British Columbia Community Newborn Assessment Checklist

HEALTH CENTRE/HEALTH AUTHORITY

SURNAME	GIVEN NAME(S)	DATE OF BIRTH: year	month	day	time
MOTHER'S SURNAME (if different from newborn's)		NURSING PRIORITY SCORE, IF USED TOTAL:		DATE:	

OUTCOME CODES ✓ - No apparent problem * **OBS** - Observe * **TRP** - Under treatment * **UNR** - Unresolved
X - Not assessed * **REF** - Referral * **TRC** - Treatment complete **Y** - yes **N** - No

Those items with an * asterisk require a narrative explanation on the Variance Record.

Date (y/m/d)				
Time (24 hour clock)				
P.P Hours (utilize hours to 96 h, then utlize number of days)				
Contact Type (HV = Home Visit TC = Telephone Call OV = Office Visit FV = Facility Visit)				
Assessment Items				
Cry (including Shaken Baby Syndrome)				
Behaviour				
Health Follow-up				
Immunization				
Safety and Injury Prevention (including SIDS)				
Physiological Items				
Head				
Eyes				
Ears / Hearing				
Mouth				
Chest				
Umbilicus				
Skeletal / Extremities				
Skin				
Neuromuscular				
Genitalia				
Elimination | **Voids/Stools**				
Vital Signs | **Temp / HR / Resp**				
Weight (grams)				
Infant Feeding				
Feeding				
Feeding - Breastmilk 100% (Y or N)				
Feeding - Mixed Milk (Y or N)				
Feeding - Breastmilk Substitute (Y or N)				
Other Needs/Concerns (specify):				
SIGNATURE OR INITIAL				

Variance Record

DATE	TIME	FOCUS	