Newborn Admission Report

Use this template to standardize communication between L&D nurse and receiving newborn/postpartum nurse

Newborn Background

☐ Newborn name
☐ Delivery provider & anticipated Pediatric provider
☐ Gestational age (weeks/days)
☐ Birth weight

Maternal and Delivery History

☐ Maternal history and pertinent risk factors
  • Delivery type (SVD, CS, Vacuum/Forceps)
  • Medical History/medication (Preeclampsia, Magnesium, GDMA, PTL, exposures, other)
  • Apgars and Newborn resuscitation requirements?

☐ Maternal blood type and status of infant cord blood

☐ GBS status (positive, negative, unknown)
  • If positive type of antibiotics, time of first dose, and number of doses

☐ Rupture of membranes (date/time)
  • Color
  • Total hours

☐ Chorioamnionitis/Intraamniotic infection concerns
  • Highest maternal temp recorded (24 hrs prior to birth & 1hr postpartum)
  • Antibiotics given?
    • Type & Time of first dose

Newborn Status

☐ Basic infant assessment
  • Vital signs and assessment
  • NEOSC completed? Recommendations?

☐ Feeding preference
  • Last feed
  • Glucose check?