Appendix X

Management of neonates who screen "at risk" but are awaiting disposition by Regional Cooling Center

Or

"What to do while contacting the Regional Cooling Center"

**Note: Each Cooling Centers may have their own criteria and management protocols for cooling. Even if your baby screens "at risk" by the CoolTool, it is the Cooling Center that ultimately determines if a baby is appropriate for transfer and initiation of cooling therapy. Please take this into consideration when communicating your assessments and plans with parents, to avoid setting up false expectations or contradictions with the Regional Cooling Center.*

1. **Patient has been screened "at risk" by CoolTool**
    a. After initial resuscitation and stabilization, screening evaluation complete.
    b. If screening criteria met, call neonatologist at regional cooling center.
    c. Discuss if patient appropriate for transport for cooling or to remain for observation.
    d. If accepted for transport by regional cooling center, see *Appendix C*.

2. **Maintain close communication with regional cooling center**
    a. Discuss management and plan if significant clinical changes develop.

3. **Maintain low normal range temperature.** **Avoid overheating.**
    a. **Target core/rectal temp = 36.5°C** (97.7°F) or **axillary/skin temp = 36.0°C** (96.8°F).
    b. Check temperature periodically (e.g., hourly for first 6 hours).

4. **Check glucose and electrolyte levels.**
    a. Check ***Glucose*** levels. **Avoid hypoglycemia**
        i. Consider maintaining high normal glucose levels (e.g., **>50-60mg/dl**)
    b. Consider checking ***Ca, K, Mg*** levels. Maintain within normal ranges.

5. **Obtain follow-up blood gases to confirm acidosis resolving**
    a. If acidosis persists, work-up other causes or discuss with neonatologist.

6. **Repeat neurologic examination** *(see appendix B)*
    a. Document initial neurologic exam.
    b. Repeat neurologic exam (eg, after 1-3 hours) if clinically indicated.
    c. Document neurologic exam at time of discharge.

7. **If initial acidosis severe, consider delaying enteral feeds (NPO) until improved**
    a. Depends upon severity of clinical presentation. Discuss with neonatologist.
    b. May require initiation of maintenance IVF fluids.

8. **Avoid iatrogenic hyperventilation and hyperoxygenation**
    a. Normal **pCO2** levels **(35-45 mmHg) –** compensatory hyperventilation may be seen.
    b. Normal **PaO2** levels **(<80mmHg)** and **oxygen saturations (<98%).**

9. **Consider ordering baseline labs:**
    a. CBC, platelets and Blood cultures.
    b. Start antibiotics if appropriate.

10. **Treat only clinical seizures –** No prophylactic antiepileptic treatments.
    a. **Lorazepam (Ativan):** 0.1mg/kg/dose IV, repeat once prn for suspected seizures.
    b. **Phenobarbital:** *20mg/kg IV load,* repeated once prn for confirmed seizures.

11. **If equipped and appropriately trained, consider bedside neuromonitoring**
    a. Amplitude integrated EEG (aEEG). Discuss plan with cooling center.