Your Hospital's Logo Here

NEONATAL DELIVERY TEAM CONSULT

PATIENT IDENTIFICATION

NAME:	SEX: ☐ F ☐ M	TIME ARRIVED IN DR: (Military Time)	
DATE OF BIRTH:	TIME OF BIRTH: (Military Time)	TIME DEPARTED IN DR: (Military Time)	
OB:	PEDS:	APGARS: 1 '	5 ' 10 '

REASON FOR REFERRAL:

ASSESSMENT

TIME (Military)	HEART RATE	RESP.	COLOR	OTHER

D.R. CARE:

☐ SUCTION ☐ OXYGEN ☐ IPPV w/ MASK ☐ IPPV w/ ETT ☐ DIRECT LARYNGO ☐ CPR ☐ OTHER

MEDS GIVEN

	DOSE	TIME (Military)	INITIALS
BICARB.			
EPINEPH.			
DEXTROSE			
VOLUME			
OTHER			

RN SIGNATURE / TITLE:	MD / NNP SIGNATURE:

DELIVERY ROOM CONSULT NOTE:

MD / NNP SIGNATURE:

WHITE - Medical Records **YELLOW - Mother's Copy** **PINK - Physician's Copy**