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: ________
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