Newborn Admission Report

LD RN → Newborn RN

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

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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?