NEWBORN NURSING ASSESSMENT

Birth Date	Birth Time	Sex	Band #
Birth Wt (g)	Head Circ. (cm)	Length (cm)	

Blood Group
Mother Baby Coombs

Feeding ☐ Breast ☐ Exclusive ☐ With suppl. ☐ Formula

GESTATIONAL AGE ASSESSMENT

	< 37 WEEKS (Preterm)	≥ 37 WEEKS (Term)
BREAST TISSUE	☐ ≤ 3 mm	☐ > 3 mm
PLANTAR CREASES	☐ Smooth, Single Crease	☐ Covering Ant. 1/3 or More
EAR	☐ Relatively Flat, Pliable	☐ Stiff Cartilage, Deep Crease at Outer Aspect
GENITALIA Male	☐ Testes in Canal	☐ Testes well within Scrotum
Female	☐ Labia Minora visible	☐ Labia Majora cover Minora

GESTATIONAL AGE

By Dates _____________wks.

By Assessment _________wks.

HEAD TO TOE ASSESSMENT

	NORMAL	ABNORMAL (comment on abnormalities)
1. GENERAL APPEARANCE	☐	☐
2. SKIN	☐	☐ Bruising ☐ Peeling ☐ Petechiae ☐ Jaundice ☐ Meconium Stain ☐ Other ☐ Edema ☐ Soft tissue wasting ☐ Moderate ☐ Severe
3. HEAD	☐	☐ Overriding suture ☐ Molding ☐ Caput ☐ Hematoma ☐ Other
4. EENT	☐	☐ Cleft Lip/Palate ☐ Other ☐ Suspected Choanal Atresia
5. RESP	☐	☐ Grunting ☐ ↓ Breath Sounds ☐ Nasal Flaring ☐ Tachypnea ☐ Retracting ☐ Other
6. CVS	☐	☐ Murmur ☐ Central Cyanosis ☐ Arrhythmia ☐ Absent Femoral Pulses ☐ Tachycardia ☐ Other
7. ABDOMEN	☐	☐ Scaphoid ☐ Other ☐ Distended
8. UMBILICAL CORD	☐	☐ Meconium Stain ☐ Thin ☐ 2 Vessels ☐ Other
9. MUSCULO-SKELETAL	☐	☐ Spine ☐ Foot abnormal ☐ Hip abnormal ☐ Other ☐ Clavicle
10. GENITO-RECTAL	☐	☐ Hydrocele ☐ Imperforate anus ☐ Hypospadias ☐ Other ☐ Undescended testes
11. CNS	☐	☐ ↓Tone ☐ ↑Tone ☐ Other ☐ Abnormal Cry ☐ Jittery

Date ______________________________ Time __________________________________

Signature ____

☐ Erythromycin eye ointment given ☐ Yes ☐ **NO**

☐ Vitamin K Dose / Route __________________

Given by ____________________________________

Newborn Screening: ☐ Discussed ☐ Done ☐ Arranged

CCHD Screening:

Age at initial screen: hours

R. Hand	Foot	% Diff	Action
			P / R / F
			P / R / F
			P / F

P=Pass / R=Repeat / F=Fail

☐ Further Assessment Required ☐ See Notes
☐ Screening Declined
☐ Not Clinically Appropriate

Date: ____________________ Time: ____________

Signature: ____________________________________

DISCHARGE Weight ____________ g

☐ Physician assessment completed
☐ Order for discharge written

Feeding: ☐ Breast ☐ Exclusive ☐ With suppl
☐ Formula ______________________
☐ Medically indicated
☐ Well Established
☐ Problems Ongoing

Follow-up Plan: ______________________________
____
____

COMMENTS

Date ______________ Time ________________

Signature ____________________________________