

PERINATAL QUALITY COLLABORATIVE OF NORTH CAROLINA
Newborn Hypoglycemia Prevention and Care Data Collection

Newborn Hypoglycemia Prevention and Care
NICU Data Collection



1. Chart Number: _____
2. Admission Date: _____ Time: _____
3. Discharge Date: _____ Time: _____
4. Gestational age at delivery: _____ weeks _____ days
5. Ethnicity
 - White
 - Asian American
 - Black or African American
 - Hispanic or Latino
 - Native Hawaiian & Other Pacific Islander
 - American Indian or Alaska Native
 - Multiracial
 - Refused
6. Payor
 - Medicaid
 - BCBS/State
 - Uninsured
 - Other
7. Did the newborn receive gel in the NBN or another facility prior to admission?
 - Yes
 - No
8. Did infant receive IV fluids?
 - Yes
 - No
- 8a. If #8 YES: Date IV infusion started: _____ Time IV infusion started _____
- 8b. If #8 YES: Date IV infusion stopped: _____ Time IV infusion stopped: _____

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9. Was an IV weaning protocol followed with this newborn?
- Yes
 - No
10. Was newborn offered feed or supplementation? (even if receiving IV fluids)
- Yes
 - No
- 10 a. If #10 YES, indicate type of feeding or supplementation newborn received: (check all that apply)
- Colostrum
 - Donor breastmilk
 - Glucose Gel
 - Formula
11. Was parent or family educated regarding hypoglycemia that is documented in the EMR/chart?
- Yes
 - No