Appendix A-2

Newborn Health Visit / Early Head Start

DATE: _____

Name: _____ DOB: _____/ _____/ _____ Gender: Male / Female

Parent's Name: _____

Baby's HCP: _____ Mother's HCP: _____

BIRTH WEIGHT	LENGTH@BIRTH	BABY		MOTHER	
		____	active, good color	____	Good
		____	sleeping, good color	____	OK
		____	jaundiced, lethargic	____	Fair
		____	other	____	Poor

Interval History:

Gest. Age at delivery: _____

APGAR score: 1 min. _____ 5 min. _____

Medications:

_____

_____

Injury or Illness:

_____

_____

Special Health Care Needs:

_____

_____

Visits to health care providers or facilities:

_____

_____

Change/Stressors in family or home:

_____

_____

Notes:

_____

_____

_____

Questions for Parent:

How are you feeling? _____

_____

How did delivery go? _____

_____

Delivery Location:
_____Hospital _____BC _____ Home _____Other

Type of Delivery:
_____Vaginal _____Cesarean Section

Length of baby's hospital stay:
_____Routine _____Non-routine (< one week)
_____One week to one month
_____Over one month

Reason for non-routine hospital stay:

_____

_____

What do you other children think about the new baby?

_____

_____

What are you questions about feeding the baby?

_____

_____

What questions or concerns would you like to discuss today?

_____

_____

Anticipatory Guidance Healthy Habits

_____ Car Seat
_____Crib Safety
_____Sleep on back
_____Water Temperature <120
_____Keep hand on baby
_____Smoke-Free environment
_____Hot liquids, cigarettes
_____Signs of illness
_____Emergency procedures

Nutrition

_____Successful breastfeeding practices (positioning, latching on, feeding on cue)
_____6-8 wet diapers per day
_____Maternal care (rest, nipple care, eating properly, follow up support)
_____Formula (preparation, equipment, semi-sitting position)
_____No bottle in bed or microwave

Infant Care

_____Cord
_____Intact penis or circumcision care
_____Vaginal discharge, bleeding
_____Skin, nails
_____Crying
_____Sneezing, hiccups
_____Burping, spitting up
_____Thumb sucking, pacifiers
_____Sleep patterns, arrangements
_____Meconium to transitional stools
_____Thermometer use
_____Layers of clothing

Parent/Infant Interaction

_____Baby's temperament
_____Console baby
_____Hold, cuddle, rock
_____Talk, sing

Family Relationships

_____Partner Involvement
_____Rest, fatigue, depression
_____Support from family/friends
_____Siblings' reactions: _____
_____

_____

_____

Other Needs:

_____Offer materials for review at home on child safety, childproofing home, breastfeeding

_____Suggest resources to help with breastfeeding

_____Provide information about parenting classes or support groups

_____Suggest community resources

_____Discuss how to access health care

Referrals

_____Health insurance/Medicaid
_____SSI
_____Part C
_____WIC
_____Food Stamps
_____Social Services
_____Housing
_____Other:
_____
_____
_____
_____

Mother's Signature: _____

Father's Signature: _____

EHS Health Staff Signature: _____