497	498
11. Unknown condition	511	512

Associated degree of respiratory distress

a. None	514
b. Slight	516
c. Moderate	518
d. Marked	520

Significant respiratory events

12. Primary apnea	22
13. Single apneic episode	524
14. Multiple apneic episodes	523
15. Resuscitation during first 5 minutes of life	522
16. Resuscitation after first 5 minutes of life	529

I. CARDIOVASCULAR CONDITIONS

☐ None

	Suspected	Definite
1. Acyanotic CHD	531	532
2. Cyanotic CHD	533	534
3. [illegible]	535	536
4. Disorders of rhythm	537	538
5. Disorders of rate	539	540
6. Cardiac enlargement	541	542
7. Decompensation	543	544
8. Specific C-V diagnosis		546
9. Other, specify (see [illegible])	573	574

J. ALIMENTARY TRACT MALFORMATIONS AND OTHER CONDITIONS

☐ None

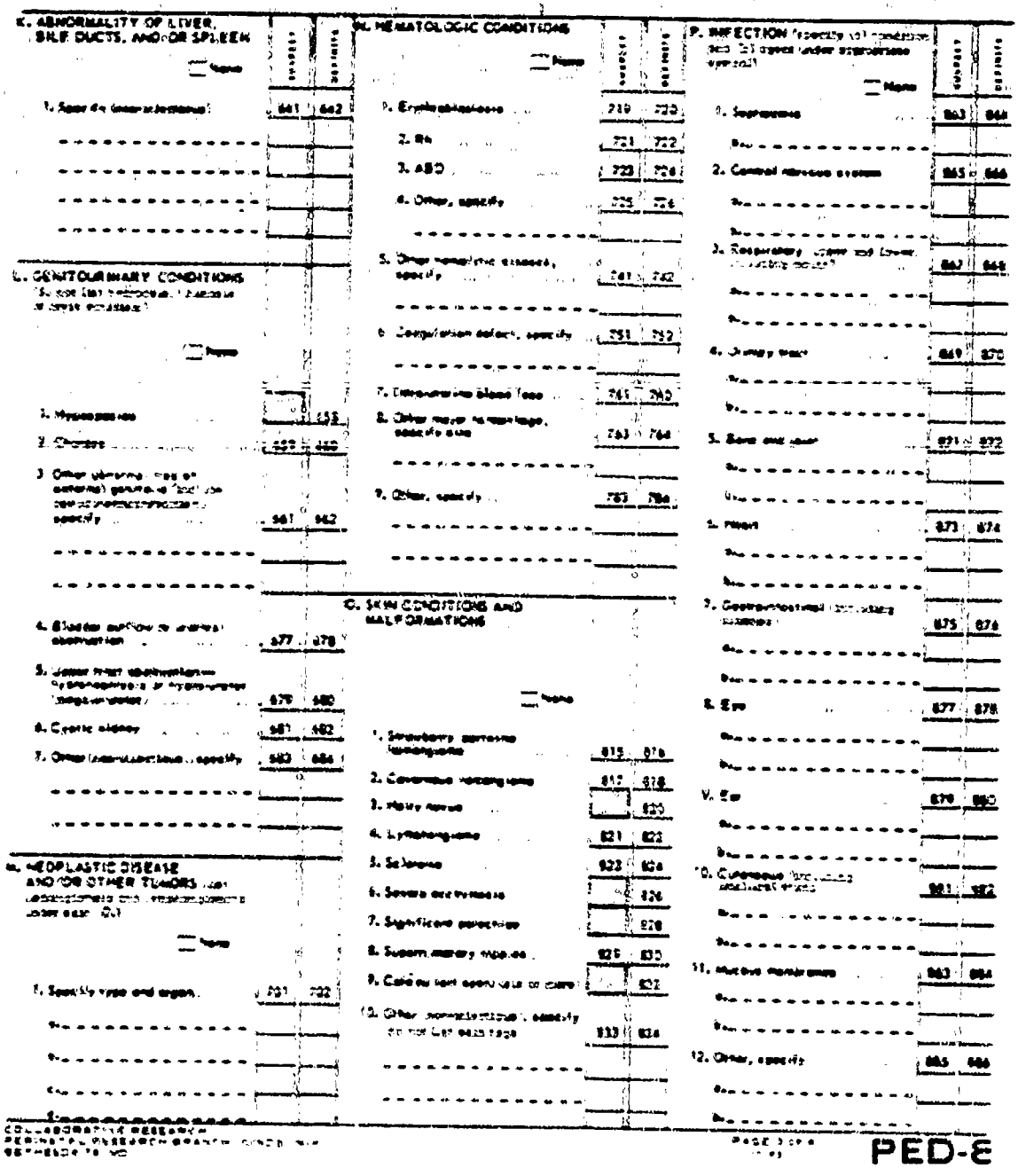
	Suspected	Definite
1. Tracheoesophageal fistula	601	602
2. Duodenal atresia	603	604
3. Malrotation	605	606
4. Omphalocele		608
5. Visceral perforation	609	610
6. Imperforate anus		612
7. Hernia, specify [illegible]		
8. Inguinal	613	614
9. Femoral	615	616
10. Other, specify	617	618
11. Other [illegible], specify	621	622

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH NINDB NIH
BETHESDA 14, MD.

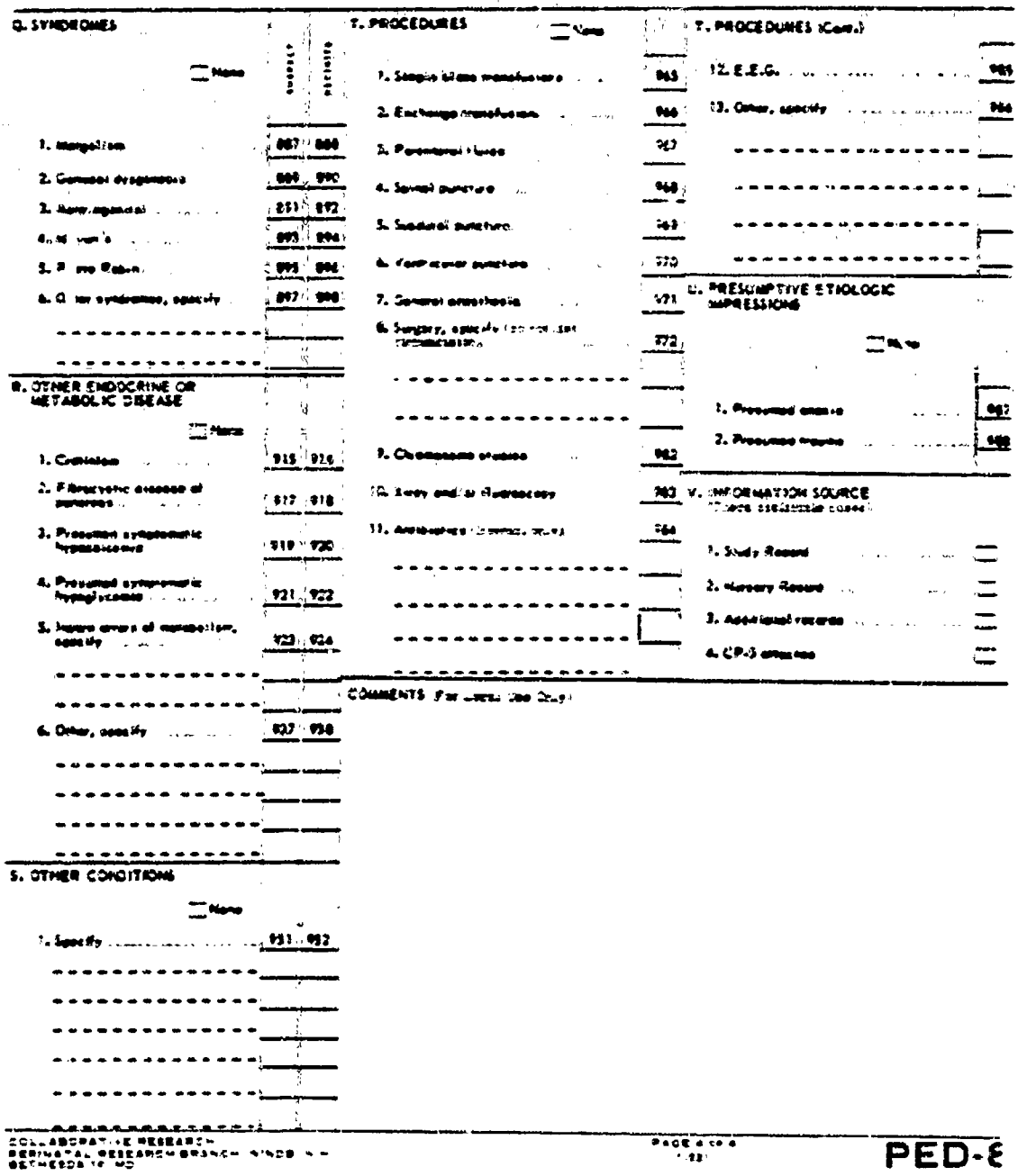
PAGE 2 OF 4
[illegible]

PED-8

NEWBORN DIAGNOSTIC SUMMARY



NEWBORN DIAGNOSTIC SUMMARY



Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	4290..PED-H	140A	54	56	Diagnoses: procedures: specific, nth, (where max n = 54)
	4292..PED-H	240A	1	80	Diagnoses: procedures: specific, repeat of card 140A for possible diagnoses 10-18
	4293..PED-H	340A	1	80	Diagnoses: procedures: specific, repeat of card 140A for possible diagnoses 19-27
	4294..PED-H	440A	1	80	Diagnoses: procedures: specific, repeat of card 140A for possible diagnoses 28-36
	4295..PED-H	540A	1	80	Diagnoses: procedures: specific, repeat of card 140A for possible diagnoses 37-45
	4296..PED-H	640A	1	80	Diagnoses: procedures: specific, repeat of card 140A for possible diagnoses 46-54
	4291..PED-H	140A	57	80	Diagnoses: procedures: specific, repeat of columns 54-56 for possible diagnosis 2 - 9
	6246....#=5		10	10	Malformation: congenital, nth, 1 year, source of information, PED-H
A.I	5423....VAR		597	597	Brain abnormality
A.I	4290..PED-H	140A	54	56	Brain abnormality, codes: 001, 002
A.I.A	5442....VAR		616	616	Brain status, abnormal, transient
A.I.A	4290..PED-H	140A	54	56	Brain status, abnormal, transient, code: 000
A.I.B	5443....VAR		617	617	Brain status, abnormal, persistent
A.I.B	4290..PED-H	140A	54	56	Brain status, abnormal, persistent, code: 002
A.I.C	5444....V `		618	618	Brain status, abnormal, on exam or no protocol exam
A.I.C	4290..PED-H	140A	54	56	Brain status, abnormal, one exam or no protocol exam, code: 004
A.I.1	5424....VAR		598	598	Seizures
A.I.1	4290..PED-H	140A	54	56	Seizures, codes: 003, 004
A.I.2	5425....VAR		599	599	Myoclonus
A.I.2	4290..PED-H	140A	54	56	Myoclonus, codes: 005, 006
A.I.3	5426....VAR		600	600	Hypertonia
A.I.3	4290..PED-H	140A	54	56	Hypertonia, codes: 007, 008
A.I.4	5427....VAR		601	601	Jitteriness: tremulousness
A.I.4	4290..PED-H	140A	54	56	Jitteriness: tremulousness, codes: 009, 010
A.I.5	5428....VAR		602	602	Hyperactivity
A.I.5	4290..PED-H	140A	54	56	Hyperactivity, codes: 011, 012
A.I.7	5429....VAR		603	603	Paralysis/paresis, hemi
A.I.7	4290..PED-H	140A	54	56	Paralysis/paresis, hemi, codes: 013, 014
A.I.8	5430....VAR		604	604	Paralysis/paresis, para
A.I.8	4290..PED-H	140A	54	56	Paralysis/paresis, para, codes: 015, 016
A.I.9	5431....VAR		605	605	Paralysis/paresis, tetra
A.I.9	4290..PED-H	140A	54	56	Paralysis/paresis, tetra, codes: 017, 018
A.I.10	5432....VAR		606	606	Paralysis/paresis, other
A.I.10	4290..PED-H	140A	54	56	Paralysis/paresis, other, codes: 019, 020
A.I.11	5433....VAR		607	607	Hypotonia
A.I.11	4290..PED-H	140A	54	56	Hypotonia, codes: 049, 050

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.I.12	5434....VAR		608	608	Hyperactivity
A.I.12	4290..PED-H	140A	54	56	Hyperactivity, codes: 051, 052
A.I.13	5435....VAR		609	609	Lethargy
A.I.13	4290..PED-H	140A	54	56	Lethargy, codes: 053, 054
A.I.14	5436....VAR		610	610	Reflexes: asymmetric, activity or tone
A.I.14	4290..PED-H	140A	54	56	Reflexes: asymmetric, activity or tone, codes: 055, 056
A.I.15	5437....VAR		611	611	Reflexes: symmetrical but abnormal
A.I.15	4290..PED-H	140A	54	56	Reflexes: symmetrical but abnormal, codes: 057, 058
A.I.16	5438....VAR		612	612	Moro: reflex abnormal
A.I.16	4290..PED-H	140A	54	56	Moro: reflex abnormal, codes: 059, 060
A.I.17	5439....VAR		613	613	Cry abnormal
A.I.17	4290..PED-H	140A	54	56	Cry abnormal, codes: 061, 062
A.I.18	5440....VAR		614	614	Suck abnormal
A.I.18	4290..PED-H	140A	54	56	Suck abnormal, codes: 063, 064
A.I.19	5441....VAR		615	615	Brain abnormality, other
A.I.19	4290..PED-H	140A	54	56	Brain abnormality, other, codes: 065, 066
A.II.1	5445....VAR		619	619	Nerve abnormality, peripheral or cranial: brachial
A.II.1	4290..PED-H	140A	54	56	Nerve abnormality, peripheral or cranial: brachial, codes: 095, 096
A.II.2	5446....VAR		620	620	Nerve abnormality, peripheral or cranial: facial
A.II.2	4290..PED-H	140A	54	56	Nerve abnormality, peripheral or cranial: facial, codes: 097, 098
A.II.3	5447....VAR		621	621	Nerve abnormality, peripheral or cranial: ocular
A.II.3	4290..PED-H	140A	54	56	Nerve abnormality, peripheral or cranial: ocular, codes: 099, 100
A.II.4	5448....VAR		622	622	Nerve abnormality, peripheral or cranial, other
A.II.4	4290..PED-H	140A	54	56	Nerve abnormality, peripheral or cranial, other, codes: 101, 102
A.III.1	5449....VAR		623	623	Skull: fractured
A.III.1	4290..PED-H	140A	54	56	Skull: fractured, codes: 119, 120
A.III.2	5450....VAR		624	624	Cephalhematoma
A.III.2	4290..PED-H	140A	54	56	Cephalhematoma, codes: 121, 122
A.III.3	5451....VAR		625	625	Hemorrhage: intracranial
A.III.3	4290..PED-H	140A	54	56	Hemorrhage: intracranial, codes: 123, 124
A.III.4	5452....VAR		626	626	Spinal cord abnormality
A.III.4	4290..PED-H	140A	54	56	Spinal cord abnormality, codes: 133, 134
A.III.5	5453....VAR		627	627	Neurologic abnormality, other
A.III.5	4290..PED-H	140A	54	56	Neurologic abnormality, other, codes: 153, 154
B.1	5454....VAR		628	628	Anencephaly
B.1	4290..PED-H	140A	54	56	Anencephaly, codes: 184
B.2	5455....VAR		629	629	Microcephaly
B.2	4290..PED-H	140A	54	56	Microcephaly, codes: 185, 186
B.3	5456....VAR		630	630	Hydranencephaly
B.3	4290..PED-H	140A	54	56	Hydranencephaly, codes: 187, 188
B.4	5457....VAR		631	631	Hydrocephaly
B.4	4290..PED-H	140A	54	56	Hydrocephaly, codes: 189, 190

Form Item Numbers linked to Data Items on PED-8, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
A.5	5458....VAR		632	632	Craniosynostosis
A.5	4290..PED-8	140A	54	56	Craniosynostosis, codes: 191, 192
A.6	5459....VAR		633	633	Cranial sutures, abnormal separation
A.6	4290..PED-8	140A	54	56	Cranial sutures, abnormal separation, codes: 193, 194
A.7	5460....VAR		634	634	Skull shape abnormal
A.7	4290..PED-8	140A	54	56	Skull shape abnormal, codes: 195, 196
A.8	5461....VAR		635	635	Encephalocele
A.8	4290..PED-8	140A	54	56	Encephalocele, codes: 197, 198
A.9	5462....VAR		636	636	Meningomyelocele; meningocele
A.9	4290..PED-8	140A	54	56	Meningomyelocele; meningocele, codes: 199, 200
A.10	5463....VAR		637	637	Pilonidal sinus, not dimple
A.10	4290..PED-8	140A	54	56	Pilonidal sinus, not dimple, codes: 201, 202
A.11	5464....VAR		638	638	Sinuses, midline, other
A.11	4290..PED-8	140A	54	56	Sinuses, midline, other, codes: 203, 204
A.12	4290..PED-8	140A	54	56	Absence of corpus callosum, code: 226
A.12	4290..PED-8	140A	54	56	Absence or hypoplasia of: olfactory nerve and/or bulb, code: 228
A.12	4290..PED-8	140A	54	56	Absence: sacrum, code: 232
A.12	4290..PED-8	140A	54	56	Absent: posterior lobe pituitary, aplasia pituitary, code: 240
A.12	4290..PED-8	140A	54	56	Arrhinencephaly, code: 234
A.12	4290..PED-8	140A	54	56	Cerebral hypoplasia-frontal, code: 236
A.12	5465....VAR		639	639	CNS malformations and related skeletal conditions, other
A.12	4290..PED-8	140A	54	56	CNS malformations and related skeletal conditions, other, codes: 221, 224
A.12	4290..PED-8	140A	54	56	Cord abnormality, code: 230
A.12	4290..PED-8	140A	54	56	Craniochisis, code: 252
A.12	4290..PED-8	140A	54	56	Cyst; septum pellucidum, code: 238
A.12	4290..PED-8	140A	54	56	Cystic mass: lumbosacral area, code: 240
A.12	4290..PED-8	140A	54	56	Hydromyelia, code: 242
A.12	4290..PED-8	140A	54	56	Hypoplasia; skull bones, code: 244
A.12	4290..PED-8	140A	54	56	Macrocephaly, code: 227
A.12	4290..PED-8	140A	54	56	Malformation, non-specific; brain, code: 246
A.12	4290..PED-8	140A	54	56	Porencephaly, code: 248
A.12	4290..PED-8	140A	54	56	Rachischisis, code: 250
A.12	4290..PED-8	140A	54	56	Suboccipital cyst, code: 229
A.12	4290..PED-8	140A	54	56	Suboccipital; sinus tract, code: 251
C.1	5466....VAR		640	640	Vertebral abnormality
C.1	4290..PED-8	140A	54	56	Vertebral; abnormality, codes: 253, 254
C.2	5467....VAR		641	641	Talipes equinovarus
C.2	4290..PED-8	140A	54	56	Talipes equinovarus, codes: 255, 256
C.3	5468....VAR		642	642	Metatarsus adductus
C.3	4290..PED-8	140A	54	56	Metatarsus adductus, codes: 257, 258
C.4	5469....VAR		643	643	Calcaneo Varqus
C.4	4290..PED-8	140A	54	56	Calcaneo Varqus, codes: 259, 260

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
C.5	5470....VAR		644	644	Hip dislocation or dysplasia: congenital
C.5	4290..PED-H	140A	54	56	Hip: dislocation or dysplasia, congenital, codes: 261, 262
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: cleft hallux, code: 285
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: femoral epiphysis, distal, code: 265
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: femur, code: 268
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: fibula, code: 272
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: fingers, code: 288
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: foot, code: 274
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: forearm, code: 279
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: hand, code: 286
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: humerus, code: 280
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: lower extremity, code: 266
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: radius, code: 282
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: ribs and spine, code: 293
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: rib, anomalies of, code: 287
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: ribs, code: 292
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: tibia, code: 270
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: toes, code: 276
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: ulna, code: 284
C.6	4290..PED-H	140A	54	56	Absence or hypoplasia of: upper extremity, code: 278
C.6	4290..PED-H	140A	54	56	Absent; sternocleidomastoid muscle, code: 289
C.6	4290..PED-H	140A	54	56	Extremity or part, specify: absence or hypoplasia of, codes: 263, 264
C.6	5471....VAR		645	645	Extremity: hypoplasia or absence
C.7	5472....VAR		646	646	Polydactyly
C.7	4290..PED-H	140A	54	56	Polydactyly, code: 294
C.8	5473....VAR		647	647	Syndactyly
C.8	4290..PED-H	140A	54	56	Syndactyly, code: 296
C.9	5474....VAR		648	648	Torticollis
C.9	4290..PED-H	140A	54	56	Torticollis, codes: 297, 298
C.10	5475....VAR		649	649	Arthrogryposis multiplex
C.10	4290..PED-H	140A	54	56	Arthrogryposis multiplex, codes: 299, 300
C.11	5476....VAR		650	650	Achondroplasia
C.11	4290..PED-H	140A	54	56	Achondroplasia, codes: 301, 302
C.12	5477....VAR		651	651	Clavicle, fractured
C.12	4290..PED-H	140A	54	56	Clavicle, fractured, codes: 101, 304
C.13	5478....VAR		652	652	Fractures, other
C.13	4290..PED-H	140A	54	56	Fractures, other, codes: 305, 306
C.14	4290..PED-H	140A	54	56	Abnormal position of: fingers, code: 338
C.14	4290..PED-H	140A	54	56	Absence: pubic fusion, code: 340
C.14	4290..PED-H	140A	54	56	Calcaneo varus (also talipes), code: 344
C.14	4290..PED-H	140A	54	56	Cervical ribs, code: 342
C.14	4290..PED-H	140A	54	56	Congenital dislocation: knees, code: 346

Form Item Numbers linked to Data Items on PED-8, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
C.14	4290..PED-8	140A	54	56	Congenital dislocation: wrist, code: 348
C.14	4290..PED-8	140A	54	56	Constricting bands: hand, code: 350
C.14	4290..PED-8	140A	54	56	Digits, marked separation of 2 or more, code: 332
C.14	4290..PED-8	140A	54	56	Dislocation: humerous (shoulder), code: 347
C.14	4290..PED-8	140A	54	56	Dislocation: toe, 5th, code: 349
C.14	4290..PED-8	140A	54	56	Enlargement: thighs and leg, code: 345
C.14	4290..PED-8	140A	54	56	Fibrous dysplasia of bone, code: 343
C.14	4290..PED-8	140A	54	56	Flexion deformity, contractions, code: 341
C.14	4290..PED-8	140A	54	56	Genu recurvatum, code: 330
C.14	4290..PED-8	140A	54	56	Hammer toes, code: 339
C.14	4290..PED-8	140A	54	56	Hemihypertrophy (left side body), code: 328
C.14	4290..PED-8	140A	54	56	Hypermobile or extensible: joints, code: 337
C.14	4290..PED-8	140A	54	56	Hypoplasia: jaw, code: 331
C.14	4290..PED-8	140A	54	56	Maxilla and mandible, abnormally long, code: 327
C.14	5479....VAR		653	653	Musculoskeletal abnormality, other noninfectious
C.14	4290..PED-8	140A	54	56	Musculoskeletal abnormality, other noninfectious, codes: 333, 334
C.14	4290..PED-8	140A	54	56	Toes: abnormal placement, position, or deviation, code: 336
D.1	5480....VAR		654	654	Chorioretinitis
D.1	4290..PED-8	140A	54	56	Chorioretinitis, codes: 351, 352
D.2	5481....VAR		655	655	Retrolental fibroplasia
D.2	4290..PED-8	140A	54	56	Retrolental fibroplasia, codes: 353, 354
D.3	5482....VAR		656	656	Cataract
D.3	4290..PED-8	140A	54	56	Cataract, codes: 355, 356
D.4	5483....VAR		657	657	Corneal opacity
D.4	4290..PED-8	140A	54	56	Corneal opacity, codes: 357, 358
D.5	5484....VAR		658	658	Microphthalmia
D.5	4290..PED-8	140A	54	56	Microphthalmia, codes: 359, 360
D.6	5485....VAR		659	659	Blindness
D.6	4290..PED-8	140A	54	56	Blindness, codes: 361, 362
D.7	5486....VAR		660	660	Nystagmus
D.7	4290..PED-8	140A	54	56	Nystagmus, codes: 363, 364
D.8	4290..PED-8	140A	54	56	Aniridia, code: 370
D.8	4290..PED-8	140A	54	56	Anophthalmia, code: 368
D.8	4290..PED-8	140A	54	56	Buphthalmos, glaucoma, code: 372
D.8	4290..PED-8	140A	54	56	Coloboma, code: 374
D.8	4290..PED-8	140A	54	56	Exophthalmos, proptosis, code: 376
D.8	5487....VAR		661	661	Eye conditions, other noninfectious
D.8	4290..PED-8	140A	54	56	Eye conditions, other noninfectious, codes: 365, 366
D.8	4290..PED-8	140A	54	56	Eye herniation, code: 378
D.8	4290..PED-8	140A	54	56	Hypoplasia of optic nerve, code: 380
D.8	4290..PED-8	140A	54	56	Papilledema, code: 382
F.1	5488....VAR		662	662	Ears, low set

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
F.1	4290..PED-B	140B	54	56	Face, low set, codes: 391, 392
F.2	5489....VAR		663	663	Ear pinna deformed
F.2	4290..PED-B	140B	54	56	Ear pinna deformed, codes: 393, 394
F.3	5490....VAR		664	664	Branchial cleft anomaly
F.3	4290..PED-B	140B	54	56	Branchial cleft anomaly, codes: 395, 396
F.4	5491....VAR		665	665	Deafness
F.4	4290..PED-B	140B	54	56	Deafness, codes: 397, 398
F.5	4290..PED-B	140B	54	56	Absence: meatus, external: ear, code: 402
F.5	5492....VAR		666	666	Ear conditions, other noninfectious
F.5	4290..PED-B	140B	54	56	Ear conditions, other noninfectious, codes: 399, 400
F.5	4290..PED-B	140B	54	56	Ruptured: tympanic membrane, code: 404
F.1	5493....VAR		667	667	Choanal atresia
F.1	4290..PED-B	140B	54	56	Choanal atresia, codes: 419, 420
F.2	5494.... VAR		668	668	Cleft palate
F.2	4290..PED-B	140B	54	56	Cleft palate, code: 422
F.3	5495....VAR		669	669	Cleft uvula, bifid
F.3	4290..PED-B	140B	54	56	Cleft uvula, bifid, code: 424
F.4	5496....VAR		670	670	Cleft lip
F.4	4290..PED-B	140B	54	56	Cleft lip, code: 426
F.5	5497....VAR		671	671	Cleft gum
F.5	4290..PED-B	140B	54	56	Cleft gum, code: 428
F.6	5498....VAR		672	672	Micrognathia
F.6	4290..PED-B	140B	54	56	Micrognathia, codes: 429, 430
F.7	5499....VAR		673	673	Epiglottis malformation: larynx malformation
F.7	4290..PED-B	140B	54	56	Epiglottis malformation: larynx malformation, codes: 431, 432
F.8	4290..PED-B	140B	54	56	Absent: antrum, floor of, code: 438
F.8	4290..PED-B	140B	54	56	Absent: nose, bridge of, code: 436
F.8	4290..PED-B	140B	54	56	Absent: uvula, code: 440
F.8	4290..PED-B	140B	54	56	Anomaly: lung: pleural defect, congenital, code: 435
F.8	4290..PED-B	140B	54	56	Bifid tongue, code: 442
F.8	4290..PED-B	140B	54	56	Choanal stenosis with absence nasal cartilage, code: 444
F.8	4290..PED-B	140B	54	56	Ranula (sublingual cyst), code: 441
F.8	5500....VAR		674	674	Respiratory tract, upper: mouth conditions, other
F.8	4290..PED-B	140B	54	56	Respiratory tract, upper: mouth conditions, other, codes: 433, 434
F.8	4290..PED-B	140B	54	56	Salivary gland, ectopic, code: 445
G.1	5501....VAR		675	675	Diaphragm anomaly
G.1	4290..PED-B	140B	54	56	Diaphragm anomaly, codes: 447, 448
G.2	4290..PED-B	140B	54	56	Absence: lung, right or left, code: 452
G.2	4290..PED-B	140B	54	56	Anomaly: lung: cyst or cysts, code: 456
G.2	4290..PED-B	140B	54	56	Anomaly: lung: hypoplasia or immaturity, code: 458
G.2	4290..PED-B	140B	54	56	Anomaly: lung: lobe or lobes absence or incomplete division, codes: 454
G.2	4290..PED-B	140B	54	56	Anomaly: lung: lobes, extra, code: 457

Form Item Numbers linked to Data Items on PFD=H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
G.2	4290..PFD=B	140B	54	56	Anomaly: lung: pneumatocele, code: 455
G.2	4290..PFD=B	140B	54	56	Anomaly: lung: pulmonary cyst, code: 453
G.2	5502....VAR		676	676	Lung anomaly
G.2	4290..PFD=B	140B	54	56	Lung anomaly, codes: 449, 450
G.3	4290..PFD=B	140B	54	56	Anomaly: chest wall: deformed thorax, code: 462
G.3	4290..PFD=B	140B	54	56	Anomaly: chest wall: pectus carinatum (Keel) (Pigeon), code: 464
G.3	4290..PFD=B	140B	54	56	Anomaly: chest wall: ribs, flaring, code: 466
G.3	4290..PFD=B	140B	54	56	Anomaly: chest wall: scapula (winged scapula), code: 461
G.3	5503....VAR		677	677	Chest wall anomaly
G.3	4290..PFD=B	140B	54	56	Chest wall anomaly, codes: 459, 460
G.4	5504....VAR		678	678	Pectus excavatum
G.4	4290..PFD=B	140B	54	56	Pectus excavatum, codes: 467, 468
G.5	4290..PFD=B	140B	54	56	Atelectasis (comp. collapse lung), code: 477
G.5	4290..PFD=B	140B	54	56	Bronchi, compression of, code: 474
G.5	4290..PFD=B	140B	54	56	Congenital laryngeal stridor, inspiratory strider, code: 471
G.5	4290..PFD=B	140B	54	56	Hemathorax, code: 476
G.5	4290..PFD=B	140B	54	56	Hydrothorax, bilateral or unilateral, code: 472
G.5	4290..PFD=B	140B	54	56	Mediastinal emphysema, and/or pneumothorax, code: 475
G.5	4290..PFD=B	140B	54	56	Rupture: trachea, code: 473
G.5	5505....VAR		679	679	Thoracic abnormality, other
G.5	4290..PFD=B	140B	54	56	Thoracic abnormality, other, codes: 469, 470
H.A	5517....VAR		691	691	Respiratory distress, degree, none
H.A	4290..PFD=B	140B	54	56	Respiratory distress, degree, none, code: 514
H.B	5518....VAR		692	692	Respiratory distress, degree, slight
H.B	4290..PFD=B	140B	54	56	Respiratory distress, degree, slight, code: 516
H.C	5519....VAR		693	693	Respiratory distress, degree, moderate
H.C	4290..PFD=B	140B	54	56	Respiratory distress, degree, moderate, code: 518
H.D	5520....VAR		694	694	Respiratory distress, degree, marked
H.D	4290..PFD=B	140B	54	56	Respiratory distress, degree, marked, code: 520
H.1	5506....VAR		680	680	Respiratory distress syndrome: hyaline membrane disease
H.1	4290..PFD=B	140B	54	56	Respiratory distress syndrome: hyaline membrane disease, codes: 479, 480
H.2	5507....VAR		681	681	Atelectasis, primary
H.2	4290..PFD=B	140B	54	56	Atelectasis, primary, codes: 481, 482
H.3	5508....VAR		682	682	Pneumonia
H.3	4290..PFD=B	140B	54	56	Pneumonia, codes: 483, 484
H.4	5509....VAR		683	683	Aspiration before or during delivery
H.4	4290..PFD=B	140B	54	56	Aspiration before or during delivery, codes: 485, 486
H.5	5510....VAR		684	684	Aspiration after delivery
H.5	4290..PFD=B	140B	54	56	Aspiration after delivery, codes: 487, 488
H.6	5511....VAR		685	685	Pulmonary hemorrhage
H.6	4290..PFD=B	140B	54	56	Respiratory abnormality, pulmonary hemorrhage, codes: 489, 490
H.7	5512....VAR		686	686	Cardiac conditions

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
H.7	4290..PED-H	140A	54	56	Respiratory abnormality, cardiac conditions, codes: 491, 492
H.8	5513....VAR		687	687	CNS abnormality
H.8	4290..PED-H	140A	54	56	Respiratory abnormality, CNS abnormality, codes: 493, 494
H.9	5514....VAR		688	688	Metabolic imbalance
H.9	4290..PED-H	140A	54	56	Respiratory abnormality, metabolic abnormality, codes: 495, 496
H.10	4290..PED-H	140A	54	56	Emphysema, code: 499
H.10	4290..PED-H	140A	54	56	Interstitial emphysema, code: 500
H.10	4290..PED-H	140A	54	56	Mucous plug in trachea, code: 501
H.10	5515....VAR		689	689	Respiratory abnormality
H.10	4290..PED-H	140A	54	56	Respiratory abnormality, other, codes: 497, 498
H.11	5516....VAR		690	690	Respiratory abnormality, unknown condition
H.11	4290..PED-H	140A	54	56	Respiratory abnormality, unknown condition, codes: 511, 512
H.12	5521....VAR		695	695	Apnea, primary
H.12	4290..PED-H	140A	54	56	Apnea, primary, code: 522
H.13	5522....VAR		696	696	Apnea, single episode
H.13	4290..PED-H	140A	54	56	Apnea, single episode, code: 524
H.14	5523....VAR		697	697	Apnea, multiple episodes
H.14	4290..PED-H	140A	54	56	Apnea, multiple episodes, code: 526
H.15	5524....VAR		698	698	Resuscitation during first 5 minutes of life
H.15	4290..PED-H	140A	54	56	Resuscitation during first 5 minutes of life, code: 528
H.16	5525....VAR		699	699	Resuscitation after first 5 minutes of life
H.16	4290..PED-H	140A	54	56	Resuscitation after first 5 minutes of life, code: 530
I.1	5526....VAR		700	700	Cardiovascular disease; congenital; acyanotic
I.1	4290..PED-H	140A	54	56	Cardiovascular disease; congenital; acyanotic, codes: 531, 532
I.2	5527....VAR		701	701	Cardiovascular disease; congenital; cyanotic
I.2	4290..PED-H	140A	54	56	Cardiovascular disease; congenital; cyanotic, codes: 533, 534
I.3	5528....VAR		702	702	Fibroelastosis
I.3	4290..PED-H	140A	54	56	Fibroelastosis, codes: 535, 536
I.4	5529....VAR		703	703	Cardiac rhythm disorder
I.4	4290..PED-H	140A	54	56	Cardiac rhythm disorder, codes: 537, 538
I.5	5530....VAR		704	704	Cardiac rate disorder
I.5	4290..PED-H	140A	54	56	Cardiac rate disorder, codes: 539, 540
I.6	5531....VAR		705	705	Cardiac enlargement
I.6	4290..PED-H	140A	54	56	Cardiac enlargement, codes: 541, 542
I.7	5532....VAR		706	706	Cardiac decompensation
I.7	4290..PED-H	140A	54	56	Cardiac decompensation, codes: 543, 544
I.8	4290..PED-H	140A	54	56	Abnormal aortic cusp, code: 730
I.8	4290..PED-H	140A	54	56	Absent; coronary artery, code: 582
I.8	4290..PED-H	140A	54	56	Absent; coronary sinus, code: 578
I.8	4290..PED-H	140A	54	56	Absent; renal artery, code: 591
I.8	4290..PED-H	140A	54	56	Absent; umbilical artery, code: 554
I.8	4290..PED-H	140A	54	56	Aneurism of; pulmonary artery, sinus valsalva, aortic valve, codes: 591

Form Item Numbers linked to data items on PFD-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
I.A	4290..PFD-H	140A	54	56	Anomalous: pulmonary venous connection and/or return, code: 558
I.A	4290..PFD-H	140A	54	56	Anomalous: subclavian, right, code: 555
I.A	4290..PFD-H	140A	54	56	Anomalus muscle band at septum, code: 729
I.A	4290..PFD-H	140A	54	56	Anomaly: vena cava, inferior, with azygous drainage, code: 594
I.A	4290..PFD-H	140A	54	56	Aorta, over-riding, code: 597
I.A	4290..PFD-H	140A	54	56	Aorta: hypoplastic, code: 548
I.A	4290..PFD-H	140A	54	56	Aortic arch, right, code: 540
I.A	4290..PFD-H	140A	54	56	Aortic arch: anomaly, code: 559
I.A	4290..PFD-H	140A	54	56	Aortic atresia, code: 547
I.A	4290..PFD-H	140A	54	56	Atresia: mitral valve, code: 563
I.A	4290..PFD-H	140A	54	56	Atrial septal defect, code: 549
I.A	4290..PFD-H	140A	54	56	Atrioventricular canal (communication), code: 550
I.A	4290..PFD-H	140A	54	56	Bilat: aortic valve, code: 583
I.A	4290..PFD-H	140A	54	56	Blalock Shunt, Post-op., code: 584
I.A	5531....VAH		707	707	Cardiovascular diagnosis, specific
I.A	4290..PFD-H	140A	54	56	Cardiovascular diagnosis, specific, code: 546
I.A	4290..PFD-H	140A	54	56	Carotid, missing (left), code: 575
I.A	4290..PFD-H	140A	54	56	Coarctation, code: 551
I.A	4290..PFD-H	140A	54	56	Common truncus, truncus arteriosis, code: 564
I.A	4290..PFD-H	140A	54	56	Cor biloculer, code: 586
I.A	4290..PFD-H	140A	54	56	Cor triloculare, code: 565
I.A	4290..PFD-H	140A	54	56	Ductus arteriosus, code: 551
I.A	4290..PFD-H	140A	54	56	Ebstein's complex, code: 566
I.A	4290..PFD-H	140A	54	56	Ectopic cord tip ventricle fused with left eye absent disc, code: 595
I.A	4290..PFD-H	140A	54	56	Endocardial cushion effect, code: 567
I.A	4290..PFD-H	140A	54	56	Endocardial sclerosis, code: 568
I.A	4290..PFD-H	140A	54	56	Heart, fatty degeneration, code: 596
I.A	4290..PFD-H	140A	54	56	Hypertrophy: ventricle, right, code: 572
I.A	4290..PFD-H	140A	54	56	Hypoplasia: auricle (left), code: 562
I.A	4290..PFD-H	140A	54	56	Hypoplastic: atrium, left, code: 571
I.A	4290..PFD-H	140A	54	56	Hypoplastic: heart, left, code: 585
I.A	4290..PFD-H	140A	54	56	Hypoplastic: ventricle, right, code: 569
I.A	4290..PFD-H	140A	54	56	Inf. vena cava to anat. left atrium, code: 587
I.A	4290..PFD-H	140A	54	56	Mitral valve, bifil ant. leaf or rudiment valve, code: 560
I.A	4290..PFD-H	140A	54	56	Myocardinal necrosis, code: 597
I.A	4290..PFD-H	140A	54	56	Persistent: vena cava, superior, code: 576
I.A	4290..PFD-H	140A	54	56	Pulmonary hemangiomatosis, code: 598
I.A	4290..PFD-H	140A	54	56	Pulmonary hypertension, code: 590
I.A	4290..PFD-H	140A	54	56	Pulmonary thrombosis or emboli, code: 599
I.A	4290..PFD-H	140A	54	56	Pulmonary: atresia or hypoplasia, code: 577
I.A	4290..PFD-H	140A	54	56	Single: pulmonary vein and artery, code: 589
I.A	4290..PFD-H	140A	54	56	Situs inversis, levroversion, dextrorotation, dextropos: ion, code: 557

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
I.A	4290..PED-H	140A	54	56	Tamponade, hemopericardium, hydropericardium, code: 556
I.A	4290..PED-H	140A	54	56	Thrombophlebitis, code: 600
I.A	4290..PED-H	140A	54	56	Transposition, code: 570
I.A	4290..PED-H	140A	54	56	Tricuspid atresia, code: 588
I.A	4290..PED-H	140A	54	56	Vascular ring, code: 581
I.A	4290..PED-H	140A	54	56	Vena cava, superior, left, code: 579
I.A	4290..PED-H	140A	54	56	Ventricular septal defect, code: 552
I.A	4290..PED-H	140A	54	56	Ventricle, single (absent ventricle), code: 561
I.B	5534....VAR		708	708	Cardiovascular diseases and conditions, other
I.B	4290..PED-H	140A	54	56	Cardiovascular diseases and conditions, other, codes: 573, 574
J.1	5535....VAR		709	709	Tracheo esophageal fistula
J.1	4290..PED-H	140A	54	56	Tracheo-esophageal fistula, codes: 601, 602
J.2	5536....VAR		710	710	Duodenal atresia
J.2	4290..PED-H	140A	54	56	Duodenal atresia, codes: 603, 604
J.3	5537....VAR		711	711	Malrotation
J.3	4290..PED-H	140A	54	56	Malrotation, codes: 605, 606
J.4	5538....VAR		712	712	Omphalocele
J.4	4290..PED-H	140A	54	56	Omphalocele, code: 608
J.5	4290..PED-H	140A	54	56	Absence; ductus arteriosis, code: 611
J.5	5539....VAR		713	713	Visceral perforation
J.5	4290..PED-H	140A	54	56	Visceral perforation, codes: 609, 610
J.6	5540....VAR		714	714	Imperforate anus((anal atresia)
J.6	4290..PED-H	140A	54	56	Imperforate anus((anal atresia), code: 612
J.8	5541....VAR		715	715	Hernia; inguinal
J.8	4290..PED-H	140A	54	56	Hernia; inguinal, codes: 613, 614
J.9	5542....VAR		716	716	Hernia; femoral
J.9	4290..PED-H	140A	54	56	Hernia; femoral, codes: 615, 616
J.10	5543....VAR		717	717	Hernia; other
J.10	4290..PED-H	140A	54	56	Hernia; other, codes: 617, 618
J.10	4290..PED-H	140A	54	56	Hernia; supra umbilical, code: 623
J.10	4290..PED-H	140A	54	56	Hernia; ventral, code: 619
J.10	4290..PED-H	140A	54	56	Volvulus of upper jejunum, code: 624
J.11	4290..PED-H	140A	54	56	Abdominal adhesions, code: 748
J.11	4290..PED-H	140A	54	56	Absence; ligament of Treitz, code: 643
J.11	4290..PED-H	140A	54	56	Adhesions of cecum to liver, code: 630
J.11	4290..PED-H	140A	54	56	Adhesive bands; duodenal obstruction, secondary, code: 626
J.11	5544....VAR		718	718	Alimentary tract malformations and conditions, other noninfectious
J.11	4290..PED-H	140A	54	56	Alimentary tract malformations and conditions, other noninfectious, codes: 621, 622
J.11	4290..PED-H	140A	54	56	Anal fissure, code: 637
J.11	4290..PED-H	140A	54	56	Atresia; colon or parts thereof, code: 633
J.11	4290..PED-H	140A	54	56	Atresia; small bowel or parts thereof, code: 634
J.11	4290..PED-H	140A	54	56	Bowel, large, acute sprositis of, code: 628

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
J.11	4290..PED-H	140A	54	56	Cecum, bowel, duplication, code: 635
J.11	4290..PED-H	140A	54	56	Chalasia, code: 636
J.11	4290..PED-H	140A	54	56	Duodenal obstruction, code: 651
J.11	4290..PED-H	140A	54	56	Esophageal atresia, code: 639
J.11	4290..PED-H	140A	54	56	Hemoperitoneum, code: 743
J.11	4290..PED-H	140A	54	56	Hirschsprung's disease (aganglionosis of ileum and colon), code: 746
J.11	4290..PED-H	140A	54	56	Hypoplastic small intestines, code: 631
J.11	4290..PED-H	140A	54	56	Ileostomy, prolapse, code: 747
J.11	4290..PED-H	140A	54	56	Intussusception, code: 745
J.11	4290..PED-H	140A	54	56	Meckel's diverticulum, code: 645
J.11	4290..PED-H	140A	54	56	Meconium ileus, code: 648
J.11	4290..PED-H	140A	54	56	Meconium peritonitis, code: 649
J.11	4290..PED-H	140A	54	56	Meinecion, code: 650
J.11	4290..PED-H	140A	54	56	Mesenteric infarct, code: 744
J.11	4290..PED-H	140A	54	56	Mesentery, common, single mesentery, code: 646
J.11	4290..PED-H	140A	54	56	Microcolon, code: 647
J.11	4290..PED-H	140A	54	56	Omphalomesenteric cyst, code: 652
J.11	4290..PED-H	140A	54	56	Pancreas, anomalous share, code: 640
J.11	4290..PED-H	140A	54	56	Pancreas, dysplasia, code: 617
J.11	4290..PED-H	140A	54	56	Pancreas, ectopic, code: 638
J.11	4290..PED-H	140A	54	56	Pancreatitis, acute, code: 627
J.11	4290..PED-H	140A	54	56	Pyloric stenosis, code: 640
J.11	4290..PED-H	140A	54	56	Rectal polyp, code: 653
J.11	4290..PED-H	140A	54	56	Rectal prolapse, code: 654
J.11	4290..PED-H	140A	54	56	Stomach ulcer (gastric), code: 629
J.11	4290..PED-H	140A	54	56	Volvulus, code: 656
K.1	4290..PED-H	140A	54	56	Bile ducts, focal malformation, code: 667
K.1	4290..PED-H	140A	54	56	Biliary atresia, code: 665
K.1	4290..PED-H	140A	54	56	Ectopic spleen in pancreas, code: 672
K.1	4290..PED-H	140A	54	56	Gall bladder, absence, code: 657
K.1	4290..PED-H	140A	54	56	Hematoma; liver, subcapsular, code: 671
K.1	4290..PED-H	140A	54	56	Hemosiderosis, code: 673
K.1	4290..PED-H	140A	54	56	Hepatitis, giant cell, code: 668
K.1	4290..PED-H	140A	54	56	Hepatitis, herpetic, code: 669
K.1	4290..PED-H	140A	54	56	Intrahepatic vein thrombosis and hepatic infraction and necrosis, code: 670
K.1	5545....VAR		719	719	Liver abnormality; bile duct abnormality; spleen abnormality
K.1	4290..PED-H	140A	54	56	Liver abnormality; bile duct abnormality; spleen abnormality, codes: 641, 642
K.1	4290..PED-H	140A	54	56	Liver, degeneration, code: 666
K.1	4290..PED-H	140A	54	56	Spleen or liver capsule, tear, code: 674
K.1	4290..PED-H	140A	54	56	Spleen, absent, code: 663

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM		DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
8.1		4290..PED-H	140A	54	56	Spleen, accessory, code: 664
8.1		5546....VAR		720	720	Hypospadias
8.1		4290..PED-H	140A	54	56	Hypospadias, code: 658
8.2		5547....VAR		721	721	Chordee
8.2	*	4290..PED-H	140A	54	56	Chordee, codes: 659, 660
8.3		5548....VAR		722	722	Genitalia, external abnormalities, other
8.3		4290..PED-H	140A	54	56	Genitalia, external abnormalities, other, codes: 661, 662
8.3		4290..PED-H	140A	54	56	Genitalia, external abnormality, other; clitoral hypertrophy, code: 675
8.3		4290..PED-H	140A	54	56	Genitalia, external abnormality, other; ventral foreskin - congenital, absence of, code: 676
8.4		5549....VAR		723	723	Bladder outflow; urethral obstruction
8.4		4290..PED-H	140A	54	56	Bladder outflow; urethral obstruction, codes: 677, 678
8.5		5550....VAR		724	724	Urinary tract obstruction, upper
8.5		4290..PED-H	140A	54	56	Urinary tract obstruction, upper, codes: 679, 680
8.6		5551....VAR		725	725	Cystic; kidney
8.6		4290..PED-H	140A	54	56	Cystic; kidney, codes: 681, 682
8.7		4290..PED-H	140A	54	56	Absent glomerulogenesis with persistence mullerian duct, code: 716
8.7		4290..PED-H	140A	54	56	Absent; bladder, right hemi-trigone, code: 713
8.7		4290..PED-H	140A	54	56	Absent; kidney hilar, code: 706
8.7		4290..PED-H	140A	54	56	Absent; ureter, code: 714
8.7		4290..PED-H	140A	54	56	Absent; ureters (both), code: 718
8.7		4290..PED-H	140A	54	56	Agenesis; bladder, code: 715
8.7		4290..PED-H	140A	54	56	Bladder diverticulum, code: 707
8.7		4290..PED-H	140A	54	56	Cervix, double, code: 709
8.7		4290..PED-H	140A	54	56	Dysgenesis; ovaries, code: 702
8.7		4290..PED-H	140A	54	56	Ectopia, code: 687
8.7		4290..PED-H	140A	54	56	Exstrophy of bladder, code: 698
8.7		4290..PED-H	140A	54	56	Follicular cyst; ovary, code: 699
8.7		4290..PED-H	140A	54	56	Gartner's duct cyst, code: 688
8.7		5552....VAR		726	726	Genitourinary conditions, noninfectious, other
8.7		4290..PED-H	140A	54	56	Genitourinary conditions, noninfectious, other, codes: 683, 684
8.7		4290..PED-H	140A	54	56	Glomerular cyst, code: 700
8.7		4290..PED-H	140A	54	56	Horseshoe; kidney, code: 703
8.7		4290..PED-H	140A	54	56	Hymen cyst, code: 685
8.7		4290..PED-H	140A	54	56	Hymen; imperforate, code: 690
8.7		4290..PED-H	140A	54	56	Hypertrophy; bladder, code: 705
8.7		4290..PED-H	140A	54	56	Hypoplastic; kidney, code: 704
8.7		4290..PED-H	140A	54	56	Hypoplastic; vagina and vulva, code: 689
8.7		4290..PED-H	140A	54	56	Kidney, decreased function, code: 794
8.7		4290..PED-H	140A	54	56	Kidney, non-functioning, code: 791
8.7		4290..PED-H	140A	54	56	Kidney, single, code: 710
8.7		4290..PED-H	140A	54	56	Ovary, multicystic, code: 706

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnosis Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
I..?	4290..PED-H	140A	54	56	Penile hypoplasia with hypoplastic testes, code: 691
I..?	4290..PED-H	140A	54	56	Periurethral cyst, code: 697
I..?	4290..PED-H	140A	54	56	Polycystic testicle, code: 709
I..?	4290..PED-H	140A	54	56	Pseudohermaphrodite, code: 691
I..?	4290..PED-H	140A	54	56	Rectourethral fistula, code: 709
I..?	4290..PED-H	140A	54	56	Rectovaginal fistula, code: 709
I..?	4290..PED-H	140A	54	56	Renal infarct, code: 791
I..?	4290..PED-H	140A	54	56	Renal tubular dysfunction, transient, code: 795
I..?	4290..PED-H	140A	54	56	Scrotum fixed to half length of penis with chordee, code: 694
I..?	4290..PED-H	140A	54	56	Ureter, ureters, double, code: 789
I..?	4290..PED-H	140A	54	56	Ureters, tortuousity, stenosis, kink, code: 711
I..?	4290..PED-H	140A	54	56	Urethral meatus; ectopic, code: 686
I..?	4290..PED-H	140A	54	56	Uric acid deposit: tubules, code: 712
I..?	4290..PED-H	140A	54	56	Uterus, bicornuate, code: 785
I..?	4290..PED-H	140A	54	56	Vagina, cystic mass protruding from, code: 787
I..?	4290..PED-H	140A	54	56	Vagina, double, code: 717
I..?	4290..PED-H	140A	54	56	Vaginal cyst, code: 697
I..?	4290..PED-H	140A	54	56	Vaginal mucosa: prolapse, code: 696
N.1	4290..PED-H	140A	54	56	Hepatoblastoma (primary), code: 989
N.1	4290..PED-H	140A	54	56	Hygroma, code: 996
N.1	4290..PED-H	140A	54	56	Leukemia, code: 814
N.1	4290..PED-H	140A	54	56	Lung; tumor of bronchial origin, large (hamartoma?), code: 990
N.1	4290..PED-H	140A	54	56	Mass, intra abdominal calcified, code: 987
N.1	4290..PED-H	140A	54	56	Mass, neck, code: 998
N.1	5553....VAR		727	727	Neoplastic disease, tumors, specified
N.1	4290..PED-H	140A	54	56	Neoplastic disease, tumors, specified, codes: 701, 702
N.1	4290..PED-H	140A	54	56	Neuroblastoma, code: 995
N.1	4290..PED-H	140A	54	56	Papilloma - vagina midline, code: 812
N.1	4290..PED-H	140A	54	56	Teratoma; sacrococcygeal area, code: 992
N.1	4290..PED-H	140A	54	56	Tumor (carcinoid); lung, code: 993
N.1	4290..PED-H	140A	54	56	Wilms' tumor, code: 994
N.1	5554....VAR		728	728	Erythroblastosis
N.1	4290..PED-B	140A	54	56	Erythroblastosis, codes: 719, 720
N.2	5555....VAR		729	729	Erythroblastosis; Rh incompatibility
N.2	4290..PED-H	140A	54	56	Erythroblastosis; Rh incompatibility, codes: 721, 722
N.3	5556....VAR		730	730	Erythroblastosis; ABO incompatibility
N.3	4290..PED-H	140A	54	56	Erythroblastosis; ABO incompatibility, codes: 723, 724
N.4	5557....VAR		731	731	Erythroblastosis, other specified
N.4	4290..PED-H	140A	54	56	Erythroblastosis, other, specified, codes: 725, 726
N.4	4290..PED-H	140A	54	56	Erythroblastosis, other; C incompatability, code: 728
N.4	4290..PED-H	140A	54	56	Erythroblastosis, other; LEA factor, code: 727
N.5	5558....VAR		732	732	Hemolytic disease, other
N.5	4290..PED-H	140A	54	56	Hemolytic disease, other, codes: 741, 742

Form Item Numbers Linked to Data Items on 1FDU-R, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
N.6	5550....VAR		731	733	Coagulation defect
N.6	4290..PED=B	140B	54	56	Coagulation defect, specify, codes: 751, 752
N.6	4290..PED=B	140B	54	56	Coagulation defect: factor 7 (VII) def., code: 753
N.6	4290..PED=B	140B	54	56	Coagulation defect: factor X def., code: 754
N.6	4290..PED=B	140B	54	56	Coagulation defect: hypoprothrombinemia, code: 758
N.6	4290..PED=B	140B	54	56	Coagulation defect: DPCA and/or PTC, code: 755
N.6	4290..PED=B	140B	54	56	Coagulation defect: thrombocytopenia, code: 759
N.6	4290..PED=B	140B	54	56	Coagulation defect: vitamin K def., code: 756
N.7	5560....VAR		734	734	Blood loss, intrauterine
N.7	4290..PED=B	140B	54	56	Blood loss, intrauterine, codes: 761, 762
N.8	5561....VAR		735	735	Hemorrhage, major, other specified site
N.8	4290..PED=B	140B	54	56	Hemorrhage, major, other specified site, codes: 763, 764
N.9	5562....VAR		736	736	Hematologic conditions, other
N.9	4290..PED=B	140B	54	56	Hematologic conditions, other, codes: 783, 784
O.1	5563....VAR		737	737	Hemangioma: strawberry/portwine
O.1	4290..PED=B	140B	54	56	Hemangioma: strawberry/portwine, codes: 815, 816
O.2	5564....VAR		738	738	Hemangioma: cavernous
O.2	4290..PED=B	140B	54	56	Hemangioma: cavernous, codes: 817, 818
O.3	5565....VAR		739	739	Nevus, hairy
O.3	4290..PED=B	140B	54	56	Nevus, hairy, code: 820
O.4	5566....VAR		740	740	Lymphangioma
O.4	4290..PED=B	140B	54	56	Lymphangioma, codes: 821, 822
O.5	5567....VAR		741	741	Scleroma
O.5	4290..PED=B	140B	54	56	Scleroma, codes: 823, 824
O.6	5568....VAR		742	742	Ecchymosis, severe
O.6	4290..PED=B	140B	54	56	Ecchymosis, severe, code: 826
O.7	5569....VAR		743	743	Petechiae, significant
O.7	4290..PED=B	140B	54	56	Petechiae, significant, code: 828
O.8	5570....VAR		744	744	Nipples, supernumerary
O.8	4290..PED=B	140B	54	56	Nipples, supernumerary, codes: 829, 830
O.9	5571....VAR		745	745	Cafe au lait spots
O.9	4290..PED=B	140B	54	56	Cafe au lait spots, code: 832
O.10	4290..PED=B	140B	54	56	Lack of subcutaneous fat, code: 838
O.10	5572....VAR		746	746	Skin conditions and malformations, other noninfectious
O.10	4290..PED=B	140B	54	56	Skin conditions and malformations, other noninfectious, codes: 833, 834
O.10	4290..PED=B	140B	54	56	Subcutaneous emphysema, code: 839
O.10	4290..PED=B	140B	54	56	Vitiligo, code: 835
O.10	4290..PED=B	140B	54	56	Webbed neck, code: 836
O.10	4290..PED=B	140B	54	56	White forelock, code: 837
P.1	5573....VAR		747	747	Infection: meningitis
P.1	4290..PED=B	140B	54	56	Infection: meningitis, codes: 861, 862
P.2	5574....VAR		748	748	Infection: central nervous system

Form Item Numbers linked to data items on PED-8, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
P.1	4290..PED-8	140A	54	56	Infection: central nervous system, codes: 865, 866
P.2	5574....VAR		748	748	Infection: CNS
P.3	5575....VAR		749	749	Infection: respiratory
P.3	4290..PED-8	140A	54	56	Infection: respiratory, codes: 867, 868
P.4	5576....VAR		750	750	Infection: urinary tract
P.4	4290..PED-8	140A	54	56	Infection: urinary tract, codes: 869, 870
P.5	5577....VAR		751	751	Infection: bone and joint
P.5	4290..PED-8	140A	54	56	Infection: bone and joint, codes: 871, 872
P.6	5578....VAR		752	752	Infection: heart
P.6	4290..PED-8	140A	54	56	Infection: heart, codes: 873, 874
P.7	5579....VAR		753	753	Infection: gastrointestinal
P.7	4290..PED-8	140A	54	56	Infection: gastrointestinal, codes: 875, 876
P.8	5580....VAR		754	754	Infection: eye
P.8	4290..PED-8	140A	54	56	Infection: eye, codes: 877, 878
P.9	5581....VAR		755	755	Infection: ear
P.9	4290..PED-8	140A	54	56	Infection: ear, codes: 879, 880
P.10	5582....VAR		756	756	Infection: cutaneous
P.10	4290..PED-8	140A	54	56	Infection: cutaneous, codes: 881, 882
P.11	5583....VAR		757	757	Infection: mucous membrane
P.11	4290..PED-8	140A	54	56	Infection: mucous membrane, codes: 883, 884
P.12	5584....VAR		758	758	Infection, other
P.12	4290..PED-8	140A	54	56	Infection, other, codes: 885, 886
Q.1	5585....VAR		759	759	Mongolism: (Down syndrome)
Q.1	4290..PED-8	140A	54	56	Mongolism: (Down syndrome), codes: 887, 888
Q.2	5586....VAR		760	760	Gonadal dysgenesis
Q.2	4290..PED-8	140A	54	56	Gonadal dysgenesis, codes: 889, 890
Q.3	5587....VAR		761	761	Adrenogenital syndrome
Q.3	4290..PED-8	140A	54	56	Adrenogenital syndrome, codes: 891, 892
Q.4	5588....VAR		762	762	Marfan syndrome
Q.4	4290..PED-8	140A	54	56	Marfan's syndrome, codes: 893, 894
Q.5	5589....VAR		763	763	Pierre Robin syndrome
Q.5	4290..PED-8	140A	54	56	Pierre Robin syndrome, codes: 895, 896
Q.6	4290..PED-8	140A	54	56	Acrocephaly-syndactyly of Apert, code: 901
Q.6	4290..PED-8	140A	54	56	Chondrodystrophia calcificans congenita, code: 902
Q.6	4290..PED-8	140A	54	56	Cleidocranial dysotosis, code: 904
Q.6	4290..PED-8	140A	54	56	Cornelia de Lange syndrome, code: 905
Q.6	4290..PED-8	140A	54	56	Cranio carpal tarsal dystrophy syndrome, code: 925
Q.6	4290..PED-8	140A	54	56	Dandy-Walker syndrome, code: 907
Q.6	4290..PED-8	140A	54	56	Eagle's syndrome, code: 908
Q.6	4290..PED-8	140A	54	56	Horner's syndrome, code: 909
Q.6	4290..PED-8	140A	54	56	Koerber Salus Elschning syndrome, code: 910
Q.6	4290..PED-8	140A	54	56	Lowe's syndrome, code: 911
Q.6	4290..PED-8	140A	54	56	Osteogenesis imperfecta, code: 906

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
O.6	4290..PED-H	140A	54	56	Post rubella syndrome, code: 913
O.6	4290..PED-H	140A	54	56	Potter's syndrome, code: 912
O.6	4290..PED-H	140A	54	56	Situs inversus, code: 914
O.6	5590....VAR		764	764	Syndromes, other
O.6	4290..PED-H	140A	54	56	Syndromes, other, codes: 897, 898
O.6	4290..PED-H	140A	54	56	Trisomy, code: 903
P.1	5591....VAR		765	765	Cretinism; hypothyroidism, infantile
P.1	4290..PED-H	140A	54	56	Cretinism; hypothyroidism, infantile, codes: 915, 916
P.2	5592....VAR		766	766	Fibrocystic disease of pancreas; (cystic fibrosis)
P.2	4290..PED-H	140A	54	56	Fibrocystic disease of pancreas; (cystic fibrosis), codes: 917, 918
P.3	5593....VAR		767	767	Hypocalcemia, symptomatic (presumed)
P.3	4290..PED-H	140A	54	56	Hypocalcemia, symptomatic (presumed), codes: 919, 920
P.4	5594....VAR		768	768	Hypoglycemia, symptomatic (presumed)
P.4	4290..PED-H	140A	54	56	Hypoglycemia, symptomatic (presumed), codes: 921, 922
P.5	4290..PED-H	140A	54	56	Albinism, code: 928
P.5	4290..PED-H	140A	54	56	Glucose-6-phosphate dehydrogenase def., code: 929
P.5	4290..PED-H	140A	54	56	Glycogen storage disease, code: 926
P.5	5595....VAR		769	769	Inborn errors of metabolism
P.5	4290..PED-H	140A	54	56	Inborn errors of metabolism, codes: 923, 924
P.5	4290..PED-H	140A	54	56	Sex linked recessive, cataract, mental retardation, renal function abnormality, code: 930
P.6	4290..PED-H	140A	54	56	Adrenal atrophy hypoplasia, hemorrhage, necrosis, code: 939
P.6	4290..PED-H	140A	54	56	Adrenal hyperplasia, code: 940
P.6	4290..PED-H	140A	54	56	Cytomegaly adrenal cortex, code: 941
P.6	5596....VAR		770	770	Endocrine diseases, other; metabolic diseases, other
P.6	4290..PED-H	140A	54	56	Endocrine diseases, other; metabolic diseases, other, codes: 937, 938
P.6	4290..PED-H	140A	54	56	Frontal and parietal bones, under mineralization of, code: 973
P.6	4290..PED-H	140A	54	56	Goiter, code: 963
P.6	4290..PED-H	140A	54	56	Hyperbilirubinemia ? mother's milk, code: 962
P.6	4290..PED-H	140A	54	56	Hyperphosphatasia, code: 943
P.6	4290..PED-H	140A	54	56	Hyperplasia (focal); thyroid, code: 944
P.6	4290..PED-H	140A	54	56	Hyperplastic islets of Langerhans, code: 945
P.6	4290..PED-H	140A	54	56	Hyperplastic; pituitary, code: 946
P.6	4290..PED-H	140A	54	56	Hypoalbuminemia, code: 947
P.6	4290..PED-H	140A	54	56	Hypogammaglobulinemia, code: 964
P.6	4290..PED-H	140A	54	56	Hypoproteinemia, code: 948
P.6	4290..PED-H	140A	54	56	Rickets and scurvy, code: 949
S.1	5610....VAR		784	784	Diseases and conditions, other specified
S.1	4290..PED-H	140A	54	56	Diseases and conditions, other specified, codes: 951, 952
S.1	4290..PED-H	140A	54	56	Fever of undetermined etiology, F.U.O., code: 953
S.1	4290..PED-H	140A	54	56	Hyperthermia, code: 954

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
S.1	4290..PED-H	140A	54	56	Hypoglycemia, chemical, code: 950
S.1	4290..PED-H	140A	54	56	Hypothermia, code: 955
S.1	4290..PED-H	140A	54	56	Macrosomia, code: 958
S.1	4290..PED-H	140A	54	56	Narcotic withdrawal syndrome, code: 956
S.1	4290..PED-H	140A	54	56	Silicone embolization, massive, code: 957
T.1	5597....VAR		771	771	Blood: transfusions, simple
T.1	4290..PED-H	140A	54	56	Blood: transfusions, simple, code: 965
T.2	5598....VAR		772	772	Blood: transfusions, exchange
T.2	4290..PED-H	140A	54	56	Blood: transfusions, exchange, code: 966
T.3	4290..PED-H	140A	54	56	Parenteral: fluid administration, code: 967
T.3	5599....VAR		773	773	Parenteral: fluids administered
T.4	5600....VAR		774	774	Spinal puncture
T.4	4290..PED-H	140A	54	56	Spinal puncture, code: 968
T.5	5601....VAR		775	775	Subdural puncture
T.5	4290..PED-H	140A	54	56	Subdural puncture, code: 969
T.6	5602....VAR		776	776	Ventricular puncture
T.6	4290..PED-H	140A	54	56	Ventricular puncture, code: 970
T.7	5603....VAR		777	777	Anesthesia, general
T.7	4290..PED-H	140A	54	56	Anesthesia, general, code: 971
T.8	5604....VAR		778	778	Surgery
T.8	4290..PED-H	140A	54	56	Surgery, code: 972
T.9	5605....VAR		779	779	Chromosome studies
T.9	4290..PED-H	140A	54	56	Chromosome studies, code: 982
T.10	5606....VAR		780	780	Radiography: x-ray and or fluoroscopy
T.10	4290..PED-H	140A	54	56	Radiography: x-ray and or fluoroscopy, code: 983
T.11	5607....VAR		781	781	Antibiotics, internal administration
T.11	4290..PED-H	140A	54	56	Antibiotics, internal administration, code: 984
T.12	5608....VAR		782	782	Electroencephalography (EEG)
T.12	4290..PED-H	140A	54	56	Electroencephalography (EEG), code: 985
T.13	5609....VAR		783	783	Procedures, other
T.13	4290..PED-H	140A	54	56	Procedures, other, code: 986
U.1	5611....VAR		785	785	Anoxia, presumed etiology of conditions
U.1	4290..PED-H	140A	54	56	Anoxia, presumed etiology of conditions, code: 987
U.2	5612....VAR		786	786	Trauma, presumed etiology of conditions
U.2	4290..PED-H	140A	54	56	Trauma, presumed etiology of conditions, code: 988
1	4261..PED-H	140A	17	18	Birth date (day)
1	4260..PED-H	140A	15	16	Birth date (mo)
1	4262..PED-H	140A	19	20	Birth date (yr)
5	4264..PED-H	140A	23	24	Discharge date (day)
5	4263..PED-H	140A	21	22	Discharge date (mo)
5	4265..PED-H	140A	25	26	Discharge date (yr)
7	4266..PED-H	140A	27	29	Age at discharge (days)
9	4267..PED-H	140A	30	30	Dysmaturity, stage

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM NO. FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
13	4281..PED-H	140A	45	45	Alimentary tract: malformation or condition
13	4280..PED-H	140A	44	44	Cardiovascular conditions
13	4271..PED-H	140A	37	37	CNS: malformations
13	4276..PED-H	140A	40	40	Ear conditions
13	4289..PED-H	140A	53	53	Endocrine disease: metabolic disease
13	4275..PED-H	140A	39	39	Eye conditions
13	4283..PED-H	140A	47	47	Genitourinary conditions
13	4285..PED-H	140A	49	49	Hematologic conditions
13	4287..PED-H	140A	51	51	Infection
13	4270..PED-H	140A	33	33	Information source: summary code
13	4282..PED-H	140A	46	46	Liver abnormality: bile duct abnormality: spleen abnormality
13	4260..PED-H	140A	32	32	Medical conditions, other: etiologic impressions, presumtive: summary
13	4277..PED-H	140A	41	41	Mouth conditions: respiratory tract, upper, conditions
13	4274..PED-H	140A	38	38	Musculoskeletal abnormality, number of
13	4284..PED-H	140A	48	48	Neoplastic condition
13	4272..PED-H	140A	36	36	Neurologic abnormality, number of
13	5622....VAR		596	596	PED-H diagnosed switch, data availability, any info in variable file locations 597-800, 1=no, 2=yes
13	4268..PED-H	140A	31	31	Procedures, number of
13	4279..PED-H	140A	43	43	Respiratory abnormality
13	4286..PED-H	140A	50	50	Skin: malformations or conditions
13	4288..PED-H	140A	52	52	Syndromes
13	4278..PED-H	140A	42	42	Thoracic conditions
13.A	5613....VAR		787	787	Neurologic abnormality, number of, (PED-H sect A)
13.B	5614....VAR		788	788	Central nervous system malformation and related skeletal conditions, number of, (PED-H sect B)
13.C	5615....VAR		789	789	Musculoskeletal abnormality, number of, (PED-H sect C)
13.D	5616....VAR		790	790	Eye conditions, number of, (PED-H sect D)
13.E	5617....VAR		791	791	Ear conditions, number of, (PED-H sect E)
13.F	5618....VAR		792	792	Oral conditions: respiratory tract, upper, conditions, number of, (PED-H sect F)
13.G	5619....VAR		793	793	Thoracic abnormality, number of, (PED-H sect G)
13.H	5620....VAR		794	794	Respiratory abnormality
13.I	5621....VAR		795	795	Cardiovascular conditions, number of, (PED-H sect I)
13.J	5622....VAR		796	796	Alimentary tract malformations and conditions, number of, (PED-H sect J)
13.K	5623....VAR		797	797	Liver abnormality: bile duct abnormality: spleen abnormality, number of, (PED-H sect K)
13.L	5624....VAR		798	798	Genitourinary conditions, number of, (PED-H sect L)
13.M	5625....VAR		799	799	Neoplastic disease: tumors, number of, (PED-H sect M)
13.N	5626....VAR		800	800	Hematologic conditions, number of, (PED-H sect N)
13.O	5627....VAR		801	801	Skin conditions and malformations, number of, (PED-H sect O)

Form Item Numbers linked to Data Items on PED-H, Newborn Diagnostic Summary

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
13.P	5628....VAR		802	802	Infection, number of, (PED-B sect P)
13.J	5629....VAR		803	803	Syndromes, number of, (PED-B sect J)
13.R	5630....VAR		804	804	Endocrine diseases; metabolic diseases, number of, (PED-B sect R)
13.S,13.U	5632....VAR		806	806	Diseases, conditions and presumptive etiologic impressions not elsewhere specified, number of, (PED-B sect S & U)
13.T	5631....VAR		805	805	Procedures, number of, (PED-H sect T)

DEFINITION OF CODES
NEWBORN DIAGNOSTIC SUMMARY
FORM PED-8 CARD 1408

FIELD		CARD COLUMN
1.	**Card Number** Code: 1	1
2.	**Form Number** Code: 408	2-4
3.	**Revision Number** Code: 0 - Form Dated: 1/63 (Livebirths) 1 - Form Dated: 1/63 (Stillbirths)	5
4.	**NIMDB Number** Nine-digit number for Patient Identification. Code: As given	6-14
5.	**Date of Birth** Six-digit code for month (cols. 15-16), day (cols. 17-18) and year (cols. 19-20) Code: As given	15-20
6.	**Date of Discharge** Item 5 Code: Same as in Field 5	21-26
7.	**Age at Discharge** Code: 000 - Less than 1 day 001-997 - Days as given 998 - 998 days or more 999 - Not reported	27-29
8.	**Dysmaturity** Item 9 Code: 0 - No signs 1 - Stage 1 2 - Stage 2 3 - Stage 3 4 - Equivocal signs 9 - Not reported	30

* Unless specified, codes and card columns refer to Revs. "0" and "1". Item numbers refer to Form Dated: 1/63

DEFINITION OF CODES (Continued)

FORM PED-8
Card 1408

FIELD		CARD COLUMN
9.	Procedures Section T Code: 0 - None 1-8 - As given 9 - Nine or more reported	31
10.	Other Conditions and Presumptive Etiologic Conditions Sections S and U Code: 0 - None 1 - Other conditions only 2 - Presumed anoxia only 3 - Presumed trauma only 4 - Combination of codes 2 and 3 5 - Combination of codes 1 and 2 6 - Combination of codes 1 and 3 7 - Combination of codes 1, 2 and 3	32
11.	Information Source Section V Code: 0 - No report 1 - Study record only 2 - Nursery record only 3 - Additional record only 4 - Combination of codes 1 and 2 5 - Combination of codes 1 and 3 6 - Combination of codes 2 and 3 7 - Combination of codes 1, 2 and 3	33
12.	Total Number of Abnormalities Reported Code: 00 - None 01-98 - As given 99 - 99 or more	34-35
13.	Neurologic Abnormality Section M Code: Same as in Field 9	36

DEFINITION OF CODES (Continued)

FORM PED-8
Card 1-C8

FIELD		CARD COLUMN
14.	Central Nervous System Malformations Section B Code: Same as in Field 9	37
15.	Musculoskeletal Abnormality Section C Code: Same as in Field 9	38
16.	Eye Conditions Section D Code: Same as in Field 9	39
17.	Ear Conditions Section E Code: Same as in Field 9	40
18.	Upper Respiratory Tract and Mouth Conditions Section F Code: Same as in Field 9	41
19.	Thoracic Conditions Section G Code: Same as in Field 9	42
20.	Respiratory Abnormality Section H Code: Same as in Field 9	43
21	Cardio-vascular Conditions Section I Code: Same as in Field 9	44
22.	Alimentary Tract Malformations and Other Conditions Section J Code: Same as in Field 9	45
23.	Abnormality of Liver, Bile Ducts and Spleen Section K Code: Same as in Field 9	46

DEFINITION OF CODES (Continued)

FORM PED-8
Card 1408

FIELD		CARD COLUMN
24.	Genito-urinary Conditions Section L Code: Same as in Field 9	47
25.	Neoplastic Conditions Section M Code: Same as in Field 9	48
26.	Hematologic Conditions Section N Code: Same as in Field 9	49
27.	Skin Conditions and Malformations Section O Code: Same as in Field 9	50
28.	Infection Section P Code: Same as in Field 9	51
29.	Syndromes Section Q Code: Same as in Field 9	52
30.	Other Endocrine or Metabolic Disease Section R Code: Same as in Field 9	53
31.	First Diagnosis or Procedure Code: See Attachment - "Diagnoses and Procedures"	54-56
32.	Second Through Ninth Diagnoses Code: Same as in Field 31 if needed	57-80

Note: Card 2 required if 10-18 diagnoses reported. Codes same as in Card 1 except card col. 1 is "2".

Card 3 required if 19-27 diagnoses reported. Codes same as in Card 1 except card col. 1 is "3".

Card 4 required if 28-36 diagnoses reported. Codes same as in Card 1 except card col. 1 is "4"

Card 5 required if 37-45 diagnoses reported. Codes same as in Card 1 except card col. 1 is "5".

Card 6 required if 46-54 diagnoses reported. Codes same as in Card 1 except card col. 1 is "6".

Code *	Name
Neurologic Abnormality	
001, 002	Brain abnormality
003, 004	Seizures
005, 006	Myoclonus
007, 008	Hypertonia
009, 010	Jitteriness or tremulousness
011, 012	Hyperactivity
	Paralysis - Paresis
013, 014	Hemi-
015, 016	Para-
017, 018	Tetra-
019, 020	Other, specify
049, 050	Hypotonia
051, 052	Hypoactivity
053, 054	Lethargy
055, 056	Asymmetry of reflexes, activity, or tone
057, 058	Symmetrical, but abnormal reflexes
059, 060	Abnormal Moro
061, 062	Abnormal cry
063, 064	Abnormal suck
065, 066	Other, specify
	Abnormal Brain Status
090	Transient
092	Persistent
094	One or no exam
	Peripheral or cranial nerve abnormality
095, 096	Brachial
097, 098	Facial
099, 100	Ocular
101, 102	Other, specify
	Other neurologic abnormality
119, 120	Fractured skull
121, 122	Cephalhematoma
123, 124	Intracranial hemorrhage
133, 134	Spinal cord abnormality, specify
153, 154	Other, specify
	Central Nervous System Malformations: Related Skeletal Conditions
184	Anencephaly
185, 186	Microcephaly
187, 188	Hydranencephaly
189, 190	Hydrocephaly
191, 192	Craniosynostosis
193, 194	Abnormal separation of sutures
195, 196	Abnormal shape of skull
197, 198	Encephalocele
199, 200	Meningomyelocele/ meningocele
201, 202	Pilonidal sinus (not dimple)
203, 204	Other midline sinuses specify
223, 224	Other, specify
	Musculoskeletal Abnormality
253, 254	Vertebral abnormality
255, 256	Talipes equinovarus
257, 258	Metatarsus adductus
259, 260	Calcaneo valgus
261, 262	Congenital dislocation or dysplasia of the hip
263, 264	Absence or hypoplasia of extremity or part specify
294	Polydactyly
296	Syndactyly
297, 298	Torticollis
299, 300	Arthrogryposis multiplex
301, 302	Achondroplasia
303, 304	Fractured clavicle
305, 306	Fractures, other
333, 334	Other, specify
	Eye Conditions
351, 352	Chorio-retinitis
353, 354	Retrolental fibroplasia
355, 356	Cataract
357, 358	Corneal opacity
359, 360	Microphthalmia
361, 362	Blindness
363, 364	Nystagmus
365, 366	Other, specify

* Odd number codes indicate suspect diagnosis; even number codes indicate definite diagnosis.

Diagnoses and Procedures (Continued)

Code *	Name
	Ear Conditions
391, 392	Low set ears
393, 394	Deformed ear pinna
395, 396	Branchial cleft anomaly
397, 398	Deafness
399, 400	Other, specify
	Upper Respiratory Tract and Mouth Conditions
419, 420	Choanal atresia
422	Cleft palate
424	Cleft uvula (bifid)
426	Cleft lip
428	Cleft gum
429, 430	Micrognathia
431, 432	Malformation of epiglottis and larynx
433, 434	Other, specify
	Thoracic Abnormality
447, 448	Anomaly of diaphragm
449, 450	Anomaly of lung, specify
459, 460	Anomaly of chest wall, specify
467, 468	Pectus excavatum
469, 470	Other, specify
	Respiratory Abnormality
479, 480	Respiratory distress syndrome (Hyaline membrane disease)
481, 482	Primary atelectasis
483, 484	Pneumonia
485, 486	Aspiration before or during delivery
487, 488	Aspiration after delivery
489, 490	Pulmonary hemorrhage
491, 492	Cardiac conditions
493, 494	C.N.S. abnormality
495, 496	Metabolic imbalance
497, 498	Other, specify
511, 512	Unknown condition
	Associated Degree of Respiratory Distress
514	None
516	Slight
518	Moderate
520	Marked

Code *	Name
	Significant Respiratory Events
522	Primary apnea
524	Single apneic episode
526	Multiple apneic episodes
528	Resuscitation--during first 5 minutes of life
530	Resuscitation--after first 5 minutes of life
	Cardiovascular Conditions
531, 532	Acyanotic CHD
533, 534	Cyanotic CHD
535, 536	Fibroelastosis
537, 538	Disorders of rhythm
539, 540	Disorders of rate
541, 542	Cardiac enlargement
543, 544	Decompensation
546	Specific C-V diagnosis
573, 574	Other, specify
	Alimentary Tract Malformations
	Other Conditions
601, 602	Tracheo-esophageal fistula
603, 604	Duodenal atresia
605, 606	Malrotation
608	Omphalocele
609, 610	Visceral perforation
612	Imperforate anus
	Hernia, specify
613, 614	Inguinal
615, 616	Femoral
617, 618	Other, specify
621, 622	Other (non-infectious)
	Abnormality of Liver, Bile Ducts, and/or Spleen
641, 642	Specify, non-infectious
	Genitourinary Conditions
658	Hypospadias
659, 660	Chordee
661, 662	Other abnormalities of external genitalia
677, 678	Bladder outflow or urethral obstruction
679, 680	Upper tract obstruction

* Odd number codes indicate suspect diagnosis; even number codes indicate definite diagnosis.

Diagnoses and Procedures (Continued)

Code *	Name
681, 682	Cystic kidney
683, 684	Other, non-infectious
	Neoplastic Disease And/Or Other Tumors
701, 702	Specify, type and organ
	Hematologic Conditions
719, 720	Erythroblastosis
721, 722	Rh
723, 724	ABO
725, 726	Other, specify
741, 742	Other hemolytic disease
751, 752	Coagulation defect, specify
761, 762	Intra-uterine blood loss
763, 764	Other major hemorrhage, specify site
765, 766	Other, specify
	Skin Conditions and Malformations
815, 816	Strawberry/portwine hemangioma
817, 818	Cavernous hemangioma
820	Hairy nevus
821, 822	Lymphangioma
823, 824	Scleredema
826	Severe ecchymosis
828	Significant petechiae
829, 830	Supernumerary nipples
832	Café au lait spots
833, 834	Other, specify
	Infection
863, 864	Septicemia
865, 866	Central nervous system
867, 868	Respiratory
869, 870	Urinary tract
871, 872	Bone and joint
873, 874	Heart
875, 876	Gastrointestinal

Code*	Name
877, 878	Eye
879, 880	Ear
881, 882	Cutaneous
883, 884	Mucous membranes
885, 886	Other, specify
	Syndromes
887, 888	Mongolism
889, 890	Gonadal dysgenesis
891, 892	Adrenogenital
893, 894	Marfan's
895, 896	Pierre Robin
897, 898	Other syndromes, specify
	Other Endocrine or Metabolic Disease
915, 916	Cretinism
917, 918	Fibrocystic disease of pancreas
919, 920	Presumed symptomatic hypocalcemia
921, 922	Presumed symptomatic hypoglycemia
923, 924	Inborn errors of metabolism specify
937, 938	Other, specify
	Other Conditions
951, 952	Specify
	Procedures
965	Simple blood transfusions
966	Exchange transfusions
967	Parenteral fluids
968	Spinal puncture
969	Subdural puncture
970	Ventricular puncture
971	General anesthesia
972	Surgery, specify
982	Chromosome studies
983	X-ray and/or fluoroscopy
984	Antibiotics

* Odd number codes indicate suspect diagnosis; even number codes indicate definite diagnosis.

Diagnoses and Procedures (Continued)

Code *	Name
985	E.E.G.
986	Other, specify

Presumptive Etiologic Impressions

987	Presumed anoxia
988	Presumed trauma

* Odd number codes indicate suspect diagnosis; even number codes indicate definite diagnosis.

Additional Codes for Other Specified Conditions*

Code*	Name
	Central Nervous System Malformations: Related Skeletal Conditions
226	Absence of corpus callosum
227	Macrocephaly
228	Absence or hypoplasia of olfactory nerve and/or bulb
229	Suboccipital cyst
230	Cord abnormality
232	Absence sacrum
234	Arrhinencephaly
236	Cerebral hypoplasia - frontal
238	Cyst septum pellucidum
240	Cystic mass lumbosacral area
242	Hydromyelia
244	Hypoplasia skull bones
246	Non-specific malformation brain
248	Porencephaly
249	Absent post. lobe pituitary, agenesis pituitary
250	Rachischisis
251	Suboccipital sinus tract
252	Cranioschisis
	Musculoskeletal Abnormality Absence or hypoplasia of extremity or part
265	Absence or hypoplasia distal femoral epiphysis
266	Lower extremity
268	Femur
270	Tibia
272	Fibula
274	Foot
276	Toes
278	Upper extremity
279	Forearm
280	Humerus
282	Radius
284	Ulna
285	Cleft hallux
286	Hand
287	Anomalies of ribs
288	Fingers
289	Absent sternocleidomastoid muscle
290	Pectoralis muscle
291	Absent rectus abdominis
292	Ribs
293	Ribs and spine
	Other
327	Abnormally long maxilla and mandible
328	Hemihypertrophy tongue
329	Hemihypertrophy (left side body)
330	Genu recurvatum
331	Hypoplasia jaw
332	Marked separation of 2 or more digits
335	Ulnar deviation hands or digits
336	Abnormal placement toes, position, or deviation
337	Hypermobile or extensible joints
338	Abnormal position of fingers
339	Hammer toes
340	Absence pubic fusion
341	Flexion deformity, contractions
342	Cerv. ribs
343	Fibrous dysplasia of bone
344	Calcaneo varus (also talipes)
345	Enlargement thigh and leg
346	Congenital dislocation knees
347	Dislocation humerus (shoulder)
348	Congenital dislocation wrist
349	Dislocation 5th toe
350	Constricting bands hand

*All diagnoses are definite.

Diagnoses and Procedures (Continued)

Code*	Name
	Eye Conditions
368	Anophthalmia
370	Aniridia
372	Buphthalmos, glaucoma
374	Coloboma
376	Exophthalmos, proptosis
378	Eye Herniation
380	Hypoplasia of optic nerve
382	Papilledema
	Ear Conditions
402	Absence external meatus
404	Ruptured tympanic membrane
	Upper Respiratory Tract and Mouth Conditions
436	Absent bridge of nose
438	Absent floor of antrum
440	Absent uvula
442	Bifid tongue
443	Ranula (sublingual cyst)
444	Choanal stenosis with absence nasal cartilage
445	Ectopic salivary gland
	Thoracic Abnormality
	Anomaly of lung
435	Congenital defect pleural
452	Absence lung, right or left
453	Pulmonary emboli
454	Absence lobe or lobes, incomplete division
455	Pneumatocele
456	Lung cyst or cysts
457	Extra lobes
458	Hypoplasia or immaturity
	Anomaly of chest wall
462	Deformed thorax
463	Square shaped
464	Pectus carinatum (Keel) (Pigeon)
466	Flaring ribs

Code*	Name
	Other
471	Cong., laryngal, stridor, inspiratory strider
472	Bilateral or unilateral hydrothorax
473	Rupture trachea
474	Compression of bronchi
475	Mediastinal emphysema, and/or pneumothorax
476	Pneumothorax
477	Atelectasis (comp. collapse
499	Emphysema lung)
500	Interstitial emphysema
501	Mucous plug in trachea
	Cardiovascular Conditions: Specific C-V Diagnosis
547	Aortic atresia
548	Hypoplastic aorta
549	Atrial septal defect
550	Atrioventicular canal (communi
551	Coarctation
552	Ventricular septal defect
553	Ductus arteriosus
554	Absent umbilical artery
555	Anomalous right subclavian
556	Tamponade, hemopericardium, hydropericardium
557	Situs inversis, dextroversion dextrorotation, dextroposition
558	Anomalous pulmonary venous connection and/or return
559	Aortic arch anomaly
560	Bifid ant. leaf mitral valve, or rudiment valve
561	Single ventricle (absent ventricle)
562	Hypoplasia auricle (left)
563	Atresia mitral valve
564	Common truncus, truncus arterosis
565	Cor triloculare
566	Ebsteins complex
567	Endocardial cushion defect
568	Endocardial sclerosis
569	Hypoplastic right ventricle

*All diagnoses are definite.

Diagnoses and Procedures (Continued)

Code*	Name
	Cardiovascular Conditions: Specific C-V Diagnosis (cont.)
570	Transposition
571	Hypoplastic left atrium
572	Hypertrophy right ventricle
575	Missing carotid (left)
576	Persistent superior vena cava
577	Pulmonary atresia or hypoplasia
578	Absent coronary sinus
579	Left superior vena cava
580	Right aortic arch
581	Vascular ring
582	Absent coronary artery
583	Bifid aortic valve
584	Post-op. Blalock shunt
585	Hypoplastic left heart
586	Cor bilocular
587	Inf. vena cava to anat. left atrium
588	Tricuspid atresia
589	Single pulmonary vein and artery
590	Pulmonary hypertension
591	Aneurysm of pulmonary artery, sinus valsalva, aortic valve
592	Myocardial necrosis
593	Absent renal artery
594	Anomaly inferior vena cava with azygous drainage
595	Ectopic cord tip ventricle fused with left eye absent disc
596	Fatty degeneration heart
597	Over-riding aorta
598	Pulmonary hemangiomatosis
599	Pulmonary thrombosis or emboli
600	Thrombophlebitis
611	Absence ductus arteriosis
729	Anomalus muscle band at septum
730	Abnormal aortic cusp

*All diagnoses are definite.

Code*	Name
	Alimentary Tract Malformations and Other Conditions
	Hernia, Other
619	Ventral
623	Supra umbilical
624	Volvulus of upper jejunum
	Other
625	Abdominal situs inversus
626	Adhesive bands secondary duodenal obstruction
627	Acute pancreatitis
628	Acute serositis of large bowel
629	Stomach ulcer (gastric)
630	Adhesions of cecum to liver
631	Hypoplastic small intestine
632	Anal fissure
633	Atresia colon or parts thereof
634	Atresia small bowel or parts thereof
635	Duplication, cecum, bowel
636	Chalasia
637	Dysplasia pancreas
638	Ectopic pancreas
639	Esophageal atresia
640	Pyloric stenosis
643	Absence ligament of Treitz
644	Common mesentery, single mesentery
645	Meckel's diverticulum
646	Anomalous shape pancreas
647	Microcolon
648	Meconium ileus
649	Meconium peritonitis
650	Megacolon
651	Duodenal obstruction
652	Omphalomesenteric cyst
653	Rectal polyp
654	Rectal prolapse
656	Volvulus
743	Hemoperitoneum
744	Mesenteric infarct
745	Intussusception
746	Hirschsprung's disease (aganglionosis of ileum and colon)
747	Prolapse ileostomy
748	Abdominal adhesions

Diagnoses and Procedures (Continued)

Code*	Name
	Abnormality of liver, Bile Ducts, and/or Spleen
657	Absence gall bladder
663	Absent spleen
664	Accessory spleen
665	Biliary atresia
666	Degeneration liver
667	Fecal malformation bile ducts
668	Giant cell hepatitis
669	Herpetic hepatitis
670	Intrahepatic vein thrombosis and hepatic infarction and necrosis
671	Subcapsular hematoma of liver
672	Ectopic spleen in pancreas
673	Hemosiderosis
674	Tear in spleen or liver capsule
	Genitourinary Conditions
	Other abnormalities of external genitalia
675	Clitoral hypertrophy
676	Absence of ventral foreskin - congenital
685	Hymen cyst
686	Ectopic urethral meatus
687	Epispadias
688	Gartner's duct cyst
689	Hypoplastic vagina and vulva
690	Imperforate hymen
691	Penile hypoplasia with hypolartic testes
692	Periurethral cyst
693	Pseudohermaphrodite
694	Scrotum fixed to half length of penis with chordee
696	Prolapse vaginal mucosa
697	Vaginal Cyst
	Other
698	Exstrophy of bladder
699	Follicular cyst of ovary
700	Glomerular cyst
703	Horseshoe kidney
704	Hypoplastic kidney
705	Hypertrophy bladder
706	Multicystic ovary
707	Bladder diverticulum
708	Polycystic testicle
709	Rectourethral fistula
710	Single kidney
711	Tortuousity of ureters, stenosis, kink
712	Uric acid deposit tubules
713	Absent right hemi-trigone bladder
714	Absent ureter
715	Agenesis bladder
716	Absent glomerulogenesis with persistence mullerian duct
717	Double vagina
718	Absent ureters (both)
785	Bicornuate uterus
786	Absent kidney bilat.
787	Cystic mass protruding from vagina
788	Double ureter, ureters
789	Double cervix
790	Rectovaginal fistual
791	Non-functioning kidney
792	Dysgenesis of ovaries
793	Renal infarct
794	Decreased function of one kidney
795	Transient renal tubular dysfunction
	Neoplastic Disease and/or Other Tumors
812	Papilloma - sacrum midline
813	Cystic mass abdominal wall probably lipoma
814	Leukemia
989	Hepatoblastoma (primary)
990	Lung - large tumor of bronchial origin (hamartoma?)
991	Myelogenous leukemia
992	Teratoma sacrococcygeal area
993	Tumor (carcinoid) of lung
994	Wilms' tumor
995	Neuroblastoma

*All diagnoses are definite.

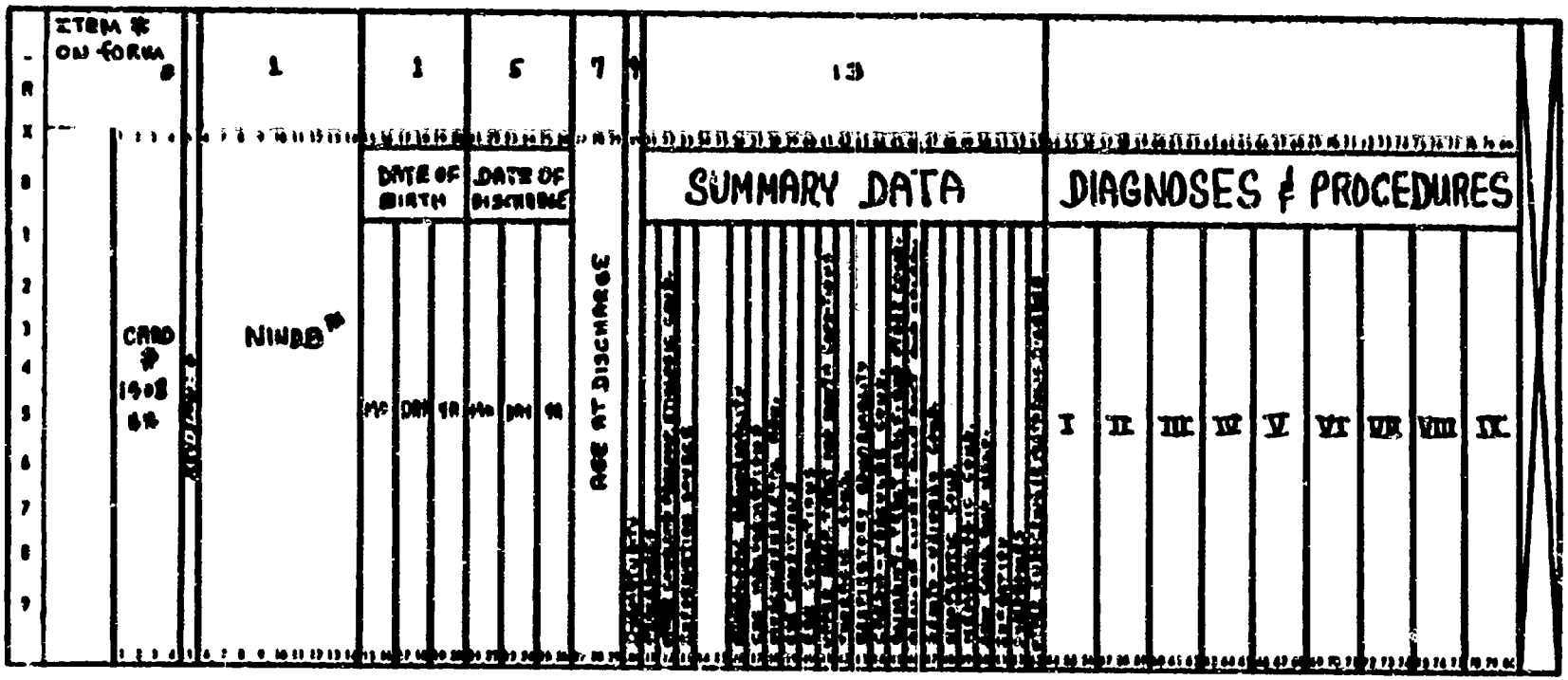
Diagnoses and Procedures (Continued)

Code*	Name
	Neoplastic Disease and/or Other Tumors (cont.)
996	Hygroma
997	Intra abdominal calcified mass
998	Mass Neck
	Hematologic Conditions
	Erythroblastosis, Other
727	LEA factor
728	C incompatability
	Hemolytic Disease, Other
929	Glucose-6-phosphate dehydrogenase def.
	Coagulation Defect
753	Factor 7 (VII) def.
754	Factor X def.
755	SPCA and/or PTC
756	Vitamin K def.
758	Hypoprothrombinemia
759	Thrombocytopenia
	Skin Conditions and Malformations
838	Lack of subcutaneous fat
839	Subcutaneous emphysema
835	Vitiligo
836	Webbed neck
837	White forelock
	Syndromes
900	Horner's syndrome
901	Acrocephaly-syndactyly of Apert
902	Chondrodystrophia calcificans congenita
903	Trisomy
904	Cleidocranial dysostosis
905	Cornelia Del Lange
906	Osteogenesis imperfecta
907	Dandy-Walker
908	Eagle's
910	Koerber Salus Elschning
911	Lowe's
912	Potter's
913	Post rubella
914	Situs inversus
925	Cranio carpal tarsal dystrophy

Code*	Name
	Other Endocrine or Metabolic Disease
	Inborn errors of Metabolism
926	Glycogen storage disease
928	Albinism
929	Glucose - 6-phosphate dehydrogenase def.
930	Sex linked recessive - cataract, mental retardation, renal function abnormality
	Other
939	Adrenal atrophy hypoplasia, hemorrhage, necrosis
940	Adrenal hyperplasia
941	Cytomegaly adrenal cortex
942	Hyperbilirubinemia 2° mother's milk
943	Hyperphosphatemia
944	Hyperplasia (focal), thyroid
945	Hyperplasia islets of Langerhans
946	Hyperplastic pituitary
947	Hypoalbuminemia
948	Hypoproteinemia
949	Rickets and scurvy
950	Chemical hypoglycemia
963	Goiter
964	Hypogammaglobulinemia
973	Under mineralization of frontal and parietal bones
	Other Conditions
953	F.U.O., fever of undetermined etiology
954	Hyperthermia
955	Hypothermia
956	Narcotic withdrawal syndrome
957	Massive silicone embolization
958	Macrosomia

*All diagnoses are definite.

NEWDOIH DIAGNOSTIC SUMMARY
FORM PED-8



* Item numbers refer to form dated: 1/63

** Additional card(s) required for more than 9 Diagnosis or Procedures

II.E.290

PED-8

MANUAL FOR THE PED-8 FORM
NEWBORN DIAGNOSTIC SUMMARY

I. Introduction

In order to be able to relate prenatal and perinatal factors to the nursery status of the infant, a classification of significant variables in terms of findings, diagnoses (conditions) and events during the nursery course is required. In turn these variables may then be related to findings at subsequent periods during follow-up. Variables should be considered of significance if they contribute to the identification of the outcome of pregnancy, or if they are descriptive of other than normal states recognized in the infant.

The arbitrary classification of observations onto a diagnostic "flag sheet" does not preclude separate analysis of individual observations or constellations of observations but it does provide a relatively standardized entry into specific areas of possible interest.

The PED-8 serves as a diagnostic "flag sheet" on which are recorded significant diagnoses and events in coded form. This record will serve as a means of organizing diagnoses for transfer to punch cards and/or computer for subsequent tabulation. Significant events and diagnoses from birth to hospital discharge, or death during the initial hospitalization, are to be included. Gross autopsy findings are to be included. If final autopsy diagnosis, including brain or other laboratory data, changes the diagnostic summary, forward a totally revised PED-8 to PRB clearly identifying this PED-8 as *Revised*. Items for coding will occur in more than one category for some conditions--particularly for syndromes. This is inherent in the structure of this form.

II. General Instructions

a. The PED-8 is to be considered a brief clinical summary of the pediatric data and events, and is *not* to include review of the mother's hospital record or history.

b. This form is to be completed on *all* liveborn infants of gravidae registered in the study. Where delivery has occurred outside the study facility and newborn study records are not available, PED-8 is to be completed from whatever means are practical.

c. Completion of the PED-8 form is the responsibility of a senior Study pediatrician. It is recognized that clinical judgment will have to include weighing the relative merits and timing of the various examinations. Differentiation between coding suspect and definite will vary according to the item and category under consideration. In general, all clear-cut unquestionable diagnoses, conditions, or states should be coded under definite. Where there is doubt regarding the presence of the condition or its existence in significant degree, the coder will encircle the appropriate code number under suspect.

d. Definitions: In general, terms and procedures used have the same definitions as previously noted in manuals accompanying the PED-1 to PED-6 forms. Modifications or extensions of these terms may be found under the particular item in question.

e. Records to be used in preparation of the Diagnostic Summary include all study and hospital pediatric records, including records of hospital care received when the infant is transferred directly from the nursery to another service or hospital for care. When the infant is finally discharged, that hospital's records should also be used to complete the PED-8 even though study forms may not be completed in that hospital. A review of the mother's records is *not* to be included in completing PED-8.

f. Time of transmittal to PRB: Completed and edited PED-8 forms are to be transmitted as part of a unit including PED-1, 2, 3, 5, 6, applicable CP-5's, and PED-4 when applicable. This unit should reach PRB as soon as possible after date of discharge or death. Records are not delayed pending final autopsy or protracted laboratory study reports.

Item 1: Patient Identification: For Study purposes prematurity is based on weight and will be identified from item 33 of Ped-1. Birth weight is recorded on the identification stamp and need not be reported elsewhere on PED-8. If the coder makes a diagnosis of prematurity on some basis *other* than birth weight; i.e., if the birth weight conflicts with the clinical impression of maturity, then the clinical impression of prematurity should be reported under 5, Other Conditions, Specify. Sex and race are also on the identification stamp.

Items 2-5: No explanation necessary.

Item 6: Discharge Time: If the infant is under 48 hours of age when discharged, record time of discharge in 24 hour clock time. If the infant is 48 hours of age or more when discharged, simply write N.A. (not applicable) in this space, but do not leave it blank as this will be interpreted as an unknown.

January 1963

Items 7-9: No explanation necessary.

Item 10: Lowest Apgar Score (optional): If no Apgar score has been done, write in N.E. (not evaluated). Apgar scores will be coded directly from PED-1.

Item 11: Highest bilirubin level (optional): Do *not* code hyperbilirubinemia or jaundice on PED-8. Bilirubin levels will be coded directly from PED-5. If no value was recorded, write in N.E. (not evaluated). Local option will decide whether to use study or other laboratory values here.

Item 12: After careful review of the pediatric study forms and the infant's hospital chart, check the "none" box if there are no items encircled under categories A through S. "None" boxes in each category are for *optional* use locally.

A. Neurologic Abnormality:

Item A-I: Brain abnormality: This refers to involvement of the "brain." Peripheral and cranial nerve abnormality is coded under A-II. Spinal cord abnormality is coded under A-III.

There are three steps in coding under A-I. First, a decision is made as to whether the brain abnormality is suspect or definite. Second, the significant manifestations of the brain abnormality are coded individually as suspect or definite under Items A-I-1 through A-I-19. The senior pediatrician is asked to record those manifestations which in his judgment reliably reflect the infant's brain abnormality. Third, the duration of the brain abnormality is coded under "abnormal brain status." (See directions under specific items.)

Manifested by:

Item A-I-1: Seizures: Definite coded if reported by a known reliable observer. In the newborn period, it is inadvisable to change a suspect to a definite merely on electroencephalographic changes.

Item A-I-2: Myoclonus: No explanation necessary.

Item A-I-3: Hypertonia: Included are rigidity, spasticity, and increased muscle tone as related to maturity.

Item A-I-4: Jitteriness or tremulousness: Code if beyond the institution's or the reviewer's standard of normal jitteriness or tremulousness.

Item A-I-5: Hyperactivity: Code if activity is judged excessive.

Item A-I-6: Paralysis-paresis: Code under 7 through 10 when applicable. Code peripheral nerve or cranial nerve paralysis-paresis under group A-II. Code paralysis or paresis from spinal cord abnormality under group A-III.

Item A-I-11: Hypotonia: Code if beyond the institution's or reviewer's limit of normal tone as related to maturity.

Item A-I-12: Hypoactivity: Refers to paucity of spontaneous activity as related to maturity.

Item A-I-13: Lethargy: This item refers to depression in the apparent state of consciousness.

Item A-I-14: Asymmetry of reflexes, activity, or tone: Definite must be observed on more than one examination or must involve more than one response during an examination.

Item A-I-15: Symmetrical, but abnormal reflexes: Code here all symmetrical but abnormal neonatal reflexes and automatisms other than Moro and suck.

Item A-I-16: Abnormal Moro: Code here an absent, generally depressed, or asymmetrical Moro; also absence of arm flexion if considered abnormal in degree. Do not code an abnormal Moro on the basis of brachial plexus palsy.

Item A-I-17 to I-19: No explanation necessary.

Abnormal Brain Status:

Items A-I-a and I-b: Transient and persistent: This judgment refers to an over-all abnormal brain status and *not* to individual manifestations. Transient refers to an abnormal brain status which has *disappeared* by the infant's discharge from the nursery. Persistent refers to an abnormal brain status that is *still* present at discharge.

Item A-I-c: One or no exam: Code this item if a decision regarding transient or persistent may not be made because only one exam or because no protocol exam had been done. In some cases with suspect findings, the pediatrician may feel that a meaningful judgment

regarding transient and persistent can not be made on the basis of one exam.

Item A-II: Peripheral or cranial nerve abnormality: Code here paralysis, paresis, or sensory abnormality based on peripheral or cranial nerve involvement.

Item A-II-1: Brachial: Code here brachial plexus palsy. Do not also code this under A-I.

Item A-II-2: Facial: Distinction is not made between paralysis or paresis of the lower versus upper motor neuron type. Do not also code this under A-I.

Item A-II-3: Ocular: This may be presumed on basis of strabismus or ptosis. Do not also code this under A-I.

Item A-II-4: Other, specify: Code here other cranial or ~~peripheral paralysis, paresis,~~ or sensory abnormality based on peripheral or cranial nerve involvement.

Item A-III: Other neurologic abnormality: Code here neurologic abnormality not covered in the above categories.

Item A-III-1: Fractured skull: In general fractures should be coded *definite* only when radiologically proven.

Item A-III-2: Cephalhematoma: Distinguish from caput succedaneum.

Item A-III-3: Intracranial hemorrhage – includes subdural, subarachnoid and/or intraventricular hemorrhage: Usually coded suspect, but definite may be coded on the basis of findings of autopsy or subdural, ventricular, or lumbar puncture.

Item A-III-4: Spinal cord abnormality: Spinal cord trauma is coded here.

Item A-III-5: Other, specify: Code here autonomic dysfunction, harlequin color change, etc.

B. Central Nervous System Malformations: Related Skeletal Conditions:

Item B-1: Anencephaly: No explanation necessary.

Item B-2: Microcephaly: Variation in size of infants makes a statement of specific measures impracticable here and reliance must be placed on the examiner's judgment.

Item B-3: Hydranencephaly: This is difficult to separate from severe hydrocephaly. Enter under definite only after direct visualization at the operating table or on autopsy.

Item B-4: Hydrocephaly: In instances of gross enlargement of the head, enlarged tense fontanelles, and typical configuration of the eyes, definite may safely be coded. The etiology, if known, should be coded under the appropriate section (example: if post-meningitis, code under P-2).

Item B-5: Craniosynostosis: Code suspect on clinical grounds, definite with radiologic support.

Item B-6: Abnormal separation of sutures: Do not code if hydrocephaly is suspected ~~or definitely present~~. Give due consideration to the maturity status of the infant.

Item B-7: Abnormal shape of skull: Code hypertelorism here.

Item B-8: Encephalocele: No explanation necessary.

Item B-9: Meningomyelocele/meningocele: Knowledge of neural tissue involvement is not needed for coding definite.

Item B-10: Pilonidal sinus: Only an actual opening or tract should be coded, i.e., dimples are disregarded.

Item B-11: Other midline sinuses: Congenital dermal sinuses (lumbar and above) should be coded here.

Item B-12: Other, specify: Rare CNS malformation and monsters may be coded and specified here. Do not code spina bifida occulta or craniotabes.

C. Musculoskeletal Abnormality:

Item C-1: Vertebral abnormality: In general, code *definite only* with radiologic documentation or autopsy. Do not code spina bifida occulta.

Item C-2: Talipes equinovarus: Code here talipes equinovarus where the forefoot is adducted, the entire foot is inverted (varus), and the entire foot is plantar flexed (equinus). If the foot can be passively moved to a normal neutral

position, this condition will not be coded as an abnormality.

Item C-3: Metatarsus adductus (varus): A metatarsus adductus deformity is one in which the forefoot is adducted and cannot be passively corrected to a normal neutral position and no other deformity is present.

Item C-4: Calcaneo valgus: Code here deformities with forefoot abducted, entire foot everted (valgus) and in a position of marked dorsiflexion (calcaneus). If the foot can be passively moved to a normal neutral position, do not code as an abnormality.

Item C-5: Congenital dislocation or dysplasia of the hip: Radiologic documentation should be obtained for coding definite.

Item C-6: Absence or hypoplasia of extremity or part, specify: Include here digits. Describe the anatomical part, and degree, i.e., absence or hypoplasia. Do not code merely decreased subcutaneous fat. Code hypoplastic mandible under F-6.

Item C-7: Polydactyly: Code extra or rudimentary digits even if no bone is demonstrated, as in postminimi.

Item C-8: Syndactyly: Code here fusions, including soft tissue fusions, of digits or parts of more than one digit.

Item C-9: Torticollis: Code torticollis from any cause, with or without sternocleidomastoid muscle abnormality.

Items C-10 and 11: No explanation necessary.

Item C-12: Fractured clavicle: Code definite with radiographic documentation.

Item C-13: Fractures, other (specify): In general, fractures should be coded definite only when radiologically proven. The bone involved should be specified. Skull fractures are coded under A-III-1.

Item C-14: Other, specify: Code here musculoskeletal deformities or diseases that do not relate directly to the nervous system. For example, aplasia of abdominal muscles, hyperplasia of an extremity, muscle group or skeletal part, abnormality of sternocleidomastoid muscle *without* torticollis, etc. Skeletal malformations of the skull, mandible, vertebrae, and thorax are not coded here.

D. Eye Conditions:

Item D-1: Chorio-retinitis: If process is active, code also under P-8.

Item D-2 to 7: No explanation necessary.

Item D-8: Other (noninfectious), specify: List here other abnormalities of the globe and eyelids. Infections are coded under P-8. Abnormality of orbit (hypertelorism, proptosis, etc.) are coded under B-7. Do *not* code retinal or conjunctival hemorrhages and *minor* remnants of the hyaloid artery and pupillary membrane.

E. Ear Conditions:

Items E-1 and E-2: No explanation necessary.

Item E-3: Branchial cleft anomaly: Pre-auricular sinuses and sinuses in other positions in relation to the ear should be coded here. Branchial cleft anomalies in other positions are also coded here.

Item E-4: No explanation necessary.

Item E-5: Other (noninfectious), specify: List here absence of external ear, imperforate ear canal, malformed middle ear or drum, and papillary masses (persistent hillocks), which occur anterior to the tragus or on the cheeks. Code infections under P-9.

F. Upper Respiratory Tract and Mouth Conditions:

Item F-1: No explanation necessary.

Item F-2: Cleft palate: Any cleft of the hard or soft palate, *excluding* cleft uvula, should be coded here.

Item F-3: Cleft uvula: Code here isolated cleft (bifid) uvula not associated with cleft palate.

Item F-4: Cleft lip: No explanation necessary.

Item F-5: Cleft gum: Code here isolated cleft gum not associated with cleft lip or palate.

Item F-6: Micrognathia: If this condition is associated with palate abnormality, then also code "Pierre Robin" under Q-5.

Item F-7: Malformations of epiglottis and larynx: Here code congenital laryngeal stenosis, laryngeal web, etc.

Item F-8: Other (non-infectious), specify: Code here benign "congenital laryngeal stridor" without demonstrable malformation, abnormality of the trachea, etc. Code here high arched palate if considered significant. Do not list tonguetie unless *extreme*.

G. Thoracic Abnormality:

Items G-1 to 4: No explanation necessary.

Item G-5: Other, specify: Do not list neoplasms and cardiovascular conditions here.

H. Respiratory Abnormality:

Items H-1 to 11: Respiratory Abnormality Associated With: Code items that are considered to be causing or contributing to respiratory abnormality. In general, documentation by X-ray, laboratory, or autopsy is desirable for coding definite.

Items H-a to d: Associated Degree of Respiratory Distress. After an entry is made under 1 through 11, the associated degree of respiratory distress is to be coded as none, slight, moderate or marked on the basis of clinical information available in the study and hospital records.

Items H-12 to 16: Significant Respiratory Events. Code items 12 to 16 if applicable.

Item H-12: Primary apnea: Code here if the primary apnea is more than two minutes in duration.

Items H-13 and 14: Single or multiple apneic episodes: Code here cessation of breathing for approximately twenty seconds or more with cyanosis, pallor, and/or collapse.

Items H-15 and 16: Resuscitation: Included are oxygen under pressure, tracheal intubation, tracheal suction, cardiac massage, and all forms of artificial respiration. Open oxygen and painful stimuli are *not* to be coded as resuscitation.

I. Cardiovascular Conditions:

Items I-1 and 2: Acyanotic and cyanotic CHD: The division of congenital heart disease on the basis of cyanosis asks the physician, at times, to make an arbitrary decision. In general, code as cyanotic those with cyanosis at rest. If there is cardiac enlargement, code *also* under I-6. If a specific diagnosis can be made, code *also* under I-8. Do *not* list murmurs; code etiology if indicated.

Item I-3: Fibroelastosis (subendocardial sclerosis): Code suspect on clinical basis, with definite coded on direct viewing at the operating table or at autopsy.

Item I-4: Disorder of rhythm: Code here changes from regular rhythm. Do not code simple sinus arrhythmia associated with respiration. If a specific diagnosis is known, code *also* under I-8.

Item I-5: Disorder of rate: Code here rates over 160 or under 100. If specific diagnosis is known, code *also* under I-8.

Item I-6: Cardiac enlargement: Code definite with autopsy or radiographic documentation. If a specific diagnosis is known, code *also* under I-8.

Item I-7: Decompensation: No explanation needed.

Item I-8: Specific cardio-vascular diagnosis: Coding here should have documentation beyond clinical impression. E.K.G., catheterization, radiography (including angiocardiography and aortography), etc., may establish the specific diagnosis. Code here patent ductus arteriosus, arteriovenous fistula, and coarctation of the aorta. Code hemangiomata and telangiectasia under O.

Item I-9: Other, specify: Code acquired heart heart disease here. Myocarditis and pericarditis would be coded here as well as under P-6. Metabolic disease with myocardial involvement would be coded here as well as under R.

J. Alimentary Tract Malformation and Other Conditions: In general, many of the diagnoses to be coded here will require radiographic confirmation, surgical exploration, or autopsy to warrant coding definite.

January 1963

Items J-1 to 6: No explanation necessary.

Item J-7: Hernia: Code diaphragmatic hernia under G-1.

Items J-8 and 9: No explanation necessary.

Item J-10: Other hernia, specify: List here complicated umbilical hernia that causes symptoms and requires treatment. This is meant to exclude umbilical hernia of minor degree so often observed in some racial groups.

Item J-11: Other (noninfectious), specify: List here meconium ileus, esophageal atresia or stenosis without fistula, short esophagus, pyloric stenosis, situs inversus abdominalis, ileal atresia, Meckel's diverticulum, annular pancreas, intestinal web or band, duplication, anal fissure, rectal fistula, etc.

K. Abnormality of Liver, Bile Ducts, and/or Spleen: Code here clinically significant primary hepatomegaly and/or splenomegaly of unknown etiology. Do not list jaundice or hyperbilirubinemia on PED-8.

L. Genitourinary Conditions:

Items L-1 to 5: No explanation necessary.

Item L-6: Cystic kidney: Code here both polycystic and multicystic kidney.

Item L-7: Other (noninfectious), specify: List here ectopic kidney, horseshoe kidney, agenesis of kidney, bladder exstrophy, etc.

M. Neoplastic Disease and/or Other Tumors: Specify type and organ. If histologic confirmation is available, attach report as a CP-5 to PED-8. Code leukemia here. Code hemangiomata and lymphangiomata under O.

N. Hematologic Conditions:

Item N-1: Erythroblastosis: Code here the clinical diagnosis of erythroblastosis. Also code under Items 2 to 4 the etiology of the erythroblastosis. Do not code laboratory evidence of isoimmunization under Items 2 to 4 without *clinical erythroblastosis*.

Item N-2: Rh: A positive direct Coombs' test should be required for coding definite. Iso-immunization due to C, c, D, E, or e factors should be included here.

Item N-3: ABO: Code here hemolytic disease due to iso-immunization with ABO factors. Whether coded definite or suspect depends on judgment of the coder.

Item N-4: Other, specify: Code here hemolytic disease other than Rh or ABO, e.g., Kell-Cellano, Duffy, MNS, etc.

Item N-5: Other hemolytic disease, specify: Code here hemolytic disease other than maternal fetal blood type incompatibility.

Item N-6: Coagulation defect, specify: Code here thrombocytopenia, hemophilia, hemorrhagic disease of the newborn, or congenital afibrinogenemia, etc.

Item N-7: Intra-uterine blood loss: Code here blood loss from the fetus while in utero.

Item N-8: Other major hemorrhage: Code major hemorrhage other than that coded in N-7 and specify site. Code cephalhematoma under A-III-2.

Item N-9: Other, specify: Unexplained splenomegaly should be coded under K.

O. Skin Conditions and Malformations:

Item O-1: Strawberry, portwine hemangioma: "Stork bites" are to be considered normal findings.

Items O-2 to 4: No explanation necessary.

Item O-5: Sclerema: This is to be differentiated from scleredema and edema.

Items O-6 to 9: No explanation necessary.

Item O-10: Other, specify: Code skin infection under P-10. Do not code skin tags or "Mongolian Spots".

P. Infection:

Items P-1 to 12: The diagnosis should be listed after the small letter (a). The agent or agents responsible for the infection should be placed after the letter (b) for each particular condition. Septicemia (Item P-1) is a diagnosis and is thus followed by only

the letter (b). List peritonitis under P-12. (See appendix for further information concerning a suggested classification of certain agents.)

Q. Syndromes: When special studies are done, code the procedure used under Section T, if applicable. The specific results of these studies should be recorded on a PED-5 with local normal values for infants of the specific study included.

Item Q-1: Mongolism: Definite clinical diagnosis of mongolism should be independently made by two examiners. Suspect mongolism may be made by a single experienced examiner's observation. Record chromosome studies, if done, under T-9.

Item Q-2: Gonadal dysgenesis: Code definite only after chromosome count or laparotomy.

Item Q-3: Adrenogenital (congenital adrenal hyperplasia): Chemical documentation is desirable.

Items Q-4 to 6: No explanation necessary.

R. Other Endocrine and Metabolic Disease: In general, coding definite should be confirmed by special studies. When applicable, code procedure used under section T. The specific results of these studies should be recorded on a PED-5 with local normal values for infants of the specific study included.

Item R-1: Cretinism: For coding definite, laboratory confirmation is desirable. This group should not be used to list just "funny or unusual looking" infants.

Item R-2: Fibrocystic disease of the pancreas: Code definite only if documented by meconium ileus, chemical changes in sweat, or other acceptable tests.

Item R-3: Presumed symptomatic hypocalcemia: Suspect is based on symptoms and response to calcium. Definite is based on symptoms and abnormal serum calcium and/or phosphorus levels.

Item R-4: Presumed symptomatic hypoglycemia: Suspect is based on symptoms and response to glucose. Definite is based on symptoms and abnormal blood glucose levels.

Items R-5 and 6: No explanation necessary.

S. Other Conditions, specify: Code here significant hypo- and hyperthermia, prematurity on a basis other than weight, drug addiction withdrawal, etc. Do not code hyperbilirubinemia or jaundice on PED-8.

T. Procedures:

Item T-1: Simple blood transfusion: Code here any blood administered regardless of amount or number of times providing this was for purposes other than as an exchange transfusion.

Item T-2: Exchange transfusion: Code without regard to amount or number of transfusions administered.

Item T-3: Parenteral fluid: Code here parenteral fluid administered to maintain and/or correct hydration and/or electrolyte balance.

Item T-4: Spinal puncture: Code attempts. Do not record the number of times the procedure is done but note untoward or severe reactions under 5.

Item T-5: Subdural puncture: As Item 4.

Item T-6: Ventricular puncture: As Item 4.

Item T-7: General anesthesia: Complications such as shock should be coded under S.

Item T-8: Surgery, specify: Do not code circumcisions and simple vein cutdowns, simple digit or skin tag ligations. List each surgical procedure separately. Do not list laparotomy, unless it was the only surgery done. Biopsy and bone marrow punctures may be recorded under this item.

Item T-9: Chromosome studies: Complete report (including method) to be reported on PED-5 or CP-5.

Item T-10: X-ray and/or fluoroscopy: No explanation necessary.

Item T-11: Antibiotics: Do not code topical antibiotics. Code only the antibiotics given internally and list specific names in space provided.

Item T-12: E.E.G. – (electroencephalogram): No comment necessary.

Item T-13: Other, specify: Code here other procedures of significance.

January 1963

U. Presumptive Etiologic Impressions: This category is *not* to be used as a substitute or blanket code for individual items that are to be coded elsewhere on PED-8. This category gives the coder an *additional* opportunity to record impressions concerning etiology of *previously* coded items as they relate to presumed anoxia and trauma.

V. Information Source: (Check applicable boxes) The coder checks all applicable boxes to indicate the records used in completing PED-8.

Item V-1: Study Record: This item is checked if the Perinatal Research Project Pediatric Study forms are used to complete PED-8.

Item V-2: Nursery Record: This item is checked if the hospital nursery record is used to complete PED-8.

Item V-3: Additional Records: This item is checked if other records within the hospital are used. In the event a newborn infant is directly transferred to another hospital, the use of that hospital's records in completing PED-8 would be recorded here. The coder is reminded *not* to use the mother's study, hospital or medical records in completing PED-8.

Item V-4: CP-5 Attached: If a CP-5 is attached to PED-8, check this item.

APPENDIX TO PED-8 MANUAL (2-63)
(for Form PED-8, dated 1-63)

SUGGESTED CLASSIFICATION OF CERTAIN AGENTS WHICH MAY BE ASSOCIATED WITH FETAL AND NEONATAL INFECTIONS.

A. PROTOZOA: Toxoplasma

B. FUNGI
Monilia (Candida albicans)

C. BACTERIA
1. Staphylococcus, hemolytic, coagulase — positive. Types 80-81 and 54.
2. Streptococcus, Type A, beta hemolytic.
3. Hemophilus Influenza.
4. Escherichia coli: (Paracolon)
O,26 : B6; O,55 : B5: O,86 : B7: O,111 : B4; O,112a : B11: O,112b : B11: O,112a : B13; O,112b - B13: O,119 : B14: O,124 : B15: O,125 : B15; O,126 : B16; O,127 : B8; O,128 : B12.
5. Pneumococcus.
6. Proteus, Pseudomonas.

D. VIRUSES
a. The Mestic Viruses
Not true viruses: respond to antibiotics.
Examples: Psittacosis, Ornithosis, Lymphogranuloma group, Trachoma
b. The True Viruses: "The Big Six"
Protection afforded by vaccines (attenuated or dead)

I. POX VIRUS (Cytoplasmic inclusions): 20 in number
150-300 Millimicrons
Smallpox
Vaccinia
Cowpox
Molluscum Contagiosum

II. HERPAVIRUS (Nuclear Inclusions Type A): 35 in number
100-200 millimicrons
Herpes simplex
Herpes zoster
Chickenpox
Salivary Gland Virus (Cytomegalic Inclusion Disease)
Measles
B virus

III. MYXOVIRUS: 20 number
80-500 millimicrons

Influenza	A, A1, A2 (Asian)
Influenza	B
Influenza	C
Parainfluenza	1 (Sendai; hemadsorption 2) - croup associated
Parainfluenza	2 (CA virus) - croup associated
Parainfluenza	3 (Hemadsorption 1) - broncho-pneumonia and bronchiolitis in children
Parainfluenza	4 (M-25)

Mumps
Respiratory Syncytial Virus - Respiratory infections in children
Newcastle Disease Virus

IV. ADENOVIRUS 28 in number
70 millimicrons
Adenovirus 1 - 28
K-9 hepatitis

January 1963

IV. ADENOVIRUS (Continued)
Diseases: Early childhood: Types 1, 2, 5
Later childhood: Types 3 and 7
Military: Types 4 and 7
Keratoconjunctivitis: Type 8

V. ARBORVIRUS (Arthropod-borne diseases): 150 in number
20-100 millimicrons
Type A: Western equine encephalitis
Eastern equine encephalitis
Type B: St. Louis encephalitis
Japanese B. encephalitis
Yellow fever
Russian Tick-borne complex
Others: Dengue
Lymphocytic choriomeningitis

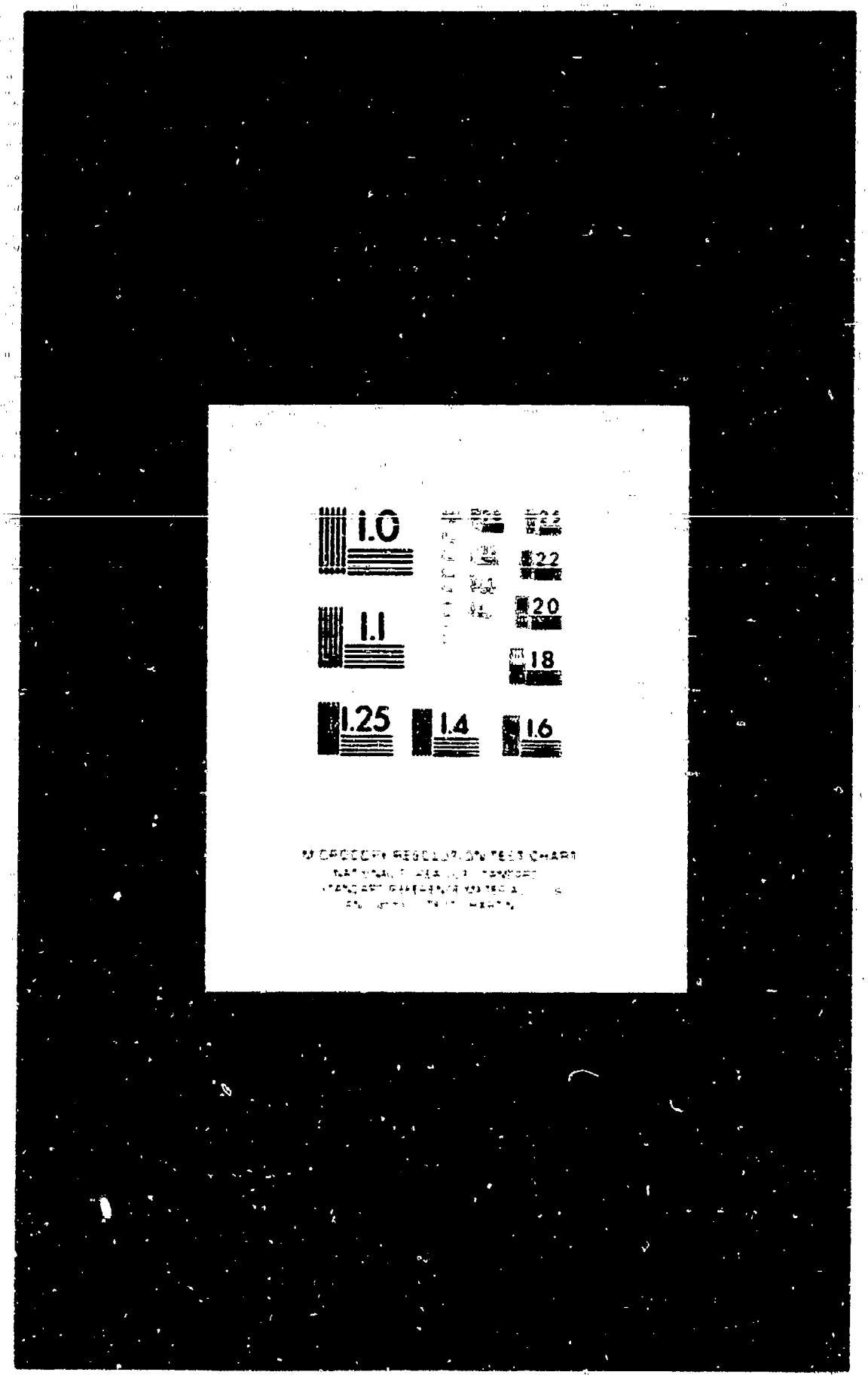
RABIES (?)

VI. PICORNAVIRUSES (Enteroviruses): 100 in number
5-30 millimicrons

A) Poliovirus - type 1
type 2
type 3.
B) Coxsackie Viruses
1. A1-A24 (except A23 — now ECHO 9)
Diseases: Herpangina
Aseptic meningitis, Types 7, 9.
2. B1-B6
Diseases: Pleurodynia, aseptic meningitis, myocarditis and encephalitis in young infants, benign idiopathic pericarditis.
C) ECHO Viruses
1. 1-28 (including former Coxsackie A23, now ECHO 9; also VIII (2060), JV-10); ECHO 11 (V-Virus) Croup Assoc. (except ECHO-10; now REO 1, 2, 3).
Diseases: Aseptic meningitis, ECHO viruses 2, 3, 4, 5, 6, 7, 9, 14, 16, 17;
Exanthemata: ECHO 9, 16
Diarrhea: ECHO 16.
2. REO Viruses: 1, 2, 3. (old ECHO 10)
D) Rhinoviruses (cold viruses) 6
M-Strain - 2
H-Strain - 4

c. HEMOVIRUSES: 15 millimicrons
3 groups culturally similar
2 causes clinical hepatitis
AR -17
WW -65
MR -1

January 1963


1.0
1.1
1.25
1.4
1.6
22
20
18

CONTINUED ON NEXT PICKE