British Columbia
Community Liaison Record
NEWBORN

1

Surname | Given Name(s)

PHN # | Hospital/Place of Birth

Permanent Address (if different from mother)

Phone: ( ) Cell phone: ( )

Temporary Address (if different from mother)

Phone: ( ) Cell phone: ( )

Comments:

Parent/Guardian | Relationship

Family Physician &/or Midwife (if different from mother) | Admitting Physician &/or Midwife (if different from mother)

Hospital consultant/Referral

2 BIRTH SUMMARY

Birthdate	Sex:	Type of birth:	Gestational age
_____ yy/mm/dd _____ Time	☐ M ☐ F ☐ Undifferentiated	☐ SVD ☐ Forceps _____ ☐ Vacuum ☐ C/S	
Birthweight _____ gms Discharge wt (if >24 h) _____ gms	Apgar score 1 min 5 min 10 min	ABO group _____ Rh _____ (if applicable)	HC _____ L _____

Other information (e.g. delivery complications, congenital anomaly)

3 NEWBORN HEALTH & WELL-BEING

Screening Tests & Procedures, Communicable Disease & Exposure

In utero exposure
- Tobacco ☐ No ☐ Yes
- Alcohol ☐ No ☐ Yes
- Substance(s) ☐ No ☐ Yes
- Specify:

Group B Strep exposure ☐ No ☐ Yes
If yes, prophylaxis _____
If no prophylaxis, reason/plan: _____

Hep B prophylaxis indicated ☐ No ☐ Yes
- ☐ HBIG given
- ☐ Hep B vaccine given

Date _____

Serum bilirubin level ☐ N/A
Initial _____ µmol/L at _____ hrs of life
D/C _____ µmol/L at _____ hrs of life
Treatment/follow-up

Blood spot card done
☐ Yes ☐ No
If no: ☐ Deferred ☐ Refused

Initial hearing screen
☐ Yes ☐ No
Needs follow-up
☐ Yes ☐ No
(by BC Early Hearing Program)

Newborn exposure to second-hand smoke
☐ No ☐ Yes

Infection/risk for infection ☐ No ☐ Yes Specify:

4 INFANT FEEDING (at discharge)

☐ Exclusive breastmilk ☐ Partial breastmilk ☐ Breastmilk substitute (specify) _____
☐ Variances (specify) ☐ Feeding plan at d/c

5 ADDITIONAL INFORMATION

Seen by other resources: ☐ Social Worker ☐ MCFD SW ☐ Other (specify) ☐ Follow-up needed (specify)

Community resources, follow-up & how to access: ☐ PHN ☐ PHCP ☐ On reserve (name) _____ ☐ Other (specify)

Comments

6 HOSPITAL DISCHARGE

☐ Home with mother ☐ Other (specify)

Date Time

☐ Seen by liaison nurse (if applic) Date:

Health Unit _____ ☐ Faxed

Signature Discharge RN/Liaison RN/Midwife (for home birth)

WHITE – Community Health YELLOW – Infant's Chart

NURSING PRIORITY SCREENING

A. CHILDREN WITH A CONGENITAL OR ACQUIRED HEALTH CHALLENGE

1. Congenital anomaly
   a) Major (probability of permanent disability) e.g.: Down Syndrome, Cerebral Palsy, FASD 9
   b) Moderate (correction may be possible) e.g.: Cleft palate 6
2. a) Major disability acquired during the first 5 years of life (probability of permanent disability) e.g.: Cerebral Palsy, severe brain damage. 9
   b) Moderate disability acquired during the first 5 years of life (correction may be possible) e.g.: loss of limb 6

B. DEVELOPMENT RISK FACTORS

3. Low birth weight
   a) 0 – 1499 gm 9
   b) 1500 – 1999 gm 8
   c) 2000 – 2499 gm 6
4. Bilirubin level: Treatment/follow-up required as noted by the primary care provider/staff in the acute care setting 8
5. Complications of pregnancy
   a) Infections that can be transmitted in utero and may damage the fetus (e.g.: rubella, HIV) 9
   b) Drugs – e.g.: alcohol or drug use diagnosed in mother 9
6. Complications of labour and birth
   a) Labour – interventions such as vacuum and forceps, vacuum/forceps and C/S 4
   b) Infant trauma or illness (e.g.: convulsions, respiratory distress syndrome) 6
   c) Apgar at 5 minutes only if less than 7. Deduct apgar score at 5 minutes from 10 points . . . . . ---
7. Family history of a disability not detectable at birth that could affect development e.g.: deafness, mental disability 4
8. Developmental concerns not already covered in any above category
   a) Acquired risk of developmental delay due to illness or trauma in first 5 years 6
   b) Delayed developmental assessment in first 5 years. 9

C. FAMILY INTERACTION RISK FACTORS

9. Age of mother
   a) 15 and under 9
   b) 16 or 17 8
   c) 18 or 19 5
10. Social Situation
    a) One parent family with other support available. 2
    b) One parent family – no support available 7
    c) Two parent family – no social support and/or severe isolation related to culture, language or geography 4
11. Financial difficulties 3
12. No prenatal care before sixth month 4
13. Mental illness or disability in mother and/or father
    Double score if both parents positive in (a) or (c)
    a) Schizophrenia or bipolar affective disorder. 7
    b) Postpartum depression or psychosis 9
    c) Mental disability of parent 6
14. Prolonged postpartum maternal separation (5 days or more)
    a) With frequent infant contacts (visits or phone as feasible) 2
    b) Little or no contact. 6
15. Assessed lack of bonding (e.g. minimal eye contact or touching) 6
16. >3 hospitalizations in one year in absence of known chronic illness or condition 7
17. Other – e.g.: marital distress, family violence, low education level, failure to thrive, parenting difficulties, maternal smoking during pregnancy, maternal low/excessive weight gain (score 0-9)
    Specify . . . . . ---

PRIORITY SCORE: 9 and over = *high priority* 6–8 = *moderate priority* 3–5 = *low priority* 0–2 = *minimal priority*

TOTAL PRIORITY SCORE ☐

British Columbia
Community Liaison Record
POSTPARTUM

1

Surname | Given Name(s)

Hospital / Place of Birth

PHN# | Birthdate (yy/mm/dd) | ☐ Interpretation Req'd: Language

Permanent Address

Phone: ( ) | Cell phone: ( )

Temporary Address

Phone: ( ) | Cell phone: ( )

Comments:

Next of Kin | Relationship

Family Physician & / or Midwife | Admitting Physician & / or Midwife

Hospital Consultant / Referral

2 BIRTH SUMMARY

G _____ T _____ P _____ A _____ L _____ (at discharge) | Infant birth date: Date (yy/mm/dd) | Time

Ages of other children | Sex of infant ☐ M ☐ F ☐ Undifferentiated

Type of birth:
☐ SVD ☐ VBAC
Asst vaginal: ☐ Vacuum
Forceps: ☐ Outlet ☐ Low ☐ Mid ☐ Rotation
C/S: ☐ Elective ☐ Emergent
Reason:

Perineum:
☐ Intact
☐ Laceration _____ °
☐ Episiotomy
☐ Repaired

Blood group _____ Rh _____
EBL: ☐ <500 mL
☐ 500–1000 mL
☐ >1000 mL
Allergies: ☐ NKA
☐ Yes _____

Intrapartum analgesia / anesthetic:
☐ No ☐ Yes
Specify

Antibiotics:
☐ No ☐ Yes
Specify

Breasts:
☐ Previous breastfeeding experience Comments _____
☐ Variances / feeding concerns ☐ No ☐ Yes ☐ Plan (specify)

☐ Other information – e.g. birth complications, referrals

3 MATERNAL HEALTH & WELL-BEING

Emotional health & well-being:
☐ Hx Depression ☐ Depression current pregnancy
☐ Medication(s) ☐ IPV
Comments

Lifestyle:
Tobacco use: ☐ Non smoker ☐ Quit before preg ☐ Quit during preg ☐ Current smoker
Alcohol use: ☐ Non drinker ☐ Quit before preg ☐ Other _____
Substance use: ☐ No ☐ Yes _____
Other

Tests & Procedures, Communicable Diseases & Exposure

Rubella status: ☐ Immune ☐ Non-immune
MMR Given: ☐ No ☐ Yes Date

Rh immune globulin
☐ Given: Date

Hep B
☐ Neg ☐ Positive

Exposure to / or other communicable disease: ☐ No ☐ Yes (specify, e.g. Hep. C)

4 ADDITIONAL INFORMATION

Seen by hospital resources: ☐ Lactation Consultant ☐ Social Worker ☐ Other (specify) ☐ Follow-up needed (specify)

Support at home (specify)

Other information:

Community resources, follow-up & how to access: ☐ PHN ☐ PHCP ☐ On reserve (name) _____ ☐ Other (specify)

Given PURPLE Crying materials ☐ Yes ☐ No | Has *Baby's Best Chance* ☐ Yes ☐ No | Prenatal education accessed ☐ Yes ☐ No

5 HOSPITAL DISCHARGE

☐ To home ☐ Other (specify) _____
Date | Time

Mother D/C with baby ☐ Yes ☐ No
Comment

☐ Seen by liaison nurse (if applic) Date:

Health Unit _____ ☐ Faxed

Signature Discharge RN / Liaison RN / Midwife (for home birth)

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