Today's date _______ / _______ / 2008 Data collector ___________________________

SEA-ORCHID Preterm Form

Second birth

1 **Survey record number of mother (eg IPH/0532 etc.)**

☐

2 **Date and time of birth**

☐☐ ☐☐ ☐☐ ☐ Unknown

D D M M Y Y

☐☐ - ☐☐ ☐ Unknown

TIME (24 hours)

3 **Respiratory distress**

☐ Yes ☐ No ☐ Unknown

(defined as respiratory distress needing supplemental oxygen or other assistance > 24 hours)

4 **Was oxygen therapy needed after resuscitation?**

☐ Yes ☐ No ☐ Unknown

If yes, number of days: ☐☐☐

5 **Was mechanical ventilation used?**

☐ Yes ☐ No ☐ Unknown

If yes, number of days: ☐☐☐

6 **Maximum inspired oxygen (FiO_2)**

☐ ☐ Unknown

7 **Length of hospital stay for baby (days)**

☐ ☐ Unknown

8 **Proven infection**

☐ Yes ☐ No (if no, go to **12**) ☐ Unknown

If culture-proven, was onset of infection 48 hours or less after birth?

☐ ≤ 48 hrs after birth ☐ > 48 hrs after birth

☐ Both ☐ Unknown

9 **Organism cultured (tick all that apply)**

☐ Group B Streptococcus

☐ Coagulase negative Staphylococcus ☐ Staph aureus

☐ E coli ☐ Klebsiella ☐ Pseudomonas

☐ Enterobacter ☐ Other ___________________

10 **For Staphylococcus infection indicate if antibiotic resistance:**

☐ methicillin resistant ☐ methicillin sensitive ☐ Unknown

11 **If E coli, Klebsiella, Pseudomonas, Enterobacter or Other, indicate if antibiotic resistance:**

☐ ESBL* ☐ non-ESBL* ☐ Unknown

* ESBL = extended spectrum beta lactamase producer

12 **Suspected infection**

☐ Yes ☐ No ☐ Unknown

If yes, duration of antibiotics: ☐ days ☐ Unknown

Third birth

1 **Survey record number of mother (eg IPH/0532 etc.)**

☐

2 **Date and time of birth**

☐☐ ☐☐ ☐☐ ☐ Unknown

D D M M Y Y

☐☐ - ☐☐ ☐ Unknown

TIME (24 hours)

3 **Respiratory distress**

☐ Yes ☐ No ☐ Unknown

(defined as respiratory distress needing supplemental oxygen or other assistance > 24 hours)

4 **Was oxygen therapy needed after resuscitation?**

☐ Yes ☐ No ☐ Unknown

If yes, number of days: ☐☐☐

5 **Was mechanical ventilation used?**

☐ Yes ☐ No ☐ Unknown

If yes, number of days: ☐☐☐

6 **Maximum inspired oxygen (FiO_2)**

☐ ☐ Unknown

7 **Length of hospital stay for baby (days)**

☐ ☐ Unknown

8 **Proven infection**

☐ Yes ☐ No (if no, go to **12**) ☐ Unknown

If culture-proven, was onset of infection 48 hours or less after birth?

☐ ≤ 48 hrs after birth ☐ > 48 hrs after birth

☐ Both ☐ Unknown

9 **Organism cultured (tick all that apply)**

☐ Group B Streptococcus

☐ Coagulase negative Staphylococcus ☐ Staph aureus

☐ E coli ☐ Klebsiella ☐ Pseudomonas

☐ Enterobacter ☐ Other ___________________

10 **For Staphylococcus infection indicate if antibiotic resistance:**

☐ methicillin resistant ☐ methicillin sensitive ☐ Unknown

11 **If E coli, Klebsiella, Pseudomonas, Enterobacter or Other, indicate if antibiotic resistance:**

☐ ESBL* ☐ non-ESBL* ☐ Unknown

* ESBL = extended spectrum beta lactamase producer

12 **Suspected infection**

☐ Yes ☐ No ☐ Unknown

If yes, duration of antibiotics: ☐ days ☐ Unknown