Assessment prior to active cooling

Name:
DOB:
Hosp number:
NHS number:

Date and Time of Birth:

Gestation: Weight: OFC:

Apgar score at 10 minutes:

Continued need for resuscitation at 10 minutes of age: Yes/No

Gases: Cord arterial Cord venous Admission gas

pH:

BE:

Lactate:

Does the infant meet any exclusion criteria (see reverse page): Yes/No

		Date:		Date:		Date:	
		Time:		Time:		Time:	
Pupils	Size, reactivity	**Left**	**Right**	**Left**	**Right**	**Left**	**Right**
Tone	Normal, hyper/hypo, flaccid						
Conscious Level	Normal, hyper-alert, lethargic, comatose						
Seizures	Yes/no						
Posture	Normal, fisting, distal flexion, decerebrate						
Moro reflex	Normal, partial, absent						
Grasp reflex	Normal, poor, absent						
Suck	Normal, poor, absent						
Respiratory support	Normal, hyperventilation, apnoea, IPPV						
Fontanelle	Normal, full, tense						
aEEG (if available)	See descriptions on reverse page						
Decision to actively cool	For treatment criteria – see reverse	Yes/No		Yes/No		Yes/No	
Reason for decision							
Name Signature Grade							

Cooling treatment criteria

A. Infants ≥ 36 completed weeks gestation admitted to the neonatal unit with at least one of the following:

- Apgar score of ≤5 at 10 minutes after birth
- Continued need for resuscitation, including endotracheal or mask ventilation, at 10 minutes after birth
- Acidosis within 60 minutes of birth (defined as any occurrence of umbilical cord, arterial or capillary pH <7.00)
- Base Deficit ≥ 16 mmol/L in umbilical cord or any blood sample (arterial, venous or capillary) within 60 minutes of birth

Infants that meet criteria A should be assessed for whether they meet the neurological abnormality entry criteria (B):

B. seizures or moderate to severe encephalopathy, consisting of:

- Altered state of consciousness (reduced response to stimulation or absent response to stimulation) and
- Abnormal tone (focal or general hypotonia, or flaccid) and
- Abnormal primitive reflexes (weak or absent suck or Moro response).

Exclusions for cooling

Do not start cooling infants if:

- Is likely to require surgery during first three days after birth
- Has other major congenital abnormalities indicative of poor long term outcome
- Is felt to be dying
- Has a significant intracranial bleed

Decision to cool infants of 34-35+6 weeks should be made by 2 consultants.

aEEG (CFM) patterns

Continuous normal voltage (lower >5mv, upper >10mv with sleep wake cycling)

Discontinuous normal voltage (lower <5mv, upper >10mv)

Continuous low voltage (lower <5mv and Upper <10mv)

Burst suppression (background 0 to 2mv with bursts >25mv)

Flat/isoelectric (all activity <5mv)

Seizures