Newborn Care Map
Greater than or equal to 36wk GA and Greater than or equal to 2500 g

CURRENT PREGNANCY *(From Maternal Database)*

Maternal Age:_____years Gravida:_____ Para (including current delivery):_____ Gestation:_____ weeks by dates/US (circle one)

FAU/US results: ☐ *Not Done*

*Significant Findings:*_____

Maternal/Infant Risk Factors:

	POS.	NEG.		Y	N
Maternal Rh	☐	☐	Maternal Diabetes	☐	☐
Hepatitis B	☐	☐	Gestation Hypertension	☐	☐
Gonococcus	☐	☐	Maternal Antepartum Hemorrhage	☐	☐
Chlamydia	☐	☐	Cigarettes	☐	☐
HIV	☐	☐	Alcohol	☐	☐
VDRL	☐	☐	Recreational (Street) Drugs	☐	☐

Other Maternal Risk Factors: _____

BIRTH Hx | **DATE/TIME OF BIRTH:**_____ **ID BAND #:**_____ ☐ *M* ☐ *F* *Multiple Birth* ☐ *Y* ☐ *N*

Type of Delivery: ☐ *SVD* ☐ *Vacuum* ☐ *Forcep* ☐ *C/S* ☐ *Breech*

Apgar Score: _____ *1* _____ *5*

Narcotics < 4h prior to delivery? ☐ *Y* ☐ *N*

Meconium ☐ *Y* ☐ *N*
Intubated ☐ *Y* ☐ *N*
Nuchal Cord ☐ *Y* ☐ *N*

Risk Factors for Sepsis Review:

GBS Status ☐ *Pos* ☐ *Neg* ☐ *Unknown*

	Y	N
GA < 37 weeks	☐	☐
ROM ≥ 18 hrs	☐	☐
Maternal fever > 38°C	☐	☐
Previous child with GBS disease	☐	☐
Previous stillbirth at term	☐	☐
Intrapartum antibiotics	☐	☐

If any risk factors for sepsis, were antibiotics given to the mother?

If yes, date and time started: _____

Number of doses antibiotics given: _____

CBC and Differential required: ☐ *Y* ☐ *N*

Comments/concerns post-delivery: _____

NEONATAL ASSESSMENT | **FEEDING INTENT**

BIRTH WEIGHT:_____*g* _____*%ile* *Head Circumference* _____ *cm* *Length:* _____ *cm* *Estimated Gestational Age:* ____ ☐ *Breast* ☐ *Infant Formula*

PHYSICAL EXAMINATION BY PHYSICIAN/MIDWIFE	**Delivery Assessment**	**Reassessement**
ADDITIONAL HISTORY _____		
General		
Skin		
Head, Neck		
Eyes		
E.N.T.		
Thorax, Breast, Lungs		
CVS		
Abdomen, Umbilicus		
Genitalia, Anus		
Musculoskeletal		
CNS		
Physician/Midwife Signature *Time* *Date*		*Physician/Midwife Signature* *Time* *Date*

Immediate Newborn Phase

Vital Signs and Assessments (birth, 1 hr, 2 hrs, 3 hrs and PRN)					
D/M/Y					
Time					
Temperature					
Heart Rate					
Respiration					
Skin Color					
Behavior					
Skin-to-Skin (Document time initiated and discontinued)					
Comments					
Initial					

Skin Color

N - Normal
P - Pale
PL - Plethoric
Ac- Acrocyanosis
M - Mottled
C - Cyanosis

Behavior

S - Sleeping
AA - Active Alert
QA - Quiet Alert
L - Lethargic
I - Irritable
H - Hyperactive

Use the Newborn Frequent Monitoring Record (NFMR) if required.

Newborn Frequent Monitoring Record Used? ☐ No ☐ Yes

Was the Newborn transferred? ☐ No ☐ Yes If yes, discontinue the Care Map and write the reason the Progress Notes.

Procedures

	D/M/Y/Time	Initial	Comments
1. Newborn initial bath ☐ Yes ☐ No	_____	_____	_____

2. **For Vacuum Deliveries:**	D/M/Y/Time	Cm/HR/R	Initial	D/M/Y/Time	Cm/HR/R	Initial
• Measure Head Circumference	_____	_____	_____	_____	_____	_____
• ✓ for presence of fluctuant mass	_____	_____	_____	_____	_____	_____
• ✓ for increase in size of fluctuant mass	_____	_____	_____	_____	_____	_____
• ✓ for increased bogginess/swelling/ tension of scalp since birth	_____	_____	_____	_____	_____	_____
• ✓ for signs of hypovolemia	_____	_____	_____	_____	_____	_____
• ✓ heart rate/respirations **q1h x3, then q3h for 24 hours**						

3. ■ **IV Therapy**

☐ See NFMR — Document on Fluid Balance Record

IV Established _____ Date/Time

IV Discontinued _____ Date/Time

☐ intact ☐ not intact

Tests

1. ■ **Newborn Screening**

D/M/Y	Time	Initial
_____	_____	_____

☐ To be done by Midwife

2. ■ **Blood Glucose**

Monitoring as per protocol — Document on Newborn Feeding Record

3. ■ **Jaundice Investigation**

■ Transcutaneous Bili Check (TCB)

■ Total Serum Bilirubin (TSB) if jaundiced prior to 24 hours of age or visible jaundice at any age

D/M/Y/Age in hrs.	mmol/L	Initial	D/M/Y/Age in hrs.	mmol/L	Initial
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

☐ **Phototherapy** ☐ Standard ☐ See NFMR

Initiated at _____ DATE/TIME — Discontinued at _____ DATE/TIME

☐ Double

Initiated at _____ DATE/TIME — Discontinued at _____ DATE/TIME

4. ■ **CBC and Differential** As per sepsis guideline	D/M/Y	Time	Initial	Comment
	_____	_____	_____	_____
5. ■ **Newborn Hearing Screening**	_____	_____	_____	_____
6. ■ **Other**	_____	_____	_____	_____

Delivery Date / Time:	Vital Signs and Assessments (q8h X 48 Hours)							
ASSESSMENTS/CONSULTS	D/M/Y							
	Time							
	Temperature							
	Heart Rate							
	Respirations							
	Initial							

	Date:						
	Time:						
	ASSESSMENT OUTCOMES						
	• **Vital signs stable**						
	• **Skin color: normal for race, and age**						
	• **Mucous membrane color: pink**						
	• **Tone: normal tone, flexion of extremities or reflecting intrauterine position**						
	• **Behavior: sleeping with some alert periods, active, consoles easily**						
	• **Cry: normal-pitched cry**						
	• **Cord: clean and drying**						
	• **Chest: no signs of respiratory distress**						
	• **Abdomen: soft and round**						
	• **Pain: no evidence of pain, normal response to stimulation, no potential reasons for pain**						
	CONSULTS						
	■ Lactation Consultant as necessary						
TREATMENT	☐ Phototherapy						
NUTRITION	• Breast or formula feed on demand (document <u>all</u> feedings on the Newborn Feeding Record)						
	5 - 24 Hours						
	• At least 4 feeding sessions have occurred within 24 hours of birth						
	• Mother is responsive to early infant feeding cues						
	On Discharge						
	• Weight loss no greater than 8% of birth weight unless feeding plan established, follow-up in place & discharge approved by physician or midwife						
	• Gestational age greater than or equal to 36 wk and weight greater than or equal to 2500 g						
	• Stooling appropriately						
	• Voiding appropriately						
	• No apparent digestive problems						
	• Effective feeding established: there have been at least two independently managed feedings observed in which:						
	• Breastfed Infant: minimum score of "one" in each category except "T" on the LATCH-R tool						
	• Formula fed Infant: feeds 6 - 10 times a day on demand and is adequately hydrated						
SAFETY/ ACTIVITY	• Positioned supine						
	• Verify presence of ID bands on mother and newborn						
	• **Back to sleep**						
PSYCHO-SOCIAL	• Assess bonding						
	• Bonding: positive maternal/infant interaction demonstrated						

DISCHARGE PLANNING

I, the parent/guardian of Baby _____, have checked the corresponding ID band #_____ and certify that they match and I am receiving the correct baby.

Parent/Guardian Signature: _____ Nurse's/Midwife's Signature: _____

Discharge Date and Time: _____ In car seat ☐ Yes ☐ No

* = Integrated Progress Note (IPN)

REVIEW OF SYSTEMS/NEONATAL ASSESSMENT

GENERAL APPEARANCE ☐ **Normal**
☐ Asymmetrical ☐ Hypotonic
☐ Extremities not flexed

SKIN ☐ **Normal**
☐ Acrocyanosis ☐ Central cyanosis ☐ Dusky
☐ Pale ☐ Plethoric ☐ Mottled
☐ Meconium stained ☐ Dry ☐ Peeling
☐ Vernix ☐ Petechiae ☐ Pustules
☐ Vesicles ☐ Milia ☐ Café-au-lait
☐ Abrasions : _____
☐ Birthmarks : _____
☐ Ecchymosis : _____
☐ Lacerations : _____
☐ Mongolian spots : _____
☐ Rash : _____
☐ Skin tags : _____
☐ Other : _____

HEAD ☐ **Normal**
☐ Molding ☐ Caput
☐ Cephalohematoma ☐ Rt. ☐ Lt.
☐ Forcep/vacuum marks: _____
☐ Asymmetrical face
☐ Fontanelles: bulging/swollen

EYES ☐ **Normal**
☐ Subconjunctival hemorrhage ☐ Discharge

EARS ☐ **Normal**
☐ Low set
☐ Sinus ☐ Rt. ☐ Lt.
☐ Skin tags ☐ Rt. ☐ Lt.

NOSE ☐ **Normal**
☐ Discharge
☐ Nares not patent ☐ Rt. ☐ Lt.

MOUTH ☐ **Normal**
☐ Cyanosis ☐ Cleft lip
☐ Cleft Palate ☐ Hard ☐ Soft
☐ Ankyloglossia (tongue-tie)

NECK ☐ **Normal**
☐ Other _____

CLAVICLES ☐ **Normal**
☐ Crepitus ☐ Rt. ☐ Lt.

CHEST ☐ **Normal**
☐ Asymmetrical ☐ Barrel chest
☐ Breast engorgement ☐ Breast discharge
☐ Other _____

Respirations ☐ **Normal**
☐ Laboured ☐ Shallow
☐ Grunting ☐ Retractions
☐ Nasal flaring

Breath Sounds ☐ **Equal & Clear**
☐ Crackles ☐ Wheezes
☐ Unequal: _____

HEART ☐ **Normal**
☐ Irregular rate ☐ Murmur _____

ABDOMEN ☐ **Normal**
☐ Asymmetrical ☐ Masses ☐ Flat
☐ Scaphoid ☐ Distended ☐ Hard
☐ Absent bowel sounds
☐ Other _____

CORD ☐ **3 Vessel** ☐ **Clamped**
☐ 2 Vessels ☐ Oozing
☐ Unable to assess # of vessels

GENITALIA
Female ☐ **Normal**
Male ☐ **Normal**
☐ Epispadias ☐ Hypospadia ☐ Hydrocele
☐ Undescended testicle ☐ Rt. ☐ Lt.
Ambiguous ☐

EXTREMITIES ☐ **Normal**
☐ Asymmetrical ☐ Limited ROM
☐ Non-palpable femoral pulses ☐ Rt. ☐ Lt.
☐ Hip clicks ☐ Rt. ☐ Lt.
☐ Polydactylism
☐ Abnormal foot position ☐ Rt. ☐ Lt.

SPINE ☐ **Normal**
☐ Asymmetry ☐ Mass
☐ Dimple ☐ Tuft of Hair

ANUS ☐ **Normal**
☐ Imperforate anus ☐ Fistula

REFLEXES ☐ **Present**
Not present: ☐ Moro ☐ Suck ☐ Grasp ☐ Root

CRY ☐ **Normal**
☐ Weak ☐ Shrill ☐ Hoarse
☐ Prolonged duration

Nurse's Comments: ☐ **See IPN**

_____

_____

Signature: _____ Date: _____ Time: _____

PHYSICIAN/MIDWIFE NOTIFICATION

Dr. _____ notified at _____ hrs. of _____ (D/M/Y) by _____