

British Columbia Newborn Record Part 1

1. Mother's Name _____ Age _____ Mother's Hospital ID # _____

Surname of Newborn _____ Partner's Name _____ Age _____

G ____ T ____ P ____ A ____ L ____ EDD / / by LMP US

Blood Group: _____ Rh: _____ Antibodies: _____

Risk Factors for Infant (Refer to Antenatal Record, Part 2)
 Exposure to Substances: Tobacco Alcohol Medication
 Other _____
 Other Risks: _____

Hospital Name _____ Date _____

Surname _____ Given Name _____

Address _____

Phone Number _____

Personal Health Number _____ Physician / Midwife Name _____

2. Apgar Score

	0	1	2	1 Min.	5 Min.	10 Min.
Heart Rate	Absent	< 100	> 100			
Resp. Effort	Absent	Weak Cry Hypo-ventilation	Good Crying			
Muscle Tone	Limp	Some Flexion	Active Motion			
Resp. to Stim	None	Grimace	Active Withdrawal			
Colour	Blue Pale	Acro-cyanosis	All Pink			
Apgar Total Score						

3. Transition to One Hour of Age

Positioned: Skin-to-Skin Radiant Warmer Other: _____

Amniotic Fluid: Clear Meconium Bloody

Suction: Oropharyngeal Trachea Mec. Below Cords Stomach Aspirated

Oxygen: None Free Flow Start _____ min. Stop _____ min.
 IPPV per mask Start _____ min. Stop _____ min.
 See Expanded Resuscitation Form

Cord Gases: Done (see lab results) Not Done

Temperature: _____ °C Pulse Oximetry: Yes No

Heart Rate: _____ Time to HR ≥100 _____ min. _____ sec.

Respirations: _____ Time to Spontaneous Breathing _____ min. _____ sec.

SIGNATURE _____ SIGNATURE _____ SIGNATURE _____
 RM/RN RM/RN MD

4. Delivery

Birthdate / / Time _____

Delivery Type _____ Newborn Hospital # _____

Identified at Birth by:
 SIGNATURE: _____ RN/RM

Identified at Transfer by: (if applicable)
 SIGNATURE: _____ RN/RM

Voided Yes No Passed Meconium Yes No

Breastfeeding Planned Yes No

8. Physical Examination at Birth (Including Stillbirths)

Gestational Age from Antenatal History _____ wks. Gestational Age by Exam (see reverse Part 2) _____ wks.

Male Female
 Undifferentiated

	Normal	Abnormal	Comments
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/> Pallor <input type="checkbox"/> Bruising <input type="checkbox"/> Petechiae	<input type="checkbox"/> Mec. Staining <input type="checkbox"/> Peeling <input type="checkbox"/> Jaundice
3. Head	<input type="checkbox"/>	<input type="checkbox"/>	
4. EENT	<input type="checkbox"/>	<input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Micrognathia	<input type="checkbox"/> Suspected Choanal atresia
5. Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Grunting <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Retracting	<input type="checkbox"/> Shallow Breathing <input type="checkbox"/> Tachypnea
6. CVS	<input type="checkbox"/>	<input type="checkbox"/> Murmur <input type="checkbox"/> Central Cyanosis	<input type="checkbox"/> Abn./ Delayed Femoral Pulses <input type="checkbox"/> Abnormal Rate/Rhythm
7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/> Scaphoid <input type="checkbox"/> Distended <input type="checkbox"/> Hepatomegaly	<input type="checkbox"/> Splenomegaly <input type="checkbox"/> Abnormal Mass
8. Umbilical Cord	<input type="checkbox"/>	<input type="checkbox"/> Mec. Stained <input type="checkbox"/> 2 Vessels	<input type="checkbox"/> Thin
9. Genito-rectal	<input type="checkbox"/>	<input type="checkbox"/> Hypospadias <input type="checkbox"/> Imperforate Anus	<input type="checkbox"/> Undescended Teste(s)
10. Musculo-skeletal	<input type="checkbox"/>	<input type="checkbox"/> Spine <input type="checkbox"/> Hip Abnormality	<input type="checkbox"/> Extremity Abnormality
11. Neuro-logical	<input type="checkbox"/>	<input type="checkbox"/> Hypotonia <input type="checkbox"/> Cry	<input type="checkbox"/> Jittery <input type="checkbox"/> Reflexes
12. Other			

DATE _____ TIME _____ SIGNATURE _____
 MD/RM

5. Routine Procedures

Cord Blood Rh Other _____

Eye Prophylaxis
 Erythromycin Other: _____ Time _____
 Informed Refusal

SIGNATURE _____ RN/RM

Vitamin K
 PO IM Dosage _____ Site _____ Time _____
 Informed Refusal

SIGNATURE _____ RN/RM

6. Evaluation of Development

(growth chart and curve on reverse)

Birthweight _____ g _____ %

Length _____ cm _____ %

Head Circumference _____ cm _____ %

Preterm Term Postterm
 SGA AGA LGA

7. Stillbirth

	No	Yes
Macerated	<input type="checkbox"/>	<input type="checkbox"/>
IUGR	<input type="checkbox"/>	<input type="checkbox"/>
Retroplacental Clot	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Autopsy Consented	<input type="checkbox"/>	<input type="checkbox"/>
Obvious Anomaly (describe below):	<input type="checkbox"/>	<input type="checkbox"/>

umbilical cord length _____ cm

British Columbia Newborn Record Part 2

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9. dd/mm/yyyy Hearing Screening (completed by BC Early Hearing Program)
 Yes Passed
 Passed with Risk Factors for Delayed Onset
 No Declined N/A
 Comment: _____
 Needs Follow-up: (by BC Early Hearing Program)
 Additional Screening Diagnostic Assessment Other _____

Hospital Name _____ Date _____
 Surname _____ Given Name _____
 Address _____
 Phone Number _____

10. dd/mm/yyyy Metabolic Screening
 Blood Dot Card Collected: Age (h) _____ Yes No Comment: _____
 Bilirubin Screening: Age (h): _____ Yes No Comment: _____ (nomogram on reverse)

Personal Health Number _____ Physician / Midwife Name _____

11. dd/mm/yyyy Prophylaxis
 HBsAg Prophylaxis Indicated: Yes No HBIG Given Hepatitis B Vaccine Given
 HIV Prophylaxis Indicated: Yes No HIV Prophylaxis Initiated
 Group B Strep Intrapartum Prophylaxis: Yes No Comment: _____

12. dd/mm/yyyy Newborn Nutrition
 Breastfeeding Initiated: ≤1 h >1-2 h >2-24 h > 24 h N/A Comment: _____
 Exclusive Breastmilk Partial Breastmilk Breastmilk Substitute Supplementation Indication: _____

13. dd/mm/yyyy Problem List	Date Resolved dd/mm/yyyy
ACoRN Sequences Initiated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See Narrative Notes	

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14. dd/mm/yyyy Progress Notes

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15. Discharge Examination
 Newborn Age: ≤12h 13-24 h 25-48 h 49 - 72 h >72 h
 Head Circumference _____ cm Weight: _____ g Weight loss: _____ %

	Normal	Abnormal	Comment
1. General	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	
3. Head	<input type="checkbox"/>	<input type="checkbox"/>	
4. EENT	<input type="checkbox"/>	<input type="checkbox"/>	
5. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
6. CVS	<input type="checkbox"/>	<input type="checkbox"/>	
7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
8. Umbilical Cord	<input type="checkbox"/>	<input type="checkbox"/>	
9. Genitorectal	<input type="checkbox"/>	<input type="checkbox"/>	
10. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
11. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
12. Other	<input type="checkbox"/>	<input type="checkbox"/>	

16. Status at Discharge

 Exclusive Breastmilk Partial Breastmilk Breastmilk Substitute
 Comment: _____

Problems Requiring Follow-up:

17. Discharged
 Home Adoption Foster Home Other Hospital _____
 Other specify _____

18. Follow-up by dd/mm/yyyy

<input type="checkbox"/> Family Physician	_____
<input type="checkbox"/> Midwife	_____
<input type="checkbox"/> Pediatrician	_____
<input type="checkbox"/> Other Consultant	_____
<input type="checkbox"/> Public Health Nurse	_____
<input type="checkbox"/> Ministry for Children & Family Development	_____

Neonatal Death
 Autopsy Consented

Date _____ SIGNATURE _____
 dd/mm/yyyy MD/RM

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Ballard Assessment of Gestational Age

Neuromuscular Maturity

Score	-1	0	1	2	3	4	5
Posture							
Square window (wrist)							
Arm recoil							
Popliteal angle							
Scarf sign							
Heel to ear							

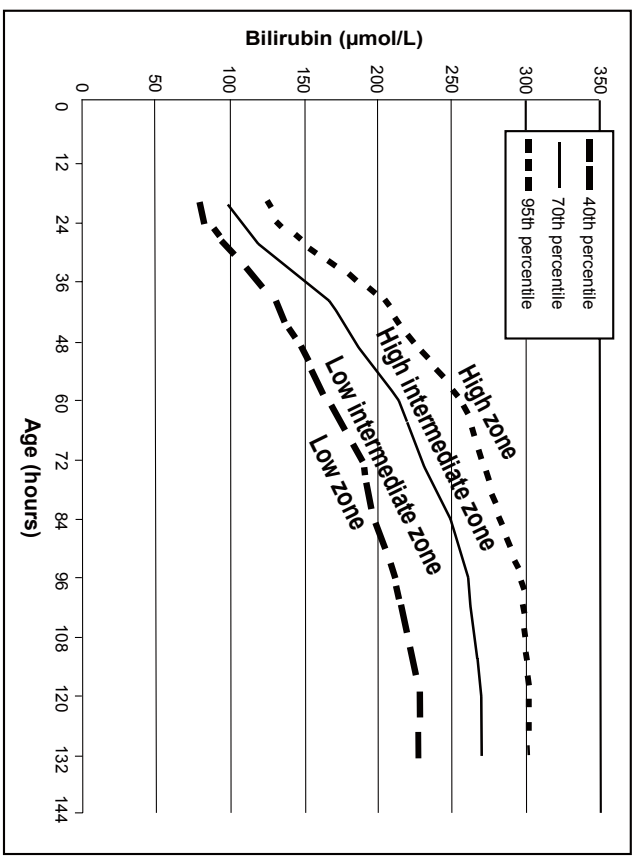
Physical Maturity

	Score	Weeks
Skin	Sticky, friable, transparent	Leathery, cracked, wrinkled
Lanugo	None	Maturity Rating
Plantar surface	Heel-toe 40-50 mm; -1 <40 mm; -2	-10 20
Breast	Imperceptible	-5 22
Eye/Ear	Lids fused loosely; -1 lids slightly; -2	0 24
Genitals (male)	Scrotum flat, smooth	5 26
Genitals (female)	Clitoris prominent, labia flat	10 28
		15 30
		20 32
		25 34
		30 36
		35 38
		40 40
		45 42
		50 44

Source: Ballard JL, Khoury JC, et al: New Ballard Score, expanded to include extremely premature infants. *J Pediatrics* 1991; 119:417-423.

Evaluation of screening total bilirubin

1. Use for term and later preterm newborns (≥ 35 weeks' gestation)
2. Plot the total serum bilirubin on this figure
3. Refer to the table below for action to be taken



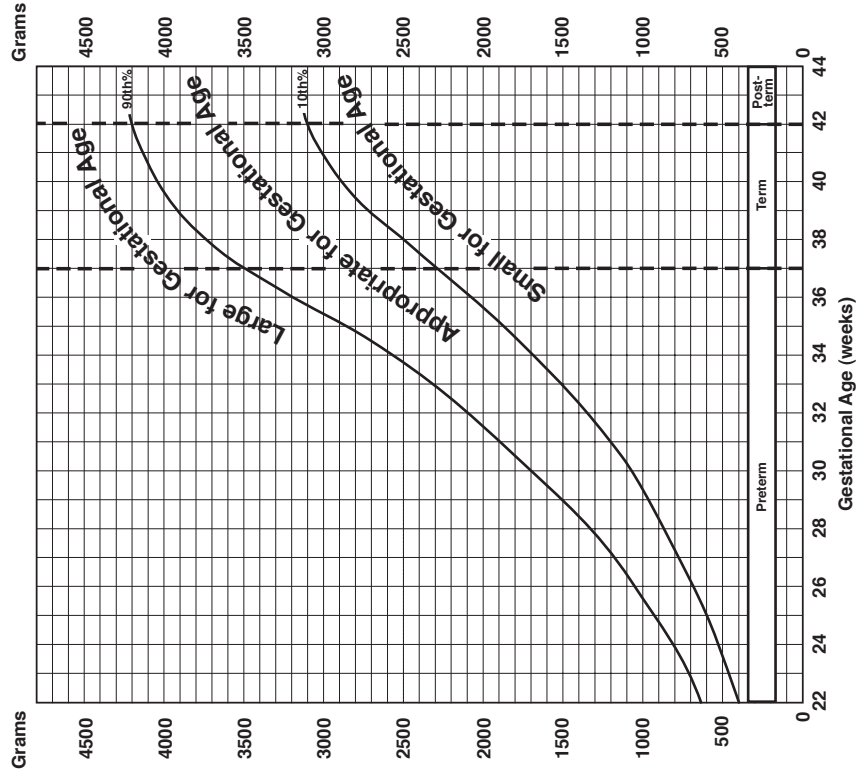
Response to results of bilirubin screening

Zone	Greater than 37 weeks' gestation and DAT-negative	35 to 37 6/7 weeks' gestation or DAT-positive	35 to 37 6/7 weeks' gestation and DAT-positive
High	Further testing or treatment required*	Further testing or treatment required*	Phototherapy required
High-intermediate	Routine care	Follow-up within 24 h to 48 h	Further testing or treatment required*
Low-intermediate	Routine care	Routine care	Further testing or treatment required*
Low	Routine care	Routine care	Routine care

*Arrangements must be made for a timely (eg within 24 h) re-evaluation of bilirubin by serum testing. Depending on the level indicated in Figure 2 of the CPS guideline, treatment with phototherapy may also be indicated. DAT: Direct antiglobulin test.

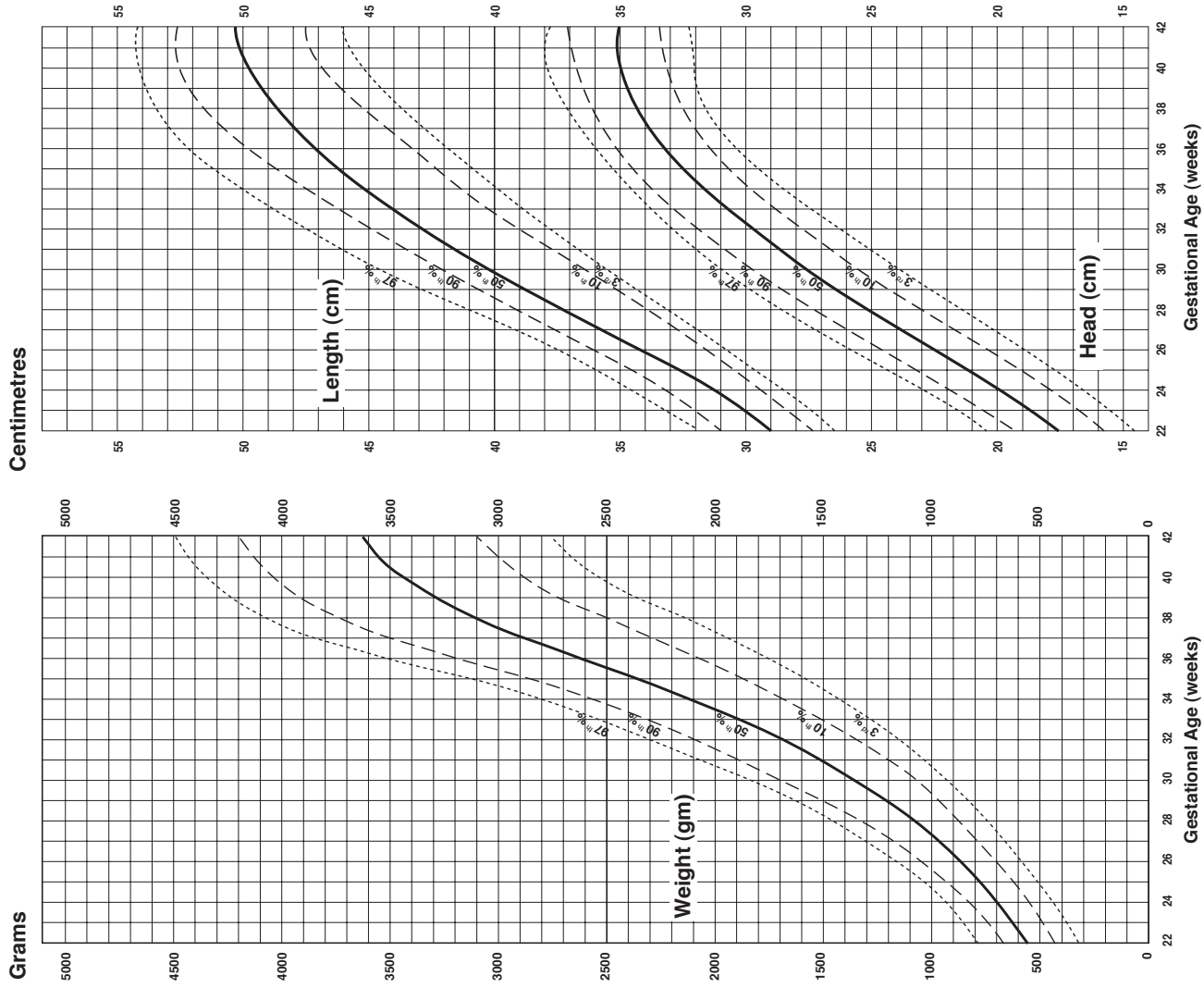
Source: Canadian Paediatric Society, FN 2007-02. Paediatr Child Health Vol 12 Suppl B May/June 2007

Classification of Newborns by Birthweight and Gestational Age



Based on data from Kitchen WH et al, 1983 Aust. Paed. J.19:157, modified by Whitfield MF, with additional data <27 weeks

Intrauterine Growth Chart (both sexes)



Based on data from Kitchen WH et al, 1983 Aust. Paed. J.19:157, modified by Whitfield MF, with additional data <27 weeks