



# Initial Newborn Weight and Color Check

## PROGRESS NOTE

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

### PARENTS' CONCERNS

Parents, what concerns do you have about your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Answer the questions below and / or check YES or NO.

PATIENT HISTORY	PHYSICIAN'S COMMENTS																				
<p><b>D E L I V E R Y</b></p> <p>🍼 Birth Date ____/____/____ Birth Weight: _____</p> <p>Discharge Date ____/____/____ Discharge Weight: _____</p> <p>Gestational age _____ weeks</p> <p>How was your baby delivered? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section → Why?</p> <p>Hospital: <input type="checkbox"/> St.Elizabeth's <input type="checkbox"/> BryanLGH <input type="checkbox"/> East <input type="checkbox"/> West (LGH)</p> <p>Obstetrician: _____</p> <p><b>Y N</b></p> <p><input type="checkbox"/> Did you have any prenatal problems?</p> <p><input type="checkbox"/> Did baby have any problems after delivery?</p>	<p><input type="checkbox"/> Responds to sounds</p> <p><input type="checkbox"/> Observe temperament</p> <p><input type="checkbox"/> Demonstrates quieting response</p> <p><input type="checkbox"/> Put to bed while baby is awake</p> <p><input type="checkbox"/> Increased crying over next 6-12 weeks, esp. at night.</p>																				
<p><b>F A M I L Y</b></p> <p><b>Y N</b></p> <p><input type="checkbox"/> Is mother experiencing any "baby blues?"</p> <p><input type="checkbox"/> Is there a family history of inheritable diseases? What?</p> <p><input type="checkbox"/> Are there any stresses in the family? If yes, what?</p> <p>Are there any smokers in your child's home?  <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room</p>	<p><input type="checkbox"/> Call with rectal temp &gt;100.5°</p> <p><input type="checkbox"/> Discussed risks of 2<sup>nd</sup> hand smoke.</p>																				
<p><b>N U T R I T I O N</b></p> <p><b>FORMULA FEEDING:</b>          How many ounces in 24 hrs? _____ What formula? _____</p> <p><b>BREAST FEEDING:</b>          How many months do you plan to breast feed?          How many times does baby nurse in 24 hrs?          How many minutes is each feeding?</p> <p>Has your milk come in yet? <input type="checkbox"/> No <input type="checkbox"/> Yes → when?  <b>Y N</b> <input type="checkbox"/> Coming in now</p> <p><input type="checkbox"/> Does baby have trouble latching on?  <input type="checkbox"/> Have you given supplemental formula?  <input type="checkbox"/> Have you pumped breast milk?</p>	<p><b>BREAST FEEDING RECOMMENDATIONS</b></p> <p><input type="checkbox"/> Night feedings maintain milk supply.</p> <p><input type="checkbox"/> 8-12 feedings in 24 hrs is typical.</p> <p><input type="checkbox"/> Duration of 20-50 minutes is normal.</p> <p><input type="checkbox"/> Don't restrict feedings / Feed on demand.</p> <p><input type="checkbox"/> Expect growth spurt at 1-3 weeks old.</p> <p><input type="checkbox"/> Don't overuse the pacifier. Is baby hungry?</p> <p><input type="checkbox"/> Vitamins usually not necessary.</p>																				
<p>How many of each per day? _____</p> <p>spit ups _____ wets _____ stools _____</p> <p style="text-align: right;"><u>Stool color?</u>          black green          brown mustard</p>	<p><b>STOOLING EXPECTATIONS</b></p> <p><input type="checkbox"/> <b>BREAST FED:</b> By 1 week old, expect 6 wets and 3-4 mustard stools per day.</p> <p><input type="checkbox"/> <b>FORMULA FED:</b> Stool frequency is variable, but should not be hard balls.</p>																				
PHYSICAL EXAM	LAB																				
<p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>Check if normal:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Jaundice to _____</td> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Head/Fontanel</td> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red reflexes</td> <td><input type="checkbox"/> Throat</td> <td><input type="checkbox"/> Femoral pulses</td> <td><input type="checkbox"/> Extremities</td> </tr> <tr> <td><input type="checkbox"/> Ears</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Genitalia</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p><small>NOTE EXAM ABNORMALITIES HERE</small></p>	<input type="checkbox"/> Jaundice to _____	<input type="checkbox"/> Nose	<input type="checkbox"/> Lungs	<input type="checkbox"/> Back	<input type="checkbox"/> Head/Fontanel	<input type="checkbox"/> Mouth	<input type="checkbox"/> Heart	<input type="checkbox"/> Hips	<input type="checkbox"/> Eyes/Red reflexes	<input type="checkbox"/> Throat	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Extremities	<input type="checkbox"/> Ears	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin		<input type="checkbox"/> Chest	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Neurologic	<p>State Newborn Screens <input type="checkbox"/> Pending <input type="checkbox"/> Normal</p> <p>Supplemental Newborn Screens <input type="checkbox"/> Pending <input type="checkbox"/> Discussed but declined</p> <p><input type="checkbox"/> DAT</p> <p><input type="checkbox"/> Blood types: Mom _____ Baby _____</p> <p><input type="checkbox"/> Bilirubin</p>
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ASSESSMENT	PLAN																				
<p>1. <input type="checkbox"/> Appropriate weight loss / gain for age. <input type="checkbox"/> Inadequate weight gain for age.</p> <p>2. <input type="checkbox"/> Jaundice</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>1. <input type="checkbox"/> Follow up in _____ days for weight check.</p> <p>2. <input type="checkbox"/> Follow up in _____ days for bili check. <input type="checkbox"/> Start phototherapy (see bili flow sheet)</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p><input type="checkbox"/> Follow up at 1 mo for Health Review. <input type="checkbox"/> Anticipatory handouts given.</p>																				

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   Do you have concerns about baby's development or behavior?	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby look at your face and follow you with his/her eyes? <input checked="" type="checkbox"/> <input type="checkbox"/> Does s/he startle to sound? <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby move arms and legs equally? <input checked="" type="checkbox"/> <input type="checkbox"/> Are arms and legs flexed? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you think your baby cries a normal amount of time? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you allow baby to self-quiet? <input checked="" type="checkbox"/> <input type="checkbox"/> Does baby hiccup, sneeze and strain a lot? (This is very common)	
S L E E P	How many hours does baby sleep at a time? _____
	<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Do you put baby down awake? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you put him/her down on his/her back? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid bulky bedding in the crib? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you alternate baby's head position to prevent flattening of the skull?
	Where does baby sleep?

SAFETY AWARENESS	
<b>Y N</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Is baby's car seat rear facing in the back seat? (Do this until 1 yr old AND 20 lbs) <input checked="" type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you monitor baby closely around young siblings or pets? <input checked="" type="checkbox"/> <input type="checkbox"/> Do you avoid putting necklaces or pacifiers on strings around baby's neck? <input checked="" type="checkbox"/> <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage?	

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**