University Medical Center

Newborn Admission / Discharge Record

Addressograph

Birth Date: ____________ Time: ____________ Gestational Age __________ wks SGA ______ AGA _______ LGA ______
Blood Type: Mother: _______ Infant: _______ Coombs: _______ (+ or -) Serology ______ HbSAg ______ Elisa ______
Rubella immune / non-immune (circle one): GBS (+ or -) ________ GBS Rx (antibiotic and date / time of Rx) ______________

Delivery Information

Significant maternal history: ______________________________
Maternal age: _________ G ____ P ____ Maternal meds: ______________________________
Mode of delivery: NSVD _____ Forceps _____ Vacuum _____ C-Section ____ Reason for C-S ______________
Presentation: Vertex ____ Breech ____ Other (describe): ____________ ROM (date & time): ______________
Apgar score: 1 min ____ 5 min ____ 10 min ____ Meconium: none _______ thin _____ thick ______
Delivery Room: Routine care _______ Oxygen ________ Bag / mask ________ Intubate _______
Additional details: ______________________________

Admission

Weight ______ gm Length _______ cm HC ______ cm
(______ lbs) (______ in) (______ in)
(✓ normal, X= abnormal & comments)

		Comments
Activity/Appearance	{ }	____________
Color	{ }	____________
Head/Fontanelles	{ }	____________
Eyes/red reflex	{ }	____________
Nose	{ }	____________
Mouth/palate	{ }	____________
Clavicles	{ }	____________
Respirations/breath sounds	{ }	____________
Heart	{ }	____________
Pulses	{ }	____________
Abdomen/umbilicus	{ }	____________
Anus	{ }	____________
Genitalia	{ }	____________
Extremities / hips	{ }	____________
Neurological	{ }	____________
Spine	{ }	____________
Other	{ }	____________

Comments:

Assessment / Diagnosis:

Plan: Routine care { }
Additional:

____________________ MD Date: ________ Time: _______

Discharge

Weight ______ gm HC ______ cm
(______ lbs) (______ in)
(✓ normal, X= abnormal & comments)

		Comments
Activity/Appearance	{ }	____________
Skin/rashes	{ }	____________
Head/Fontanelles	{ }	____________
Eyes/red reflex	{ }	____________
Respirations/breath sounds	{ }	____________
Heart	{ }	____________
Pulses	{ }	____________
Abdomen/umbilicus	{ }	____________
Genitalia	{ }	____________
Hips	{ }	____________
Extremities	{ }	____________
Neurological	{ }	____________
Other	{ }	____________

Significant lab results / tests:

Hearing screen: Pass ☐ Refer: R ☐ L ☐ Both ☐
Circumcision: Yes ☐ No ☐
Highest bilirubin (mg / dl) ____________ Date: ___________
Discharge bilirubin (mg / dl) ____________ Date: ___________
Treatment: ______________________________

Discharge Instructions: Reviewed (if done)
☐ Breast/Bottle feeding ☐ Sleep Position
Car seat trial (if < 37 wks) ☐ Pass ☐ Fail
Pediatrician: ______________________________
Follow-up visits: ______________________________
Medications: Immunizations:

Diagnosis:

Comments:

____________________ MD Date: ________ Time: _______