

NEWBORN EVALUATION



Baby's Name _____

Time of Birth: _____ AM PM

_____ Male Female

_____ Date of Birth _____

NEP Chart Name _____ Room Number _____

Attend NEP Prenatal: Yes No

RK AM TP JD EC GC

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: _____ Initial _____

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: _____

D/C WT: _____

D/C DX: _____

First Visit To Be: _____

Discharge Guidelines Given: Yes No

Enroll baby Reminder: _____

(Name of Insurance Plan)