

## Example

Study number: 1 | 2 | 3 | 4 | 5

Please start on day of birth (day 1) and continue until the final column is completed.

### Part C: Enteral Feed Details

Please tick each type of milk given on each day and give the total daily volume in ml/kg.

Date (dd/mm - add to top row)	D.O.B.	18/07	19/07	20/07	21/07	22/07	23/07	24/07	25/07	26/07	27/07	28/07	29/07	30/07
No milk given		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressed maternal milk		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Donor breast milk		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Premium formula (see Part B)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Term formula (see Part B)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total milk enteral/day		0   0   2	0   0   8	0   0   4			0   0   7	0   2   6	0   5   8	0   7   3	1   2   9	1   6   6	1   1   0	
Feed directly from the breast		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Please collect the first stool sample on day 14 or as near as possible to this date:

When was this stool sample sent off? 3 | 1 | 0 | 7

### Part D: Antibiotics and Antifungals

Please tick each day that systemic antibiotics AND/OR antifungals are given. Please include antibiotics or antifungals given for prophylaxis.

Any penicillin (Benzyl pen, Flucloz, Amp etc.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any tetracyclides (Cotrimox, Amoxicillin etc.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any glycopeptide (Vancomycin, Teicoplanin etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any carbapenem (Imipenem, Meropenem etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any β lactam / inhibitor (Ampicillin, Co-amoxiclav etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any macrolide (Erythromycin, Clarithromycin etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other antibiotic (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prophylactic antifungal	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antifungal to treat suspected or proven infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Part E: Antacids

Please tick each day that systemic ranitidine / proton pump inhibitor are given.

Ranitidine or proton pump inhibitor (e.g. Omeprazole)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------



## Form 2: Daily Data Collection

Please complete in black ballpoint pen

### Points to remember when completing this form:

- If the baby is transferred before this form is completed (i.e. if less than 14 days post-natal age), that the partially completed form is copied and the original is transferred with the baby (the copy is to be filed in the PiPS Data Collection File)
- If you are unable to photocopy the whole A3 sheet then copy each side onto A4 paper so that you have 4 pages ensuring the Study Number is on each page
- When this form has been completed, return to the Trial Office using a FREEPOST envelope from the PiPS Documentation Box
- If you make a mistake when filling out this form, strike through once and initial and date the correction (please do not use Tipp-ex!)
- Please ensure all questions are answered and that you record as much information as possible, this will avoid unnecessary work in chasing missing data
- An example of how this form should be filled out is given on the back page
- If you have any questions about this form or how to answer any of the questions please contact the Trial Office on [REDACTED]

### Part A: Baby details

Name of hospital: \_\_\_\_\_

Baby's surname: \_\_\_\_\_ First name: (if known) \_\_\_\_\_

Study number (5 digits): [ ][ ][ ][ ][ ]

Date of birth: [D]/[M]/[Y]

### Part B: Proprietary milk formulas

Please list below the names of all proprietary milk formulas the baby has received during the first two weeks after birth: (This information is needed because some of these contain prebiotic which might influence probiotic colonisation)

