

NEWBORN EVALUATION



Baby's Name _____ AM PM
 Time of Birth: _____
 _____ Male Female _____
 Date of Birth _____
 NEP Chart Name _____ Room Number _____

Attend NEP Prenatal: Yes No
 RK DL AM TP JD

Mother's Name _____
 Last _____ First _____ Occupation _____

Obstetrician: _____

Father's Name _____
 Last _____ First _____ Occupation _____

Pediatrician to Follow:
 N.E.Peds Stamford N.C.
 Other: _____

Address
 Street _____ City _____ State _____ Zip _____

Contact Phone Number _____

Siblings

Name _____	Age _____	Name _____	Age _____
Name _____	Age _____	Name _____	Age _____

Newborn Family History

Pregnancy
 Age/G/P: _____
 Weeks Gestation: _____
 Meds/Complications: _____

Maternal Screen
 Blood Type: _____ Mother _____ Baby _____
 Coombs: _____
 HIV: _____
 GBS: _____
 Other: _____

Hep B: _____
 RUB: _____
 VDRL: _____
 GC: _____
 Chlamydia: _____

Birth History
 Delivery: NSVD VBAC
 C/S FOR
 APGARS
 1 min.- _____
 5 min.- _____

WT _____
 LT _____
 HC _____
 Hearing Screen:
 L _____ R _____

Hep B Disc: Yes
 Give Hep B: No Yes
 Date Given: _____
 Circumcision: No Yes
 Permit Obt: _____
 Block: _____ By: _____

Feeding Plan: Breast Bottle
 Mom to Work: No Yes
 When: _____
 Child Care Plans: _____

Hospital Course:

Daily Weights	Grams	Lbs.
Day 1	_____	_____
Day 2	_____	_____
Day 3	_____	_____
Day 4	_____	_____

Admission Findings / Clinical Course:

Date	Lab/Test Result
_____	_____
_____	_____
_____	_____

Discharge
 Discharge Date: _____ First Visit To Be: _____
 D/C WT: _____ Discharge Guidelines Given: Yes No
 D/C DX: _____ Enroll baby Reminder: _____
 (Name of Insurance Plan) _____