Product Description

Overview

The **NeoData NICU Patient Data System** is a computerized, multi-user data system designed to assist physicians and other medical care providers in the clinical management of patients from admission through discharge and to produce major NICU patient documentation, including:

- Admission summaries
- Progress notes
- Discharge summaries
- Report sheets for rounds
- TPN and other fluid orders

In the process, a broad range of clinical information is captured and available for data reports and analysis.

The NeoData program runs on standard PCs using the **Windows XP, or Windows Vista** operating systems. It is designed for use over a network to accommodate multiple data entry workstations.

NeoData is designed so that all data entry may be performed by the NICU medical staff on workstations located in the NICU area. Documents are printed immediately upon completion of data entry, signed, and placed directly in the patient chart. These tasks are performed as part of the daily patient care routine, in precisely the same manner as if notes were handwritten. This approach requires no dictation, filling out of forms, or involvement of clerical staff.

The NeoData system provides a number of benefits, including:

- Consistent terminology, standard formatting, and increased legibility of documentation;
- Improved tracking of data and management plans;
- Data analysis using the built-in Query and Report module;
- Support for billing operations;
- Significant time savings.

Note that NeoData is not intended to completely replace the standard paper chart. Similar to pen and paper, it is a tool for tracking information and producing paper documents for inclusion in the official chart. With no further effort, it also stores substantial amounts of information for queries and reports.

The design of NeoData is based on several major principles:

- The most reliable and efficient way to capture in computerized form large amounts of patient information for later analysis is to design a data entry system for use directly by the medical staff as part of routine patient care, since virtually all important patient information is eventually processed in some form by these personnel.
- To be consistently and reliably used, a data entry system intended for use by busy medical staff **must be perceived by its users as benefiting them directly**, such as by improving patient care or by saving time.

The requirement that a data system handle a large amount and range of information, coupled with the goal of having virtually all data entry able to be performed directly by the medical staff, demands a carefully designed system which has been proven in real-world use in active NICUs. This is what NeoData offers.
Data Entry Screens

NeoData includes 16 major **forms**, or data entry screens. The main screen, the **Select Patient Form**, allows users to perform the following functions:

- Maintain a list (the **Current Patient List**) of all patients currently admitted to the NICU service;
- Select patients from the Current Patient List for data entry or viewing;
- Search for any patient previously entered into the system, including discharged patients, for data entry or viewing.

At any given time, one patient is the **currently selected patient**. To insure data integrity, only one workstation on the network can enter data for a given patient at a time.

The other 15 forms are the actual **Data Entry Forms**. While the program is running, any form may be selected by clicking on its **index tab**.

The 16 major forms and their functions are listed here; click on the form name to view a screen shot of the form:

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Patient</td>
<td>Selection of patients and management of the Current Patient List.</td>
</tr>
<tr>
<td>Pregnancy Information</td>
<td>Maternal information, pregnancy, and labor.</td>
</tr>
<tr>
<td>Birth Information</td>
<td>Delivery, birth information, patient identification, resuscitation, and delivery addendum.</td>
</tr>
<tr>
<td>Admission Information</td>
<td>Admission information and measurements, prior hospitalizations, transport addendum, and admission addendum.</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>Daily measurements, vital signs, and physical findings.</td>
</tr>
<tr>
<td>Respiratory Support</td>
<td>Current respiratory support settings, blood gas results, apnea and bradycardia, and ECMO information.</td>
</tr>
<tr>
<td>Daily Fluids</td>
<td>IV fluids and TPN, feedings and supplements, and extensive nutritional calculations.</td>
</tr>
<tr>
<td>Other Daily Information</td>
<td>Additional fluid intake information, daily progress note addendum, and procedure or supplemental progress notes.</td>
</tr>
<tr>
<td>Tracking Information</td>
<td>Ophthalmologic screening, hearing screening, state newborn screening, immunizations, and discharge planning.</td>
</tr>
<tr>
<td>Problems and Diagnoses</td>
<td>Problem and diagnosis list with associated medications, procedures, and plans for each problem.</td>
</tr>
<tr>
<td>Radiology Studies</td>
<td>Radiologic studies.</td>
</tr>
<tr>
<td>Lab Results 1</td>
<td>Hematology and chemistry lab results.</td>
</tr>
<tr>
<td>Lab Results 2</td>
<td>Cultures, drug levels, and other lab results.</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>Discharge information, measurements, treatment, follow-up, and addendum.</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>Status of ophthalmologic screening, hearing screening, state newborn screening, and immunizations as of discharge; respiratory and nutritional support chronologies during the admission.</td>
</tr>
<tr>
<td>Other Patient Information</td>
<td>Final outcome and miscellaneous patient information.</td>
</tr>
</tbody>
</table>

At the bottom of the NeoData screen, always visible, is a **display panel** which can show any one of the following:

- Basic patient information including name, birthdate, birthweight, gestation, admission date, and admission weight;
- A section of document text for the data currently being edited as it will appear in a summary or progress note;
- Any lab results for the currently selected patient.
**Printed Documents**

NeoData generates all standard patient documentation and other reports and printouts. Examples of the first pages of the following documents printed by the NeoData program may be viewed by clicking on the document name:

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Summary</td>
<td>Admission summary.</td>
</tr>
<tr>
<td>Progress Note</td>
<td>Daily progress note.</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>Discharge or transfer summary.</td>
</tr>
<tr>
<td>Round Sheets</td>
<td>Sheets with current respiratory, fluid, laboratory, and other information</td>
</tr>
<tr>
<td></td>
<td>for all patients in the NICU, 3-4 patients to a page. May be photocopied</td>
</tr>
<tr>
<td></td>
<td>to give a set to each person on rounds.</td>
</tr>
<tr>
<td>Daily Fluid Orders</td>
<td>Fluid orders (including TPN, other IVs, and feedings) based on the</td>
</tr>
<tr>
<td></td>
<td>information in the <a href="#">Daily Fluids Form</a>.</td>
</tr>
</tbody>
</table>

**Note:** The precise page layout used for each type of document depends on a number of configuration settings. Among other options, you may configure the document to include or not include the header, footer, background frame, imprint area, logo, etc. Notice that the Admission Summary and Progress Note are formatted with these features turned on, while the Discharge Summary is formatted with most of them turned off.
NeoData includes a powerful and flexible **Query and Report Module** which allows you to rapidly create a variety of user-defined **queries** (data searches) and **reports** (printouts of query results). With this feature, you can review and analyze patient information stored in the NeoData data file directly from within the program. Once configured, queries can be stored for repeated use.

Three different types of reports can be produced by the NeoData Query Module:

- **Spreadsheet Report**: A Spreadsheet report creates a vertical list of the patients or admissions in the Query Results list with one or more items of information for each arranged in columns. Information for a single patient or admission is displayed on a single line:

<table>
<thead>
<tr>
<th>Pt Last Name</th>
<th>Pt First Name</th>
<th>Sex</th>
<th>Twin</th>
<th>Med Rec ID</th>
<th>Birth Date</th>
<th>Birth Weight</th>
<th>Gest Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>3/6/04</td>
<td>0.647</td>
<td>23</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>4/25/04</td>
<td>1.286</td>
<td>20</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>0.566</td>
<td>24</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>0.499</td>
<td>25</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Hannah</td>
<td>Female</td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>1.154</td>
<td>28</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>0.573</td>
<td>23</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Ciera</td>
<td>Female</td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>0.573</td>
<td>23</td>
</tr>
<tr>
<td>Patient2784l</td>
<td>Female</td>
<td></td>
<td></td>
<td>27342784</td>
<td>4/14/04</td>
<td>0.573</td>
<td>23</td>
</tr>
</tbody>
</table>

- **Statistics Report**: In a Statistics report, each cell in the report table displays statistical information pertaining to the patients or admissions which meet the cell’s respective column and row conditions. A typical example of one type of Statistics report would be a crosstabulation of **admission outcomes** (discharged home, transferred, died, etc.) arranged horizontally (columns) versus **birth weight ranges** (500-1000 grams, 1001-1500 grams, etc.) arranged vertically (rows). The resulting table would show the number patients who had each particular outcome within each birth weight range:

<table>
<thead>
<tr>
<th>Birth Weight</th>
<th>Discharged Home</th>
<th>Transfer Of Service</th>
<th>Acute Transfer</th>
<th>Convalescent Transfer</th>
<th>Died</th>
<th>Chronic Care</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>501 - 1000</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (2.28)</td>
</tr>
<tr>
<td>1001 - 1500</td>
<td>7 (11.5)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>7 (11.5)</td>
</tr>
<tr>
<td>1501 - 2000</td>
<td>12 (19.7)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (3.38)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>14 (23.0)</td>
</tr>
<tr>
<td>2001 - 2500</td>
<td>6 (9.9)</td>
<td>2 (3.22)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (1.64)</td>
<td>0 (0)</td>
<td>9 (14.9)</td>
</tr>
<tr>
<td>2501 - 3000</td>
<td>3 (4.82)</td>
<td>5 (8.33)</td>
<td>1 (1.64)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>9 (14.8)</td>
</tr>
<tr>
<td>3001 - 3500</td>
<td>3 (4.92)</td>
<td>5 (8.33)</td>
<td>1 (1.64)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>7 (11.5)</td>
</tr>
<tr>
<td>3501 - 4000</td>
<td>3 (4.92)</td>
<td>5 (8.33)</td>
<td>1 (1.64)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>9 (14.8)</td>
</tr>
<tr>
<td>Totals</td>
<td>34 (55.7)</td>
<td>15 (24.6)</td>
<td>4 (6.66)</td>
<td>3 (4.92)</td>
<td>1 (1.64)</td>
<td>0 (0)</td>
<td>57</td>
</tr>
</tbody>
</table>

- **Multiline Report**: Like a Spreadsheet report, a Multiline report creates a vertical list of the patients or admissions in the Query Results list. However, the information for each patient or admission can be displayed over multiple lines. In addition, Multiline reports can include one or more Subreports; these are supplemental tables of information (lab results, medications and dosages, etc.) that are included in each patient or admission section. In the example below, 6 report columns (on 2 lines) and 2 subreports (medications and procedures) are included in the report:
In addition, queries can be generated using Microsoft Access or most other Windows-based data management software. Access is a particularly good choice since it is both powerful and easy-to-use, includes extensive querying capabilities and excellent support for the industry-standard SQL language, and can be used with both Access and SQL Server databases.
### Other Features

Some of the other features of the NeoData program are listed here. If the name of the feature is underlined, you may click on the name to see an example:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Support</td>
<td>Automatic and manual entry of CPT billing codes and printout of weekly charge sheets and other billing reports.</td>
</tr>
<tr>
<td>TPN Worksheet</td>
<td>Complete TPN order entry module with built-in overrange warnings.</td>
</tr>
<tr>
<td>Nutritional Calculations</td>
<td>On-screen display of extensive nutritional calculations, based on the information in the <strong>Daily Fluids Form</strong>. These may also be included on the <strong>Growth Charts</strong>.</td>
</tr>
<tr>
<td>Vermont Oxford Database Support</td>
<td>Direct interface to the Vermont Oxford Network's eNICQ software providing automated enrollment of eligible patients and extraction of most VON data items from the inpatient database.</td>
</tr>
<tr>
<td>Weekly Patient Summaries</td>
<td>Printout of weekly patient summaries for billing support or for updates to referring physicians.</td>
</tr>
<tr>
<td>FollowUp Clinic Module</td>
<td>Patient enrollment, information tracking, and printout of clinic visit summaries.</td>
</tr>
<tr>
<td>Growth Charts</td>
<td>On-screen display and printout of growth and nutritional intake charts using various time scales.</td>
</tr>
<tr>
<td>Lab Results Graphs</td>
<td>On-screen display and printout of graphs of various lab values (e.g., WBC, serum sodium, arterial pO2).</td>
</tr>
<tr>
<td>Blood Gas Module</td>
<td>Complete data entry system for blood gas results designed for use by NICU blood gas lab personnel; includes automated transfer of specimen results from a blood gas analyzer.</td>
</tr>
<tr>
<td>Macros</td>
<td>Predefined blocks of text which can be entered into a field with a few mouse clicks.</td>
</tr>
<tr>
<td>Templates</td>
<td>Predefined entries for entire groups of fields (physical exam, x-rays, procedures) which can be recalled with a few mouse clicks.</td>
</tr>
<tr>
<td>Spelling Checker</td>
<td>Spell checking as data is entered with full control over which fields are checked.</td>
</tr>
<tr>
<td>Patient Alerts</td>
<td>Display informational messages, reminders, or warnings, and optionally insert standard text into progress notes, based on current patient status.</td>
</tr>
<tr>
<td>Consults</td>
<td>Enter information on consults outside the NICU (delivery room attendance, normal nursery consults, prenatal consults, etc.) and print notes for the chart. Billing charges can be entered and charge sheets printed for each consult.</td>
</tr>
<tr>
<td>Management Protocols</td>
<td>On-screen display of patient management protocols and/or any other text documents.</td>
</tr>
<tr>
<td>Address List</td>
<td>Rapid entry and recall of names and addresses.</td>
</tr>
<tr>
<td>Calculators</td>
<td>Medication drip calculator, gestational age calculator, standard arithmetic calculator, and general-purpose formula evaluator.</td>
</tr>
<tr>
<td>Patient Export/Import</td>
<td>Exporting and importing of patient information to or from an external file for use when transferring a patient between facilities.</td>
</tr>
<tr>
<td>Support for Multiple NICU Teams</td>
<td>Support for multiple teams or services with separate patient lists, creation and storage of multiple progress notes per day, and support for different user categories (e.g., Attendings, Residents, NNP’s) with different data entry privileges and different progress notes.</td>
</tr>
</tbody>
</table>
Configuration

Given the complexity of a data system which attempts to capture most of the patient information handled by the NICU medical team each day, the ability to configure, or adapt, the program to the needs and work habits of a given NICU is crucial to the usefulness of the program. The program allows a system administrator (that person or persons responsible for the installation and management of the system) to configure the program in a number of ways.

Adding configurability to the program is and will continue to be an ongoing priority for MetaSoft. We welcome suggestions from users as to which features might be made configurable; wherever possible, we will add such capabilities as each new version is developed.

Some of the available configuration settings are listed below:

**General Program Behavior**
- Patient identifier definitions
- Data entry customizations
- Macro definitions
- Control over which data items are carried forward from day to day
- Spell checking settings

**Data Entry Screens**
- Number and order of data screens
- Organization of fields within screens
- Ability to create new data screens and to add new fields

**Documents**
- Fonts, margins, borders, logos, imprint areas, barcodes, and other formatting options
- Control over document sections, their headings, and their order within the document
- Customization of most document text
- Creation of electronic documents for inclusion in hospital CPR
- Customization of Round Sheets

**Fluids**
- Data entry customizations for TPN and other IVs
- Content of Daily Fluid Orders
- TPN additive defaults (vitamins, trace elements, etc.)
- Out-of-range alerts for nutritional calculations (e.g., total potassium)

**Drop-down Lists**
- Content of all drop-down lists
- List names

**Field Parameters**
- On-screen field labels
- Drop-down lists associated with text fields
Out-of-range alerts for numeric fields
Field status (normal, disabled, hidden, or required)

Billing Features
- Customization of the Daily Charge Sheet
- Automatic entry of bundled and procedure charges

Security
- Password protection of access to configuration screens and other functions
- Program login settings
- User login names and passwords
- User categories and associated privileges for all program functions
- Database type and login settings
- Auditing of logins, data viewing, and data entry
**HL7 Interface**

The **NeoData HL7 Module** is an optional add-on tool for exchanging information with other hospital systems.

NeoData uses the HL7 standard so that it can exchange information with any system that also supports HL7. This means that separate links to different hospital information systems (HIS) such as Cerner, EPIC, Meditech, etc. are not necessary. A single interface serves the purpose of linking to all these systems.

The **NeoData HL7 Module** supports the receipt of admissions and some labs and the sending of Patient Note text.

The **NeoData HL7 Module** receives admission information from the hospital system and converts it into a format that can be used by NeoData. The user can review admissions that were received from the interface and accept or reject the information that was received. They can also add to the information as they accept the patient into NeoData.

The **NeoData HL7 Module** receives lab values for existing patients from the hospital system and converts them into a format that can be used by NeoData. The lab values are made available for review by a clinician. In many cases, not all lab values will be accepted - just those that are appropriate for that day’s progress note.

The core of NeoData provides the ability to generate electronic versions of patient notes and save them as files. These files can be in different formats such as RTF (Microsoft Word) and PDF (Adobe Acrobat). These files can be imported into the hospital system for storage or even for electronic signatures.

HL7 also provides a standard for exchanging patient notes. The **NeoData HL7 Module** uses that standard to provide a means to send the text of a Patient Note directly to the hospital system.

For more information on the **NeoData HL7 Module**, including the detailed HL7 specification, contact Isoprime Sales at 630-955-0022.
**Licensing & Pricing**

**Licensing**

Licensing for the NeoData system is per NICU. The software may be installed on any number of computers and may be used by any number of people as long as all operations are in support of a licensed NICU and the terms of the license are otherwise protected.

Several different licenses are available based on the maximum daily census which can reasonably be expected in your NICU. Note that you will need a license for the maximum number of patients expected on any given day. See the **Pricing** section below.

A license agreement signed by both parties is required. A maintenance agreement is an integral part of each license; this agreement provides for unlimited technical support and program upgrades. Your site will be invoiced for an annual maintenance fee based on the amount of the original license fee. The first maintenance fee is due 12 months after signing of the license agreement.

**Multi-site licensing** is available with pricing discounts for the additional units.

<table>
<thead>
<tr>
<th>Pricing</th>
<th>License Fee</th>
<th>Maintenance Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core System License</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited (15 beds)</td>
<td>$10,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Limited (25 beds)</td>
<td>$12,000</td>
<td>$1,800</td>
</tr>
<tr>
<td>Limited (45 beds)</td>
<td>$15,000</td>
<td>$2,250</td>
</tr>
<tr>
<td>Unlimited</td>
<td>$18,000</td>
<td>$2,700</td>
</tr>
<tr>
<td><strong>HL7 Interface Module</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One test server and one production server</td>
<td>$7,000</td>
<td>$1,050</td>
</tr>
<tr>
<td><strong>Multi-Site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Isoprime Sales</td>
<td>630-955-0022</td>
<td></td>
</tr>
</tbody>
</table>
**Using the Demo Program**

Isoprime provides a **Demonstration Version** of NeoData free of charge; you may request a copy on our [web site](#) or by contacting Isoprime.

**After installing the demo program:**

1. Review the **Installation Notes**.
2. Review the **Getting Started Tutorial**. The tutorial can be accessed from within the program itself via the **Help menu**.
3. Familiarize yourself with the **NeoData Help document**. The Help document can be accessed by selecting **NeoData Help** from the NeoData Demonstration program folder or from within the program itself via the **Help menu**.
4. For information on configuring the program, see the chapter titled **System Administration** in the Help document.

**Note:** Administration functions and billing functions each require a **password**; these passwords are case-insensitive (they may be entered in either uppercase or lowercase) and may be changed if desired. The default passwords are:

**Administration Password:** nicu4321

**Billing Password:** charges
Further Information

Isoprime Web Site:

If you are interested in a more detailed look at the NeoData system, we recommend that you obtain a copy of the Demonstration Version of the program. You can request a copy of the demo program on our web site at:

http://www.isoprime.com

Contacting Isoprime:

If you have any other questions, you can contact Isoprime as follows

<table>
<thead>
<tr>
<th>Address:</th>
<th>Isoprime Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4300 Commerce Court</td>
</tr>
<tr>
<td></td>
<td>Suite 315</td>
</tr>
<tr>
<td></td>
<td>Lisle, IL  60532</td>
</tr>
<tr>
<td>Office Phone:</td>
<td>630-955-0022</td>
</tr>
<tr>
<td>Office Fax:</td>
<td>630-955-0088</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:isosupport@isoprime.com">isosupport@isoprime.com</a></td>
</tr>
</tbody>
</table>

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### Pregnancy Information Form

**Maternal Information**
- **Mat Last Name**: SamplePatient
- **Mat First Name**: Donna
- **Mat Admission ID**: 1234567
- **Mat Med Rec No**: 123456
- **Mat Birth Date**: 1/10/63
- **Mat Age**: 20

**Pregnancy and Labor**
- **Mat Transfer From**: Jefferson Regional Medical Center
- **Primary OB**: 
- **Delivering OB**: 

**Maternal Lab Results**
- **Blood Type**: O-SS
- **Syphilis Ab**: Negative, On 11/4/03
- **HB Ab**: Negative, On 11/4/03
- **HIV**: Negative, On 11/4/03
- **Rubella**: Immune, On 11/4/03

**Other Maternal Lab Results**
- **Mother's Name**: SamplePatient, Donna

<table>
<thead>
<tr>
<th>Function</th>
<th>File</th>
<th>Edit</th>
<th>View</th>
<th>Procedures</th>
<th>Tools</th>
<th>Help</th>
</tr>
</thead>
</table>

**Patient Name**: SamplePatient, Natchole (Girl) | **Current Age**: 6 days
**Med Rec ID**: 0053433 | **Admission ID**: 1234567
**Birth Weight**: 0.082 kg | **Admission Date**: 4/3/4
**Gestation At Birth**: 27 weeks 0 days | **Current Gestation**: 27 weeks 0 days

Mother was admitted at the morning of delivery with bleeding. Ultrasound showed a partial abortion and an emergency cesarean section was done.
# Birth Information Form

![Image](image_url)
Admission Information Form

Patient Name: SamplePatient, Natalie (Girl)
Med Rec ID: 6052433
Birth Dates: 4/14/94
Birth Weight: 0.883 kg
Gestation At Birth: 27 weeks 0 days
Mother’s Name: SamplePatient, Donna

Current Age: 0 days
Admission ID: 1234567
Admission Date: 4/14/94
Admission Weight: 0.883 kg
Current Gestation: 27 weeks 0 days

Admission Indications: prematurity
Transport Addenda: On admission to the NICU, the patient was pink with mild respiratory distress. She was placed on a ventilator.

Admission Information Form
### Daily Fluids Form

**New IV Fluids** (use drag & drop to change order of fluids)

<table>
<thead>
<tr>
<th>Date</th>
<th>Dex gm/l</th>
<th>Dex mg/kg</th>
<th>Normal Saline</th>
<th>Normal NaCl</th>
<th>Lipid gm/l</th>
<th>Lipid g/kg</th>
<th>Heparin</th>
<th>Calc Magnesium</th>
<th>Calc Calcium</th>
<th>Total K+</th>
<th>+Mg HCl</th>
<th>Mg HCl</th>
<th>NaCl HCO3</th>
<th>K+ Bone</th>
<th>K+ HCO3</th>
<th>Ca HCO3</th>
<th>Mg HCO3</th>
<th>Ca HCO3</th>
<th>TPN</th>
<th>Worksheets</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/7/04</td>
<td>11.0</td>
<td>11.5</td>
<td>2.0</td>
<td>1.0</td>
<td>1.3</td>
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<td>5.5</td>
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<td>24.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/10/04</td>
<td>28.3</td>
<td>104.0</td>
<td>28.0</td>
<td>104.0</td>
<td>28.0</td>
<td>104.0</td>
<td>28.0</td>
<td>104.0</td>
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<td>28.0</td>
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<td>28.0</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Old IV Fluids** (use drag & drop to copy Old fluids to New)

<table>
<thead>
<tr>
<th>Date</th>
<th>Dex gm/l</th>
<th>Dex mg/kg</th>
<th>Normal Saline</th>
<th>Normal NaCl</th>
<th>Lipid gm/l</th>
<th>Lipid g/kg</th>
<th>Heparin</th>
<th>Calc Magnesium</th>
<th>Calc Calcium</th>
<th>Total K+</th>
<th>+Mg HCl</th>
<th>Mg HCl</th>
<th>NaCl HCO3</th>
<th>K+ Bone</th>
<th>K+ HCO3</th>
<th>Ca HCO3</th>
<th>Mg HCO3</th>
<th>Ca HCO3</th>
<th>TPN</th>
<th>Worksheets</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/7/04</td>
<td>12.0</td>
<td>25.0</td>
<td>2.0</td>
<td>1.0</td>
<td>1.0</td>
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<td>1.5</td>
<td>0.25</td>
<td>0.30</td>
<td>5.5</td>
<td>24.0</td>
<td>PVC</td>
<td>24.0</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4/10/04</td>
<td>22.0</td>
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<td>28.0</td>
<td>104.0</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Potassium

<table>
<thead>
<tr>
<th>Date</th>
<th>Na+</th>
<th>K+</th>
<th>Ca</th>
<th>Mg</th>
<th>CO2</th>
<th>BUN</th>
<th>Creat</th>
<th>Urea</th>
<th>Cr</th>
<th>Ca</th>
<th>Mg</th>
<th>CO2</th>
<th>HCO3</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/9/04</td>
<td>134</td>
<td>4.1</td>
<td>14.0</td>
<td>9.2</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/10/04</td>
<td>134</td>
<td>4.1</td>
<td>14.0</td>
<td>9.2</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sample Patient ID:** 1234567

**Patient Name:**

**Date:** 4/10/04

**Time:** 22:00

**Route:** IV
Other Daily Information Form

![Image of the Other Daily Information Form]

**Forms**
- Other Fluid Information
  - Actual Intake Prev 24hrs: 133.0 144.0
  - Actual Output Prev 24hrs: 59.0 5.0
  - Dial Feeding Schedule:
    - Well
  - Fluids Comments:
    - Advance feedings slowly

**Other Daily Information**
- Daily Admission:
- Attending Admission:
- Daily Attending MD: William W. Lowe, MD

**Supplemental Notes**
- Date: 4/10/04
- Time: 14:39
- Procedure: central venous catheter (percutaneous)
- Attending MD: William W. Lowe, MD
- Prepared By: Dr. Doe
- The site was prepared with sedation without difficulty. The patient tolerated...

**Patient Information**
- Patient Name: Sample Patient, John
- Med Rec ID: 123456
- Birth Date: 6/20/04
- Gender: Male
- Gestation at Birth: 37 weeks 3 days
- Mother's Name: Sample Patient, Donna
- Current Age: 28 days
- Admission Date: 6/10/04
- Admission Weight: 3.500 kg
- Current Gestation: 28 weeks 3 days
### Tracking Information Form

**Patient Name:** SamplePatient, Michelle (G)  
**Current Age:** 64 days  
**Med Rec #:** 063430  
**Birth Date:** 4/29/04  
**Birth Weight:** 1.580 kg  
**Gestation At Birth:** 37 weeks 0 days  
**Mother’s Name:** SamplePatient, Donna

**Function:** 
- Off
- On
- Spell Check
- Lab

---

### Immunization/Prophylaxis

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<thead>
<tr>
<th>Date</th>
<th>Immunization</th>
<th>Next Due</th>
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</thead>
<tbody>
<tr>
<td>4/29/04</td>
<td>Hepatitis B</td>
<td>4/16/04</td>
</tr>
<tr>
<td>4/29/04</td>
<td>DTP</td>
<td>5/16/04</td>
</tr>
<tr>
<td>6/29/04</td>
<td>Hib</td>
<td>5/16/04</td>
</tr>
</tbody>
</table>

**Discharge Planning**

- Home nutrition not indicated
- Home oxygen not indicated

**Discharge Plans**

- Parents are prepared for infant’s discharge home. Parents have received DD/monitoring training and rooming-in is well-tolerated.
Problems and Diagnoses Form

FINDINGS:
The patient presented with the following symptoms:

- Coughing
- Difficulty breathing
- Fatigue

DIAGNOSIS:

- Pneumonia
- Asthma
- Chronic obstructive pulmonary disease (COPD)

TREATMENT:

- Oral antibiotics
- Nebulizer therapy
- Oxygen therapy

LAB RESULTS:

- Hemoglobin: 12.5 g/dL
- White blood cell count: 11,000/mm³
- Creatinine: 1.2 mg/dL

COMMENTS:

- The patient is responding well to treatment.
- Regular follow-up appointments are recommended.

NEXT STEPS:

- Continue antibiotic therapy for 7 days.
- Schedule a follow-up appointment in 1 week.

PATIENT COOK PROGRESS

- Completed antibiotics
- Full recovery expected in 10 days

MEASUREMENTS:

- Body temperature: 37.2°C
- Oxygen saturation: 98%
- Blood pressure: 120/80 mmHg
## Radiology Studies Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Category</th>
<th>Study Name</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/3/04</td>
<td>10:40</td>
<td>Chest</td>
<td>chest way</td>
<td>severe cardiomegaly, decreased expansion, ET tube in good position</td>
</tr>
<tr>
<td>4/4/04</td>
<td>11:20</td>
<td>Cranial</td>
<td>cranial ultrasound</td>
<td>normal findings</td>
</tr>
<tr>
<td>4/4/04</td>
<td>08:30</td>
<td>Chest</td>
<td>babygram</td>
<td>diffusely increased, bilateral fluid in the tissues</td>
</tr>
<tr>
<td>4/5/04</td>
<td>05:00</td>
<td>Chest</td>
<td>chest way</td>
<td>bilateral haze, increased thickness, decreased expansion</td>
</tr>
<tr>
<td>4/5/04</td>
<td>13:20</td>
<td>Cranial</td>
<td>cranial ultrasound</td>
<td>normal findings</td>
</tr>
<tr>
<td>4/7/04</td>
<td>05:40</td>
<td>Chest</td>
<td>chest way</td>
<td>clearing of mild hazing, bilaterally E1 slightly high</td>
</tr>
<tr>
<td>4/7/04</td>
<td>05:00</td>
<td>Chest</td>
<td>chest way</td>
<td>essentially clear lung fields</td>
</tr>
</tbody>
</table>

### Patient Information
- **Name**: Sample Patient, Nichole (girl)
- **Medical Rec. ID**: 69002432
- **Birth Date**: 4/3/04
- **Birth Weight**: 3.65 kg
- **Gestation at Birth**: 37 weeks 6 days
- **Mother's Name**: Sample Patient, Donna
- **Current Age**: 7 days
- **Admission Date**: 04/04/04
- **Admission Weight**: 3.65 kg
- **Current Gestation**: 37 weeks 6 days

### Function
- **Function**: Off
- **Spell Check**: On
- **Date**: 10-Apr-2004 14:48:44
### NeoData Product Information

#### Lab Results 1 Form

#### Hematology

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<th>Date</th>
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<th>Hgb (g/l)</th>
<th>Hct (%)</th>
<th>MCH (pg)</th>
<th>MCV (fl)</th>
<th>RBC (x10^9/l)</th>
<th>PLT (x10^3/l)</th>
<th>E</th>
<th>L</th>
<th>N</th>
<th>Eo</th>
<th>B</th>
<th>M</th>
<th>Moe</th>
<th>My</th>
<th>WPBC</th>
<th>Retc (%)</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>4/4/04</td>
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<td>11.1</td>
<td>15.6</td>
<td>44.4</td>
<td>20.6</td>
<td>52</td>
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<td>4</td>
<td>44</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4/5/04</td>
<td>05:00</td>
<td>18.6</td>
<td>13.4</td>
<td>39.8</td>
<td>20.6</td>
<td>41</td>
<td>1</td>
<td>50</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/5/04</td>
<td>06:00</td>
<td>50.0</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Chemistry 1

<table>
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<tr>
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<th>Time</th>
<th>Na (mEq/l)</th>
<th>K (mEq/l)</th>
<th>Cl (mEq/l)</th>
<th>CO2 (mEq/l)</th>
<th>BUN (mg/dl)</th>
<th>Creat (mg/dl)</th>
<th>Blig (mg/dl)</th>
<th>Cal (mg/dl)</th>
<th>Mg (mEq/l)</th>
<th>Album (mg/dl)</th>
<th>Other</th>
</tr>
</thead>
<tbody>
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<td>7.1</td>
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<td>61</td>
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<td>7.1</td>
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<td>60</td>
<td>13.9</td>
<td>13.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/6/04</td>
<td>04:10</td>
<td>135.4</td>
<td>4.6</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4/7/04</td>
<td>06:00</td>
<td>129.4</td>
<td>4.3</td>
<td>104</td>
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<td>5.1</td>
<td>10</td>
<td>40</td>
<td>5.7</td>
<td>4.1</td>
<td>2.3</td>
<td>14.9</td>
</tr>
<tr>
<td>4/10/04</td>
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<td>126.5</td>
<td>5.0</td>
<td>103</td>
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<td>11</td>
<td>66</td>
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#### Chemistry 2

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<th>Time</th>
<th>BI (mg/dl)</th>
<th>Gbi (mg/dl)</th>
<th>Tmg (mg/dl)</th>
<th>AllNa U/L</th>
<th>TPNT U/L</th>
<th>Alb g/dl</th>
<th>AST U/L</th>
<th>ALT U/L</th>
<th>GGT U/L</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/4/04</td>
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<td>3.3</td>
<td>0.1</td>
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<tr>
<td>4/5/04</td>
<td>05:00</td>
<td>2.9</td>
<td>0.0</td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
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<td>50</td>
<td>145</td>
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<td></td>
</tr>
<tr>
<td>4/7/04</td>
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<td>0.2</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>3.4</td>
<td>0.1</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

#### Patient Information

- **Patient Name:** Sample Patient, Inc.
- **Med Rec No.:** 0002-030
- **Birth Date:** 4/5/04
- **Birth Weight:** 0.85 kg
- **Gestational Age at Birth:** 27 weeks 6 days
- **Mother's Name:** Sample Patient, Donna

#### Functions

- **Function:**
  - **Current Age:** 7 days
  - **Admission Date:** 4/3/04
  - **Admission Weight:** 0.85 kg
  - **Current Gestation:** 27 weeks 6 days
## Lab Results 2 Form

### Cultures

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Culture Type</th>
<th>Result</th>
<th>Comments</th>
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</thead>
<tbody>
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<td>4/2/04</td>
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<td>blood</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>4/2/04</td>
<td>11:30</td>
<td>urine-urine</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>4/2/04</td>
<td>11:20</td>
<td>blood</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>4/2/04</td>
<td>05:45</td>
<td>blood</td>
<td>negative</td>
<td></td>
</tr>
</tbody>
</table>

### Drug Levels

<table>
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<tr>
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<th>Time</th>
<th>Drug Type</th>
<th>Interval</th>
<th>Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
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<td>10.8</td>
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</tbody>
</table>

### Other Labs

<table>
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<th>Time</th>
<th>Lab Type</th>
<th>Results</th>
<th>Comments</th>
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</thead>
<tbody>
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<td>Blood Type</td>
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<td>4/2/04</td>
<td>09:50</td>
<td>Direct Coombs</td>
<td>negative</td>
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<tr>
<td>4/2/04</td>
<td>09:50</td>
<td>RPR</td>
<td>non reactive</td>
<td></td>
</tr>
<tr>
<td>4/4/04</td>
<td></td>
<td>Urine Drug Screen</td>
<td>neg</td>
<td></td>
</tr>
<tr>
<td>4/4/04</td>
<td></td>
<td>MedStat</td>
<td>neg</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Information

- **Patient Name:** SamplePatient, Nicole (Girl)
- **MedRec IDs:** 6093433
- **Birth Date:** 4/3/04
- **Birth Weight:** 0.852 kg
- **Gestation At Birth:** 27 weeks 0 days
- **Mother's Name:** SamplePatient, Donna
- **Current Age:** 7 days
- **Admission ID:** 1234567
- **Admission Date:** 4/3/04
- **Admission Weight:** 0.852 kg
- **Current Gestation:** 28 weeks 0 days

**Function:**
- Refresh
- Split Screen
Discharge Information Form

NeoData Product Information

Discharge Information
- Discharge Type: Discharged home
- Discharge Date: 3/5/01
- Discharge MD: Dr. Smith
- Discharge Time:
- Transferred to:
- Indications for Transfer:
- Cause of Death:
- Discharge Diagnosis:
  - Premature delivery
- Discharge Weight: 2.005 kg
- Discharge Length: 50.5 cm
- Discharge Head circumference: 32.0 cm
- Discharged Date:
- Discharged to:

Treatment and Follow-Up
- Discharge Instructions:
- Discharge Feeding:
- Discharge Medications:
- Discharge Appointments:
- Other Follow-Up:

Discharge Addendum
- Discharge Receiving MD:
- Discharge Preparing MD:
- Discharge Summary Copy To:

Patient Information
- Name: SamplePatient, Nicholas (Boy)
- ID: 60505000
- Birth Weight: 0.852 kg
- Gestation At Birth:
- Mother’s Name: SamplePatient, Donna
- Current Age: 64 days
- Admission Date: 12/5/99
- Admission Weight: 0.525 kg
- Current Gestation: 56 weeks 1 day

Function:
- Off
- Refresh
- Blank Check
- Click

Date: 06-Jan-2004 14:48:44
### Discharge Summary Form

**Summary Information**
- Peak Bk Tidal: 25
- Peak Airflow Rate: 10
- Date of Admission: 8/11/04
- Photo Rx Days: 12
- Last Hematocrit: 35
- Last Platelet Count: 5
- Day of First Feed: 6
- Room Air: 15
- Oxygen: 15
- Oxygen at 23: 11
- CPAP: 23
- Oxygen at Week 3: 25
- Ventilator: 3
- Length of Stay: 25
- Days: 3

**Immunization/Allergies**
- Date: 8/2/04
- Immunization: Hepatitis A
- Next Due: 4/4/02
- Date: 8/2/04
- Immunization: DPT
- Next Due: 5/15/02
- Date: 8/4/04
- Immunization: Hib
- Next Due: 8/15/02

**Respiratory Support**
- Support: Start Date: 6/28/04
  - CPAP: 4/12/04
  - Ventilator: 4/22/04
  - Nasal CPAP: 4/12/04
  - Nasal Cannula: 5/22/04
  - Ventilator: 5/22/04
  - Nasal Cannula: 5/22/04

**Nutritional Support**
- Support: Start Date: 6/22/04
  - Enteral: 4/15/04
  - TPN only: 4/15/04
  - Enteral: 4/15/04

**Screening Studies**
- Date: 6/24/04
  - Study Name: Newborn Screen
  - Results: All normal results
- Date: 5/25/04
  - Study Name: Hearing Screen
  - Results: Normal
- Date: 6/24/04
  - Study Name: ROP Screen
  - Results: Stage 1 ROP Zone 2-3 bilaterally

**Further Screening**
- ROP screen indicated 7/10/04
- Hearing screen indicated at 6 months adjusted age
- Nutritional screen not indicated

**Discharge Information**
- Last Hematocrit: 25 on 6/5/04
- Last Platelet Count: 5 on 6/5/04
- Last Hemoglobin: 3.6 on 6/5/04

**Discharge Information**
- Last Discharge: 6/5/04
  - Date: 6/5/04
  - Discharge: 6/5/04
  - Date: 6/5/04
  - Discharge: 6/5/04

**Discharge Information**
- Date: 6/5/04
  - Discharge: 6/5/04
  - Date: 6/5/04
  - Discharge: 6/5/04
Sample Documents

Admission Summary

Cape Fear Valley Medical Center

SAMPLEPATIENT2E 1234567 ADMISSION SUMMARY PAGE 1 OF 2 04/03/2004

Saturday, April 3, 2004
Printed: 7/26/04 14:12h

NAME: Sample Patient, Nicole (Ork)
ADMITTED: 4/3/04
MED. REC: 9853923

PREGNANCY & LABOR
MATERNAL AGE: 35 years, WP 92 lbs.
ESTIMATED DATE OF DELIVERY: 4/9/04, ESTIMATED GESTATION BY SD 20 weeks.
PREGNANCY COMPLICATIONS: None
LABOR: Spontaneous, TOCOLYSIS: None
DELIVERY: ELLIJOY HOSPITAL Jefferson Regional Medical Center LABOR & DELIVERY COMPLICATIONS: Precipitous onset of labor and fetal distress.
Mother was admitted on the evening of delivery with bleeding. This ensued showed uterine distention and an emergency cesarean section was done.

BIRTH
DATE: 4/3/04
TIME: 00:23 hours
WEIGHT: 9.325 lbs
LENGTH: 24.0 cm
Gestation: 35 weeks
AGA: No

RUPTURE OF MEMBRANES: At delivery, AMNIONIC FLUID: Clear
PRESENTATION: Vertex
ADMISSION: 8:15 am
Cord: No
CONDITION AT DELIVERY: Active, cyanotic and refractory.
TREATMENT AT DELIVERY: stimulation of uterine and endotracheal tube ventilation.
The infant was vigorous at birth, well-vascularized and spontaneous activity of respiratory effort, but at exchange was poor. She was suctioned and given fluids to help establish respiration and was with 12 hours.

ADMISSION
ADMISSION DATE: 4/3/04
TIME: 00:30 hours
ADMISSION TYPE: Immediate following delivery. ADMISSION INDICATION: Primary respiratory distress.
On admission to the NICU the patient was pale with respiratory distress. She was placed on an ventilator.

PHYSICAL EXAM
WEIGHT: 9.325 lbs
LENGTH: 24.0 cm
TEMP: 97.2°佛 Hb: 160, PR: 44, BP: 95/44, O2 SAT: 85-90%
CONDITION: Pink and quiet in mild.
FREQUENCY: Soft and flat, regular, consistent, STN: No change, radial: well marked, and patient.
RESPERATORY: Moderate retractions, good air exchange bilateral and symmetrically.
CARDIA: Normal rate and rhythm good perfusion, strong and regular pulses and no murmur.
ABDOMEN: Soft, non-tender abdomen, no organomegaly.
NO: Normal per rectal findings.
NEURO: BCS: Resistant to all stimuli, normal muscle tone and good deep tendon reflexes.
EXTREMITIES: No clubbing.

LABORATORY STUDIES
4/3/04 08:50h: Blood cultures: pending
4/3/04 11:20h: Urine: E.D. pending
4/3/04 08:00h: PER: normal

Jefferson Regional Medical Center
Progress Note

Cape Fear Valley Medical Center

SAMPLE PATIENT FE 1234567

PROGRESS NOTE PAGE 1 OF 2

04/10/2004

Saturday, April 10, 2004
Printed: 7:54/10:51h

AGE: 34. ADJ GEST AGE 29w 6d. WEIGHT: 0.8900g (Up 37g)

SPECIAL SIGNS & PHYSICAL EXAM

WEIGHT: 1100g
LENGTH: 34.5cm. HC: 25.7cm
EDMA: Normal HR: 152-148. RR: 40-60. BP: 95/52. URINE OUTPUT: 430mL/h. GLUCOSE SCREENING: 80 - 110mg%. STOOL:
Mucus in 48 hours. URETHRAL ANALYSIS: 1+ protein.

CONDUCTION: Face and skin pink and warm.
HEENT: Soft and flat fontanelle and overlapping sutures.
RESPIRATORY: Good air exchange bilaterally, unscratched cradles and good respiratory effort.
CARDIAC: Normal sinus rhythm, good perfusion and strong and equal pulses.
ABDOMEN: Soft and non-tendered abdomen and moderately decreased bowel sounds.
HISTORY: No SBC. Responsive but gastrointestinal type and described as generally.

LABORATORY STUDIES

4/6/04 07:38: WBC 8500/µL. HGB: 14.9. HCT: 44.3. PLT: 201,000. SOD: 2.2. L24 M12 E2
4/8/04 09:00: WBC 12,000/µL. HGB: 13.4. HCT: 39.3. PLT: 52,000. SOD: 2.6. L26 M14 E0
4/10/04 09:23h.: Hb 120
4/10/04 09:45h. Blood culture negative

RADIOLOGY STUDIES

Skull fracture on 4/8/04 at 13:00h. Normal findings.

CT scan on 4/9/04 at 00:00h. Essentially normal findings.

CURRENT MEDICATION

Caffeine (100 mg IV gtt 12h started on 4/6/04 completed 3 of 7 days)
Vaccines: 1/27/04 IV gtt started on 4/6/04 completed 1 day
Caffeine 45 mg IV q4h started on 4/5/04 completed 1 day

RESPIRATORY SUPPORT

SUPPORT: Ventilator chest 4/6/04
PO2: 91% RT 26% RR: 20% Hemoglobin 10: 0.964: FL: 0.937: 60mm Hg
COS: 04/10/04 10:54% pH: 7.409. pCO2: 33. P02: 83.3. BE: 3.54
COS: 10/04 04:10% pH: 7.392. pCO2: 33. P02: 83.3. BE: 3.1

CURRENT PROBLEMS & DIAGNOSES

PULMONARY INSUFFICIENCY OF PREMATURE MILD
OBSERV: 5/04 STATUS Decubitus
PO4: 15/04 STATUS: Active
PO4: 15/04 STATUS: Active
MEDICATION: Fluid restriction 2000mL qid started on 4/6/04 completed 5/02

PHARMACIES:

INJECTION: 4/10/04 STATUS: Active
MEDICATION: Caffeine cts 100 mg IV gtt 12h started on 4/7/04 completed 3 of 7 days.

COMMENT: Plaintiff was started on antibiotics because of a change in respiratory status in conjunction with an abnormal CBC.

AT RISK FOR APNEA

OBSERV: 5/04 STATUS: Active
MEDICATION: Caffeine cts 100 mg IV gtt 12h started on 4/7/04 completed 3 of 7 days.

COMMENT: Started on caffeine on 4/8/05 in anticipation of extubation.
Discharge Summary

SAMPLE PATIENT ID: 123456

ADMITTED: 4/30/04
DISCHARGED: 5/6/04

PREGNANCY & LABOR

Gestation: 40 weeks
ESR: 0.5 FSH

BIRTH

DATE: 4/30/04	TIME: 09:30 hours
WEIGHT: 8.03kg	LENGTH: 56.0cm
GESTATIONAL AGE: 40 weeks
GROWTH: A normal
REPTURE OF MEMBRANES: At delivery. AMNIOTIC FLUID: Clear. PRESENTATION: Vertex. DELIVERY: Emergent cesarean section. INDICATION: Suspected placenta accreta. SITE: In the delivery room. ANESTHESIA: General ANESTHETIC: 6-17 minutes, 0.5-1.5 fentanyl. OXYCOCINE: 2.2 mg/kg. CONDITION AT DELIVERY: Active, uninvolved, and adequate labor.

ADMISSION

ADMISSION DATE: 4/30/04	TIME: 09:30 hours
ADMISSION TYPE: Immediately following delivery. FOLLOW-UP PHYSICIAN: Dr. Smith. ADMISSION INDICATIONS: Postpartum and respiratory distress.

On admission to the NICU, the patient was described as having respiratory distress. She was placed on a ventilator.

PHYSICAL EXAM

WEIGHT: 8.03kg	LENGTH: 56.0cm
CONDITION: Pale and quiet, mild acidosis.
HEENT: Soft and supple, normal cranial nerves, normal fundi, no headache.
RESPIRATORY: Decreased respiratory effort, good chest excursion bilaterally, no adventitious breath sounds.
CARDIOVASCULAR: Normal heart sounds, clear, no murmurs, no rubs, no edema.
ABDOMEN: Soft, non-tender, bowel sounds present, no masses.
NEUROLOGIC: Responsive, no focal changes, normal deep tendon reflexes, and normal cranial nerves.
EXTREMITIES: No edema.

LABORATORY STUDIES

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<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Result</th>
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<tr>
<td>4/30</td>
<td>CBC</td>
<td>Hgb 14.3</td>
</tr>
<tr>
<td>4/30</td>
<td>BUN</td>
<td>4.4</td>
</tr>
<tr>
<td>4/30</td>
<td>CRP</td>
<td>0.5</td>
</tr>
<tr>
<td>4/30</td>
<td>PT/INR</td>
<td>1.2</td>
</tr>
<tr>
<td>4/30</td>
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<tr>
<td>4/30</td>
<td>ALT</td>
<td>60</td>
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</table>

RESPIRATORY DISEASE: Syndrome MODERATE

03/01: 4/5/04 RESOLVED 4/5/04
PELOZIER Administration from 4/5/04 to 4/5/04, antiaggregatory therapy from 4/5/04 to 4/4/04 (4 doses).
## Round Sheets

### PATIENT: MA 160041

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<th>Value 3</th>
<th>Value 4</th>
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<td>96.8</td>
<td>10.0</td>
<td>0.1</td>
<td>1.0</td>
</tr>
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</table>

### PATIENT: MA 160007

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<th>Value 2</th>
<th>Value 3</th>
<th>Value 4</th>
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<tbody>
<tr>
<td>05/10/2004</td>
<td>96.8</td>
<td>10.0</td>
<td>0.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Daily Fluid Orders

**NAME:** Sample Patient, Nichole (Girl)  
**ADMISSION ID:** 1234567  
**MED REC ID:** 6053433  
**DATE:** 9/10/04  
**TIME:** 10:57 hr  
**Fluids:** 135mL/kg/d  
**Weight:** 0.90 kg

**IV Fluid #1:** TPN w/ PCVC to infuse at 3.9 mL/h over 24 hours (102.5 mL)  
- Dextrose: 11 g/mL  
- TPN 10%: 2 g/mL  
- Nac: 1 mL/kg  
- Na Acetate: 2 mL/kg  
- K: 1 mL/kg  
- K Phosphate: 1.5 mL/100mL as K$_4$  
- Calcium: 1.5 mL/kg  
- CR Ca Elemental: 30 mg/mL  
- Macromune: 0.25 mL/kg  
- CR Mg Elemental: 3.05 mg/mL  
- Heparin: 0.5 Units/mL  
- MV1 Feeder: 1.5 mL  
- PTX45% (2:1): 0.4 mL/kg  
- Cystine HCl: 56 mg/mL  

**IV Fluid #2:** IV Fluid to infuse at 0.5 mL/kg over *23* hours (12.7 mL/kg)  
- Concentration: 20%  
- Amount: 11.5 mL over 23h (2.53 g/mL)

**Feeding #1**  
- Formula: Enfamil Premature 24  
- Strength: 12 kcal/mL (0.5 strength)  
- Amount: 1 mL every hour 6 hours on, 2 hours off

**Signature:**

---

Jefferson Regional Medical Center  
Sample Patient, Nichole (Girl)  
**Admission ID:** 1234567  
**Birth Date:** 4/1/01  
**Admit Date:** 4/3/01
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